Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Kisha Punchihewa, Head of Legal, 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
Jarrod Hughes, Scrutiny Officer, Professional Standards Authority
Georgina Devoy, 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 11 September 2019.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 25 June 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:

- Counsel’s Detailed Case Review and Case Meeting Note
- Transcripts of the hearing dated 3, 4, 5, 6, 7, 12, 13, 17, 18, 19, 25 June 2019
- NMC response to the Authority’s Notification of s. 29 Meeting dated 28 August 2019
- NMC letter to Registrant, power to review initial decision dated 17 July 2018
- NMC letter to Registrant, power to review final decision dated 21 August 2018
- Case Examiners’ Report dated 1 November 2017
- 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 [Redacted] (the Trust). The Registrant is one of three nurses who faced joined fitness to practise proceedings in relation to the death of Patient A as a result of events at the Trust on 17 April 2015. The cause of Patient A’s death was aspiration pneumonia and misplacement of a nasogastric feeding tube and the administration of feed and medicine into her right lung.

8.2 At 14:20 on 17 April 2015, the Registrant inserted a nasogastric tube into Patient A with the assistance of one of the other respondents to the proceedings, KR, who was more experienced in this procedure. Use of the tube to feed a patient is not to commence until aspirate within an identified range of pH values has been obtained from the tube as an aid to ensure that the tube is in the stomach and not the lung. This process requires the involvement of two nurses, the second to check and confirm both that the aspirate has been obtained and that is has the correct pH value. The Registrant and KR were unable to obtain any aspirate during the 14:20 aspiration. The Trust’s policy required that second attempt be carried out after twenty minutes.

8.3 A second attempt to obtain aspirate from Patient A was conducted at 17:00 on the same day by the third respondent, AI, on her own. AI claimed that once the aspirate had been obtained, she went to the Registrant who was in another bay of the ward and showed her the measuring stick with the colour code so as to secure the Registrant’s confirmation that the pH value reading was 2 to 2.5.

8.4 The Registrant gave different and contradictory accounts of her involvement in the process of confirming the acidity of the aspirate. In a fact finding interview carried out by the Trust the following day, the Registrant was recorded as saying that AI had shown her the stick which she had used to measure the pH and that she had seen that it was ‘2 or 3’, ‘well within range’, ‘orange, red’, thereby confirming the reading and meeting the requirements for a second checker. When interviewed by the Police in October 2015, the Registrant said that she had not seen the stick and that AI had only told her that she obtained aspirate with a pH of 2 to 2.5, a position she maintained when she gave evidence to the Coroner at the Inquest into Patient A’s death (and a position which the Coroner accepted).

8.5 The Registrant claimed that she had not been able to think straight at the fact finding interview and that she felt pressure to say what she was recorded as saying. The Registrant also played the interviewers a voice mail left on her mobile phone by AI, in which AI asked whether she (the Registrant) could remember her (AI) showing her the aspirate or the stick.

8.6 The NMC informed the Registrant by letter dated 24 January 2018 that the Case Examiners had decided that there was no case for her to answer and that no further action would be taken. The Case Examiners’ reasons included their
view that there was sufficient evidence to indicate that the Registrant was anxious and muddled at the fact finding interview and that they had not seen any evidence that she deliberately produced a misleading and dishonest account of her role in the 17:00 aspiration. With respect to clinical concerns, the Case Examiners were satisfied that the Registrant should have taken steps to ensure that the second attempt to aspirate Patient A's stomach took place twenty minutes after the initial attempt and that the Registrant's record keeping was not of an acceptable standard. However, in light of evidence of remediation and the fact that Patient A's death occurred two years prior, the Case Examiners determined that a finding of impairment was not necessary for the purposes of public protection or the wider public interest.

8.7 The Case Examiners' decision to not refer the case to the Panel was subsequently reviewed by the Assistant Registrar. While no material is available from this review, the Assistant Registrar ultimately referred the complaint against the Registrant to the Panel.

8.8 The NMC alleged that the Registrant had not told the truth at the fact finding interview in order to protect her colleague, AI. The allegation addressed to the Registrant advanced the position that the Registrant's statement to the Police and the Coroner was the truth and that her statement at the fact finding interview was thereby dishonest. The NMC alleged that AI misinterpreted the pH value of the aspirate obtained, dishonestly attempted to influence the fact finding exercise (by leaving the Registrant the voice mail message) and had dishonestly given inconsistent accounts of her involvement in the care of Patient A. The NMC charged KR, who it was said to be in a supervisory role over the Registrant, with clinical and record keeping failures in relation to the attempted aspiration of Patient A at 14:20.

8.9 The case was heard over 13 days and the NMC called nine witnesses. A nursing expert witness gave evidence that the nurses had not followed proper practice or Trust policy in respect of the placement of the tubes and nasogastric feeding. A Consultant Gastroenterologist expert witness gave evidence that Patient A had been silently aspirating gastric fluid into her lungs as a consequence of her multiple sclerosis, giving rise to the possibility that the alleged pH reading of 2 at 17:00 was, misleadingly, of aspirate from Patient A's lungs and not her stomach.

8.10 The Panel determined that, while the Registrant was found to have said what she was alleged to have said at the fact finding interview, the facts upon which the NMC's allegation of dishonesty depended, namely that the Registrant had not seen or checked the colour of the pH strip, were not proved. The Panel rejected the Registrant's evidence given to the Police and the Coroner that she had not seen the stick, describing this evidence as 'unconvincing' and noting that the Registrant may have had a motive to deny that she had seen the stick once the Police had become involved in Patient A's death. The Panel also noted that a pH reading of 2 was possible, even when the aspirate came from Patient A's lung, on the basis of the expert medical evidence. As the underlying factual contention of the Registrant's dishonesty was not made out, there was no basis upon which the Registrant could be found guilty of misconduct.
8.11 The Panel did not find any of the facts alleged against AI proved. The Panel found that KR failed to ensure that the Registrant had measured the length of the nasogastric tube accurately and failed to follow, or ensure that the Registrant followed, the infection control procedure. This was found to amount to misconduct and KR's fitness to practice as a nurse was found to be impaired on the grounds of the wider public interest and the Panel imposed a caution for 12 months.

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:

*Failure to charge the Registrant with dishonesty in the alternative event that her statements to the Police and the Coroner were false*

9.3 The Members considered whether the NMC made a serious procedural error in failing to charge the Registrant with dishonesty in the alternative event that the statements she made to the Police and the Coroner, namely that she had not been shown the stick by AI, were false.

9.4 The Members noted that the Panel considered for itself whether the case had been properly charged and invited submissions on the matter. After hearing submissions (including submissions that the NMC did not wish to amend the charges), the Panel concluded that introducing a new charge of dishonesty during the hearing would put the NMC in the position of 'riding two horses' and would be unfair to the Registrant.

9.5 The Members expressed the view that the NMC's failure to charge the Registrant with dishonesty in the alternative deprived the Panel of the opportunity to determine which of the Registrant's statements (if any) were false and potentially dishonest. Notwithstanding this, the Members noted a number of vitiating circumstances, including the following:

9.5.1 The approach taken by the Panel to this case is likely to be commended in that the Panel directly addressed the issue of under-charging and invited submissions on the matter. In the circumstances of this difficult multi-registrant case, the Panel's approach is likely to be accorded considerable respect.

9.5.2 The NMC had reasons for its charging decision as detailed in its response to the Authority's Notification of s. 29 Meeting dated 28 August 2019. In this letter, the NMC states that the allegation brought against the Registrant was consistent with the NMC's case against AI (namely that AI pressured the Registrant to provide a false account at the fact findings meeting) and was also consistent with the terms of the referral made by the Assistant Registrar and the findings of the Coroner. The letter also states that, had the NMC charged in the alternative, it would need to rely on the evidence of AI, who was not an NMC witness (because she was a co-defendant) and did not participate in the hearing.
9.5.3 The Panel accepted evidence that the Registrant was distressed and muddled during the fact finding interview. In these circumstances, it cannot be said with certainty that, had dishonesty been charged in the alternative, it would be found proved.

9.5.4 In determining grounds to contest the Panel’s decision, the Authority cannot rely on the benefit of hindsight in understanding how a case unfolded before the Panel.

9.6 The Members expressed the view that the Panel may have balanced the public interest in amending the charges with fairness to the Registrant by allowing an adjournment. However, the Members resolved that the Panel’s failure to allow an adjournment does not provide sufficient grounds to challenge the Panel’s decision and is most appropriately dealt with by way of Learning Points (see Annex C).

9.7 The Members concluded that, in all the circumstances, the failure to charge the Registrant with dishonesty in the alternative event that her statements made to the Police and the Coroner were dishonest does not provide sufficient grounds to challenge the Panel’s decision as an under-prosecution.

**Failure to charge the Registrant with clinical errors in relation to the attempted aspiration of Patient A at 14:20**

9.8 The Members considered whether the NMC made an error in failing to charge the Registrant with clinical errors in relation to the attempted aspiration of Patient A at 14:20, including failures relating to the application of the tube, record keeping, and her failure to re-attempt the aspiration after twenty minutes had lapsed.

9.9 The Members noted that Trust protocol required any nurse involved in aspiration to be up to date with clinical knowledge of the process. The Members also noted that, while KR was regarded as being in a supervisory position with respect to the Registrant and therefore the subject of the charges, both nurses had a similar level of clinical experience.

9.10 The Members expressed the view that the NMC could have charged the Registrant with clinical errors in relation to the attempted aspiration of Patient A at 14:20 as both the Registrant and KR were clearly involved. However, the Members expressed doubt as to whether these charges, if proved, would be sufficiently serious to necessarily support a finding of misconduct.

9.11 In all the circumstances, the Members concluded that the NMC’s failure to charge the Registrant with clinical errors in relation to the attempted aspiration of Patient A at 14:20 did not provide sufficient grounds to challenge the Panel’s decision as an under-prosecution.

**Failure to charge the Registrant with clinical errors in relation to her role in the 17:00 aspiration of Patient A**
9.12 The Members considered whether the NMC made an error in failing to charge the Registrant with clinical errors in relation to her role in the 17:00 aspiration of Patient A.

9.13 The Members noted that if the statements made by the Registrant during the fact finding interview were indeed true, questions arise about the Registrant’s clinical performance, including whether she carried out the second check appropriately and in accordance with the Trust’s policy.

9.14 The Members noted that the Trust’s policy was unclear on the precise duties to be carried out by a second checker. The Members also noted that the evidence of the Registrant’s conduct in relation to the 17:00 aspiration was unclear and contested. In all the circumstances, the Members concluded that the NMC’s failure to charge the Registrant with clinical errors in relation to her role in the 17:00 aspiration did not provide sufficient grounds to challenge the Panel’s decision as an under-prosecution.

Conclusion on insufficiency for public protection

9.15 The Members were concerned with the NMC’s failure to charge the Registrant with dishonesty in the alternative event that her statements to the Police and the Coroner were false. The Members were also concerned that the Panel failed to allow an adjournment to balance the public interest in amending the charges while maintaining procedural fairness for the Registrant. Nevertheless, for the reasons set out above, the Members concluded that the decision was not one which no reasonable Panel could have made. In all the circumstances, therefore, it was not insufficient for public protection.

10. Referral to court

10.1 Having concluded that the panel’s Determination was not insufficient for public protection, the Members were not required to consider whether they should exercise the Authority’s power under Section 29 to refer the case to the relevant court.

11. Learning points

11.1 The Members agreed that the learning points set out at Appendix C should be communicated to the Regulator.

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Alan Clamp (Chair) Dated
12. Annex A – Definitions

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

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<thead>
<tr>
<th>The Authority</th>
<th>The Professional Standards Authority for Health and Social Care</th>
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<tr>
<td>The Panel</td>
<td>A Fitness to Practise Panel of the Nursing and Midwifery Council</td>
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<tr>
<td>The Registrant</td>
<td>[Redacted]</td>
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<tr>
<td>The Regulator</td>
<td>Nursing and Midwifery Council</td>
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<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
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<tr>
<td>The Act</td>
<td>The National Health Service Reform and Health Care Professions Act 2002 as amended</td>
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<tr>
<td>The Members</td>
<td>The Authority as constituted for this Section 29 case meeting</td>
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<tr>
<td>The Determination</td>
<td>The Determination of the Panel sitting on 25 June 2019</td>
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<tr>
<td>The Court</td>
<td>The High Court of Justice of England and Wales</td>
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