Section 29 Case Meeting

7 February 2020

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Adedehinbo Olusile

Members present
Alan Clamp, (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority
Simon Wiklund, Head of Legal, Professional Standards Authority

In attendance
David Bradly, Counsel, 39 Essex Chambers Legal Advisor (attendance by telephone)

Observers
Briony Alcraft, Scrutiny Team Co-ordinator, Professional Standards Authority
Rebecca Senior, Solicitor, Professional Standards Authority

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public
- to maintain public confidence in the profession concerned, and
- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of Justice of England and Wales and the statutory time limit for an appeal would expire on 14 February 2020.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 6 December 2019.

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the panel dated 6 December 2019
- The Authority's Detailed Case Review
- Transcripts of the hearing dated 18-20 September 2019 & 5-6 December 2019
- Counsel's Note dated 6 February 2020
- Regulator's Bundle
- Case Examiners' Bundle
- The NMC's Sanctions Guidance in force at the time of sanction stage
- The Code, Professional Standards of Practice and Behaviour for Nurses and Midwives, 29th January 2015
- The Authority's Section 29 Case Meeting Manual.

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

7.2 The Members and the Legal Advisor were provided with a copy of a response from the NMC to the Authority's Notification of s.29 Meeting. The Members considered the response having received legal advice and after they reached a conclusion on the sufficiency on the outcome.

8. Background

8.1 The Registrant was employed as a nurse at Elmwood Care Home, and was the nurse in charge of the shift at the time of the incident. The allegations relate to her failure in 2017 to record and escalate two reports she received from a junior healthcare assistant (SAG) that a resident at the Home had been physically assaulted by VA, a senior healthcare assistant (who was said to be a friend of the Registrant's). An additional particular relating to the Registrant's failure to assist SAG was not found proved.

8.2 The Panel found the allegation of misconduct proved and that the Registrant's fitness to practise is impaired on public interest grounds alone. The panel imposed a caution order for a period of one year.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members discussed the following concerns about the decision:

Sufficiency of sanction

9.3 The Members first looked at whether the sanction, in terms of the charges faced by the registrant, is sufficient for public protection. They were concerned at the panel's statement in determining whether suspension would be appropriate – 'that a suspension order is a very serious regulatory sanction, and should not be considered appropriate solely on the basis that conditions of practice are not required to protect the public''. This statement was ambiguous and it was unclear what relevance the need for conditions had to the decision whether suspension was required to address the wider public interest.

9.4 The Members were also concerned at the panel's finding that the Registrant's failure to escalate is not at the more serious end of the spectrum of impairment, given the failure of the Registrant to take any action after the first report led to at least one more incident of abuse by VA towards a vulnerable patient.

9.5 However, they considered the misconduct, as alleged, was not so serious that it necessarily required a suspension order. They concluded that on the basis of the charges before the panel, a caution order could not be considered to be an insufficient sanction, although noted that the panel was lenient in imposing it for the minimum period.

Under-prosecution

9.6 The Members were struck from the outset that this is a case which was under-prosecuted by the NMC, in that the allegation failed to allege the Registrant's

disclosure of the complaint to VA or the reasons why she deliberately failed to progress a complaint of physical abuse against a vulnerable resident in circumstances where that complaint was made against a friend who was also a colleague.

9.7 Further, the Members noted with concern that the Registrant had told SAG not to tell anyone about the abuse when SAG reported it to her, and more so, that she had disclosed to VA that SAG had reported her alleged abuse of the resident to her, resulting in a subsequent incident of bullying and intimidation of the whistle-blower SAG by VA. The Registrant had subsequently failed to report this bullying, suggesting to the Members that the Registrant was trying to protect her colleague, VA, because they were friends.

9.8 The Members noted that none of the above formed part of the charges against the Registrant, and that despite all the relevant information apparently being available to the Panel in the evidence, the Members did not consider it had properly grappled with any of these issues in determining impairment or sanction, concluding that it was not possible to rationalise the Panel's decision on the basis of what it knew.

9.9 It was unclear to the Members whether the Registrant's failure to take any safeguarding action was partially due to substandard management or whether this was a clear case of lack of integrity, but concluded that the NMC's failure to address in the charges these issues meant that serious concerns about the Registrant's safeguarding of vulnerable residents, attitude and integrity were not examined by the Panel. They considered that had they been, it was likely to have made a difference to the outcome of the case.

The Case Examiners' referral

9.10 The Members next discussed their second concern about the decision - that the allegation did not reflect the basis of the referral made by the NMC Case Examiners. They discussed whether there was any reasonable explanation for the discrepancy between the basis of that referral and the charges that were brought by the NMC.

9.11 They noted that at the hearing itself, the cross-examination of the Registrant did not include many of the aspects that were before the case examiners. The Members referenced the Case Examiner decision letter which pointed to evidence that highlighted fundamental concerns about the registrant's attitude and trustworthiness by asking SAG not to tell anyone about the alleged assault when she was in a position of authority at the Home, and that the abuse of the Resident continued after SAG reported the incident to Registrant. The Members noted that the Case Examiners considered ''that the concerns in this case fall within the types of behaviour where action may need to be taken by the Fitness to Practise Committee."

9.12 The Members could not find any explanation for these further allegations not being brought before the panel, and therefore considered this amounted to a serious procedural irregularity, given the basis on which this case was referred by the Case Examiners.

The Panel's assessment of mitigation and remediation

9.13 The Members noted that the NMC case presenter described the Registrant's failings as remediable. However, the Members did not consider that behaviour which victimises a whistle-blower raising valid concerns about abuse is easy to remedy, and that this conduct should have been addressed at the impairment stage of the hearing. The Members were concerned that the Panel failed to take into account the seriousness of the Registrant's misconduct, and that the Panel was wrong to consider the difficult environment at the Home to be a mitigating factor, given the Registrant was potentially responsible for this environment.

9.14 The Members, however, considered the evidence the Registrant put before the Panel in terms of her insight, remorse and remediation, including evidence from her employer. They noted that the safeguarding issues have been addressed. They therefore discussed whether the charges were properly phrased for the Panel to consider all aspects of the case in terms of the public interest and whether, had additional charges been brought, this would have made any material difference to the outcome, given the evidence about the Registrant's current practice. They noted that she is now working in a home that appears to run efficiently and no further concerns have been raised about her practice. However, the Members were concerned that despite this, there are no assurances that the Registrant will not return to working in a poorly functioning home where repetitions could occur.

9.15 The Members concluded that it was impossible to tell what the Registrant's response would have been to these further allegations, and could not reach a conclusion on what the likely outcome would have been had the additional charges been brought.

Conclusion on insufficiency for public protection

9.16 In light of their concerns, the Members concluded that the panel's failure to bring the additional charges outlined above was a serious procedural irregularity which meant the Members were unable to determine whether the outcome of the case was insufficient.[2]

9.17 The Members considered there was *Prima facie* evidence to establish additional charges and that there had been insufficient inquiry into the full extent and reasons for the Registrant's conduct.

10. Referral to court

10.1 Having concluded that the panel's Determination was insufficient for public protection, the Members moved on to consider whether they should exercise the Authority's discretion to refer this case to the relevant court.

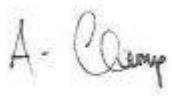
10.2 In considering the exercise of the Authority's discretion, the Members received legal advice as to the prospects of success and took into account the need to

[2] *Ruscillo* at [72]

use the Authority's resources proportionately and in accordance with the over-arching objective.

10.3 In considering alternatives to a court referral, the Members considered the NMC's response did not adequately address the concerns identified in the case. They considered this case raises important themes around the duty of candour and the safeguarding of vulnerable patients, and in the circumstances, a referral was the only means of securing adequate public protection.

10.4 Taking into account those considerations, along with advice on the prospects of success, the Members agreed that the Authority should exercise its power under Section 29 and refer this case to the High Court of Justice of England and Wales.



…….. 31 March 2020……..

Alan Clamp (Chair) **Dated**

11. Annex A – Definitions

11.1 In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	A Fitness to Practise Panel of the Nursing and Midwifery Council
The Registrant	Adedehinbo Olusile
The Regulator	The Nursing and Midwifery Council
Regulator's abbreviation	NMC
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on 5-6 December 2019
The Court	The High Court of Justice of England and Wales
The Code	Regulator's Code of Practise in force at time of incident
The SG	Regulator's Indicative Sanctions Guidance in force at sanction stage