Section 29 Case Meeting

14 December 2020

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Nichola Susan Connolly

Members present
Tom Frawley (in the Chair), Board Member, Professional Standards Authority
Mark Stobbs, Director of Scrutiny and Quality, Professional Standards Authority
Simon Wiklund, Head of Legal (senior solicitor), Professional Standards Authority

In attendance
Peter Mant of counsel 39 Essex Chambers

Observers
Remi Gberbo, Lawyer, Professional Standards Authority
Rebecca Senior, Lawyer, Professional Standards Authority
Georgina Devoy, 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. 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 18 December 2020.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 23 October 2020.

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 23 October 2020
- The Authority's Detailed Case Review
- Transcripts of the hearing
- Counsel's Note dated 10 December 2020
- The NMC's Code
- 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. The Members considered the response having received legal advice and after they reached a conclusion on the sufficiency on the outcome.

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

8. Background

8.1 The Registrant was employed as registered nurse by the Heart of England Foundation Trust (the Trust).

8.2 In August 2017, members of the team in which the Registrant worked were clearing her desk to make room for a new member of staff. Three Mentorship Assessment Records dated March 2016 were discovered which contained what purported to be the signature of another team member (Nurse A) confirming assessments having been carried out and the Registrant's completion of requirements for the SLAIP qualification (Standards to Support Learning and Assessment in Practice).

8.3 The SLAIP qualification is a teaching/mentoring qualification and was delivered by the Trust on an in-house basis but was accredited by Staffordshire University. The course included a taught module and an oral viva as the assessed part of the course for which students were required to bring their portfolio including evidence of teaching and assessment activities undertaken and signed off by a mentor's confirmation that they had achieved the required standard. The SLAIP "sign-off" mentor is required to be qualified as a sign off mentor and be listed on the mentor database.

8.4 Each of the Assessment Records prepared by the Registrant purported to have been signed by Nurse A included the following note of confirmation by the assessor signing the form: 'By signing this form you confirm that you are currently on the Mentors Register for this placement or have recognised Assessor Training'.

8.5 Suspicions were raised as the signatures were different to that of Nurse A and appeared to have been written by the Registrant. Nurse A was shown the documents and confirmed that she had never seen the documents before, the signature was not hers and had no knowledge of the matters purported to have been assessed.

8.6 The matter was escalated, and a disciplinary investigation was undertaken, and a referral made to the NMC in 2018. The qualification was subsequently removed from the Registrant and she was later dismissed by the Trust.

8.7 At the hearing, the Registrant admitted the allegations advanced, including that her actions had been dishonest, save head of charge 2(b) that she knew that Staff Nurse A had not observed her carrying out any of the requisite activities. The Panel found this allegation not proved.

8.8 The Panel found that the admitted allegations amounted to misconduct but found that the Registrant's fitness to practise was not impaired.

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:

Was the impairment decision wrong having regard to the inherent seriousness of a finding of dishonesty generally and the particular seriousness of the finding of dishonesty relating to qualifications in this case?

9.3 The Members were concerned that the Panel failed to address the seriousness of the dishonesty and had failed to adequately address the public interest.

9.4 The Members noted that the Registrant's dishonesty was not minor and there was nothing "unusual" or "exceptional" about her case that could justify the finding of no impairment. The Members also considered there were a number of factors adding to the seriousness of the misconduct which the Committee failed to address or give sufficient weight to, including:

- The impact of the Registrant's dishonesty on the integrity of the system of mentoring qualifications (see, by analogy, *GMC v Thodoropoulos* [2] at [36]-[37] and cases cited therein);
- The potential for risk of harm to patients: the Committee erred in conflating risk of harm with evidence of actual harm;
- The fact that the Registrant did not simply forge signatures to attest to actions which may have been observed, but fabricated the subjective assessments which she attributed to Staff Nurse A;
- The potential impact of her actions on Staff Nurse A and failure to make any attempt to contact Staff Nurse A after the event;
- The fact that the Registrant continued to act as a mentor – in reliance on a qualification that had been dishonestly obtained and that she knew had been obtained in reliance on falsified documents - for a year and a half, making no attempt to disclose or remedy her dishonesty until it was discovered;
- The fact that the dishonesty related to a qualification entitling her to act as a mentor in a position of responsibility where she would have been expected to set an example to others.

9.5 Finally, the Members noted that the Panel's impairment decision was inconsistent with case law on dishonesty, noting three specific cases;

> Dishonesty generally lies at the top end of the spectrum of gravity of misconduct (see, eg., *PSA v GMC & Igwilo* [3][]);
>
> Any instance of dishonesty is likely to impair a practitioner's fitness to practise (*R (Hassan) v General Optical Council* [4] at [39]); and
>
> It will be an unusual case where dishonesty does not lead to a finding of impairment (*PSA v HCPC & Ghaffar* [5] at [45] and [46]; *GMC v Nwachuku* [6][at [48]).

[2] [2017] EWHC 1984 (Admin)
[3] 2016] EWHC 524
[4] [2013] EWHC 1887
[5] [2014] EWHC 2723
[6] 2017] EWHC 2085 (Admin)

Did the Panel fail to have regard to relevant guidance and depart from it without good reason?

9.6 The Members noted that the NMC Guidance on sanctions for serious cases states: "In cases involving dishonesty… it's likely that we would need to take action to uphold public confidence in nurses, midwives or nursing associates, or to promote proper professional standards".

9.7 The Members agreed that the Panel failed to apply this guidance and/or provide adequate reasons for departing from it.

9.8 The Committee erred in its assessment of the public interest by placing undue weight on matters of remediation and personal mitigation without sufficient focus on the nature and extent of the dishonesty

Did the Panel err in its assessment of the public interest by placing undue weight on matters of remediation and personal mitigation without sufficient focus on the nature and extent of the dishonesty?

9.9 The Members considered that the Panel relied almost exclusively on matters of personal mitigation which are of much less relevance to impairment on public interest grounds.

9.10 The Members agreed the Panel should have focused primarily on the nature and extent of the dishonesty when considering what was necessary to address public confidence and professional standards.

Did the Panel err in holding that the public interest would be sufficiently satisfied by the Registrant's actions being "marked" by the regulatory process and a finding of misconduct?

9.11 The Members considered that without a finding of impairment, the misconduct decision could not be marked publicly with a sanction recorded on the register, and the Panel's determination would not be published. The hearing, whilst notionally "public", was held remotely; members of the public did not attend, and the charge was not published in advance (see *CHRE v NMC and Grant* [7] at [74]; cf. GMC cases where a finding of misconduct and no impairment can still be marked formally with a warning).

9.12 Further, the Members concluded that in this case the mere fact that a regulatory process has been undertaken did not of itself satisfy the relevant public interest considerations nor send a sufficient signal to either the public or members of the profession: see *GMC v Patel* [8] at [68].

Was the legal assessor's advice materially flawed?

9.13 The Members noted the legal assessor's advice and considered that it:

- Failed to address the inherent seriousness of a finding of dishonesty and/or any relevant case law on dishonesty;

[7] [2011] EWHC 927 (Admin)
[8] [2018] EWHC 171 (Admin)

- Focused on issues of remediation and personal mitigation without advising that these matters may be of less weight in considering the public interest and without referring to any relevant case law on the weight to be placed on these matters;
- Specifically, cited *Cohen v GMC*[9] in the context of his advice on the public interest, without any reference to *Yeong* [2010] 1 WLR 548); and
- Set out a list of mitigating factors without identifying any of the aggravating factors.

Conclusion on insufficiency for public protection

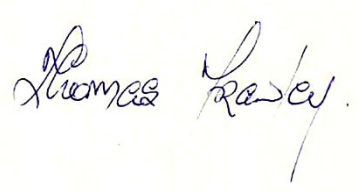
9.14 The Members concluded that the Panel's decision to find the Registrant not impaired was insufficient for public protection for the reasons detailed above.

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. The Members considered the response received from the NMC and noted the NMC case presenter had sought a finding of impairment at the hearing.

10.2 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. The Members also had regard to the impact of any appeal on the Registrant and whether there were any alternative means to secure public protection.

10.3 Taking into account all of the above, 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.



29/01/21

Tom Frawley (Chair) **Dated**

[9] [2008] EWHC 581 (Admin)

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 NMC
The Registrant	Nichola Susan Connolly
The Regulator	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 23 October 2020
The Court	The High Court of Justice of England and Wales
The Code	Regulator's Code of Practise
The ISG	Regulator's Indicative Sanctions Guidance