Section 29 Case Meeting

17 November 2020

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

[redacted]

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny & Quality (Performance), Professional Standards Authority

In attendance
Michael Standing, Counsel, 39 Essex Street Chambers

Observers
Seun Fagbonun, Data Administrator, Professional Standards Authority
Rachael Martin, Scrutiny Team Co-ordinator, Professional Standards Authority
Steve Wright, Senior Scrutiny Officer, 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. Although the Registrant has lapsed from the Register the Legal Advisor confirmed that this did not prevent the Authority from bringing an appeal against the decision. 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 24 November 2020.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on [redacted].

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 [redacted]
- The Authority's Detailed Case Review
- Transcripts of the hearing dated [redacted]
- Counsel's Note dated 16 November 2020
- SOR Hearing Bundle
- IC Masters
- BW Duty of Candour update
- CPD certificate
- IC decision and notice of referral letter

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

- Notice of decision letter
- The NMC's Indicative Sanctions Guidance
- The Authority's Section 29 Case Meeting Manual

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.

8. Background

8.1 The Registrant, a Nurse, was found impaired at a substantive hearing in [redacted] in relation to allegations that, over three days, she failed to take appropriate action to ensure that Co-careldopa was administered to Patient X (a patient with Parkinson's disease) in that she failed to administer the drug within one hour of the prescribed administration time of 08.00; failed to request that the on-call pharmacist dispense Co-careldopa for Patient X; and failed to ensure that the drug was administered promptly. The Panel also found proved allegations that the Registrant failed to respond appropriately when Patient Y was found unresponsive in that she bleeped the Clinical Site Manager, did not know whether Patient Y had a DNAR order in place, failed to promptly put out a crash call, failed to alert colleagues that Patient Y required rescue, and failed to commence CPR.

8.2 The substantive Panel found the Registrant's insight and remorse insufficient and was not satisfied that the risk of repetition had been alleviated given that the Registrant had only completed one CPR course shortly after the misconduct occurred in [redacted] and there was no information submitted of any subsequent training, education or references. The substantive Panel made a finding of impairment on both public protection and public interest grounds and imposed a Conditions of Practice Order.

8.3 The Order was reviewed in [redacted] and [redacted]. At both review hearings the Order was extended, and a finding of continuing impairment was made on both grounds.

8.4 At the third and most recent review hearing which is the relevant decision for the Members' consideration, the Panel concluded that the Registrant was not impaired. Therefore, she is now able to practise without restriction.

8.5 The Registrant attended the final review hearing and was represented. She did not give any oral evidence. Documentary evidence of three courses she had attended and reflections on the duty of candour were presented although there was no evidence of any clinical work undertaken on a ward since the last review hearing.

8.6 When considering current impairment, the Panel relied on evidence of a Return to Practice (RTP) course from [redacted] which had been considered and rejected as practical experience by both previous review Panels.

8.7 At the time of the section 29 case meeting the Registrant's registration had lapsed from the register although the NMC had informed the Authority that the Registrant intended to renew her registration.

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:

Lack of clinical practice

9.3 The Members noted that the Registrant has not practised since the misconduct occurred in [redacted] and has not therefore been in a position to fully comply with the Conditions of Practice Order since it was first imposed in [redacted]. The Registrant's lack of clinical practice was noted by the two previous Panels and further deskilling would have occurred between the last and current review hearing.

9.4 The previous review Panels concluded that the Registrant was not safe to return to unrestricted practice and the Conditions of Practice Order imposed required her to practise under supervision. Since the last review hearing, the Registrant had not secured a nursing position where registration was required and there was therefore no new evidence of any clinical practice to demonstrate that the Registrant's learning and remediation had been embedded into her practice.

9.5 The Members noted that the areas of practice which were of concern and specifically addressed in the conditions had not been addressed any further than at the last review. The Members concluded that the Registrant's continued lack of clinical practice over such a prolonged period of time and limited evidence of other remediation indicated that there was no basis on which the Panel could have concluded that the Registrant was now safe to return to practice compared to 12-months ago.

Return to Practise Course

9.6 The Members noted that the guidance on RTP courses indicates that the course does not exist to remedy any fitness to practise concerns. However, the course does address any clinical shortcomings in a registrants' practice and therefore might be relevant for cases concerning allegations of a clinical nature.

9.7 The previous two review Panels, however, did not consider the RTP course sufficient evidence of remediation. The Members were mindful that the Panel made findings that it was entitled to make in terms of remediation, but it ought to have explained why its view of relevance of the RPT course differed from that of the previous Panels.

Had the Registrant done all she reasonably could to demonstrate remediation

9.8 The Members acknowledged that the Panel made findings which it was entitled to make in terms of insight, remorse and training. Indeed, previous review Panels had considered that the Registrant's training had gone above and beyond what was required. The Members further acknowledged that it was for the Panel to determine remediation and deference would be given to that decision. There was no requirement for it to refer in its decision to every single relevant factor.

9.9 Despite this, the Members were concerned that the tasks of medicines management, record keeping, and resuscitation, all of which were fundamental roles of nursing and found to have been of concern in the Registrant's practice, had not been addressed any more than they had been at the last review hearing.

9.10 Whilst there had clearly been progression in terms of the Registrant's training and insight, there remained a lack of practical clinical experience. The Members were further concerned by the Panel's failure to provide a sufficient explanation as to why this had fallen away in significance in terms of current impairment.

9.11 The Members acknowledged that the Registrant had demonstrated some insight in that she realised she would require some form of support from her employers on her return to practice due to her long absence from practice but were not comfortable that this would be done without any formal regulatory oversight and restrictions that conditions provide.

9.12 The Members did not consider that there was evidence at the current review hearing to indicate that the Registrant posed any lower risk to the public than she did at the last review 12-months ago. In fact, the Members considered her further absence from clinical practice suggested she was likely to be further deskilled than she was at the last review hearing.

9.13 The Members considered that it would not have been unreasonable for the Panel to have concluded that the Registrant had done all that she could to demonstrate current fitness to practise had impairment only been found on public interest grounds. However, the Members considered that public protection had not been fully addressed by the Registrant as she had yet to return to clinical practice and demonstrate that her learning and remediation had ben embedded into her practice.

9.14 The Members also noted that the Registrant did not give evidence to the Panel and the Panel therefore had no knowledge as to what the Registrant would do differently if confronted with similar circumstances. The Members further noted that this was an issue noted by the previous review Panels and they were satisfied that the Registrant could not be sure that she would act differently and considered that there remained a risk of repetition. As the reviewing Panel had heard no further evidence from the Registrant on this matter the Members were concerned by the Panel's failure to address this continuing concern in its decision.

9.15 The Members felt that if the Registrant had given evidence at the review hearing and explained her intentions and plans for returning to practice this may

have eased their concerns and there was some reassurance in her Counsel's comments that she would like some supervision within her role. The Members noted that the Panel were reliant on the Registrant's Counsel's comments regarding a monitored reintegration to practice and this required a great deal of trust which, when weighing up with public protection, was of concern.

Conclusion on insufficiency for public protection

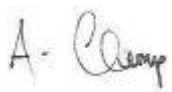
9.16 The Members concluded that the Panel's decision to find the Registrant no longer impaired was insufficient for public protection. The Members concluded that it was difficult to see how the Panel had addressed the previous Panel's concerns regarding the Registrant's continued lack of clinical practice. The Members concluded that the decision to find the Registrant no longer impaired was insufficient given the Registrant's deskilling and prolonged absence from practice. The additional material submitted by the Registrant at the review hearing was minimal and the only reassurance in terms of public protection was the assurance by the Registrant's Counsel that the Registrant was aware her return to practice would need to be monitored. The Members were concerned that this required trust on the Registrant to ensure precautions were in place on her return to practise. In addition, the Members concluded that the Panel's reasoning was insufficient in that it lacked detail which was necessary since its opinion differed from previous review Panels, and it was therefore not clear how it had come to conclude that the Registrant was now safe and fit to practise.

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 use the Authority's resources proportionately and in the public interest.

10.3 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.



30 November 2020

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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 Committee of the Nursing & Midwifery Council
The Registrant	[redacted]
The Regulator	Nursing & Midwifery Council
NMC	Nursing & Midwifery Council
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 [redacted]
The Court	The High Court of Justice of England and Wales
The SG	Regulator's Indicative Sanctions Guidance