# Section 29 Case Meeting

**30 June 2020**

**157-197 Buckingham Palace Road, London SW1W 9SP**

professional standards authority

**[redacted] and [redacted]**

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

***In attendance***
David Bradly of 39 Essex Chambers, Legal Advisor

***Observers***
Glenys Stacey, Chair, Professional Standards Authority
Remi Gberbo, Lawyer, Professional Standards Authority
Rebecca Senior, Lawyer, Professional Standards Authority
Briony Alcraft, Scrutiny Team Co-ordinator, 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 17 July 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 Determinations which include the charges and findings are set out at Annex B.

## 7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determinations of the Panel dated [redacted]
- NMC joint meeting bundle
- NMC Case Examiner's Bundle
- The Authority's Detailed Case Review
- Counsel's Note dated 30 June 2020
- The NMC's Sanctions guidance – January 2020
- 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 s29 Meeting.

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

## 8. Background

8.1 The registrants were both employed by the [redacted] in a ward at [redacted] for the in-patient care of patients with early onset dementia, [redacted] as a Staff Nurse and Deputy Ward Manager and [redacted] as a Staff Nurse. The misconduct alleged and found against them involved their failures in the care of Patient A, a vulnerable and dependent patient who suffered a seizure and a fall, and later a further fall from his bed, on the morning of [redacted], and who died the following day from a subdural haemorrhage as a consequence of a traumatic brain injury.

8.2 Patient A had been placed in his bed and left there without being the subject of neurological observations or receiving food or water (he was a diabetic). His deteriorating condition was only detected and the emergency services called later that evening. [redacted] had been on duty at the time of the fall and remained on duty for some of the day; [redacted] took over the responsibility for Patient A when he came on shift later that day.

8.3 Both registrants were dismissed from their employment for gross misconduct and referred to the NMC after an inquiry into the events leading up to Patient A's death conducted by the Health Board during the course of [redacted]. Both registrants were made the subject of interim orders (first conditions of practice and later suspension) in the period between the referral and the Fitness to Practise Panel meeting.

8.4 A criminal investigation was subsequently initiated and both Registrants were charged with wilful neglect contrary to Section 20(1) of the Criminal Justice and Courts Act of 2015. At [redacted] Crown Court on [redacted] both Registrants were found not guilty of willful neglect, the deliberate element of the offence not being supported by evidence.

8.5 [redacted] faced allegations that her fitness to practise was impaired by reason of misconduct in that she, in summary, directed an unqualified assistant to conduct neurological observations every four hours (rather than every 30 minutes for the first two hours), to leave Patient A to sleep over lunch and to elevate his legs when his blood pressure was said to be outside the normal range; failed to escalate the situation to a doctor when Patient A failed to react to the neurological observations she herself carried out, when he fell out of bed, when his blood pressure fell or when he dry retched; failed to commence timely neurological observations when Patient A fell; did not ask for Patient A to be reviewed by a doctor; failed to make the necessary records of events (did not record Patient A's seizure, fall or the graze he sustained to the back of his head in the fall or a body map of the injuries he had sustained); and did not conduct an adequate handover (reporting that Patient A was still sleeping but had not problems and not reporting that he had dry retched or his low blood pressure reading).

8.6 [redacted] faced allegations that his fitness to practise was impaired by reason of misconduct in that he failed to conduct timely neurological observations of Patient A having been told on handover that Patient A had fallen and suffered an injury to his head; did not escalate Patient A's condition when Patient A was sleeping for prolonged periods after a fall; did not direct observations of Patient

A; and when asked if Patient A should be woken for dinner directed that Patient A be left sleeping.

8.7 While both registrants had made admissions to the particulars ([redacted] the majority of them; [redacted] all of them) in case management forms, neither registrant attended the hearing and neither provided any evidence for the Panel to consider. The Panel found that the facts proved (all bar one in [redacted]'s case; all in [redacted]'s case) were such as to amount to misconduct and that their fitness to practise is impaired on both public protection and wider public interest grounds. The Panel imposed suspensions for 9 months in the case of [redacted] and 3 months in the case of [redacted], with reviews being ordered in each case.

## 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.

### *Under prosecution*

9.3 The Members discussed their concerns regarding the evidence which the NMC had in its possession but failed to put before the Panel. They noted that relevant documents were considered by the NMC case examiners during the investigation – namely an expert report by a [redacted] [redacted] which had been prepared for the purposes of the criminal trial and which provided a detailed analysis of the degree of neglect which occurred in the care provided to Patient A by both Registrants. The Members noted that, in addition, the Senior Coroner's Regulation 28 Report was not before the Panel.

9.4 The Members took into account the NMC response to the Authorities' queries, which set out that as it was not alleging causation, contribution or loss of chance, it was unnecessary for it to rely on [redacted]'s report, which it believed to touch on concepts that have no analogy in regulatory proceedings. The Members, in contrast, considered that the report contained extremely relevant observations about what was appropriate care for a vulnerable patient with diabetes, and highlighted the gravity of the mistakes made by the registrants, the lack of basic nursing care provided to Patient A, and viewing their actions as 'grotesque'. The Members considered that this was certainly relevant to the assessment of the seriousness of the failings of both registrants, an important aspect which the Members considered was lacking in the Panel's determination.

9.5 The Members considered [redacted]'s report was in contrast to the witness statement of [redacted] (a senior nurse with relevant expertise and knowledge of local practice), on which the NMC instead relied and considered was better placed to assist the Panel. The Members however did not consider [redacted] to be an appropriate expert, but a witness of fact who

[2] [redacted] of Psychiatric Nursing at the Institute of Psychiatry, Psychology and Neuroscience, Kings College, University of London

was unable to give the balanced, in-depth view that an expert can give. They considered that his statement failed to provide an opinion on the extent the registrants had departed from the expected standards of conduct and that although his views seemed to coincide with the expert in places, some statements were generalised, and failed to address the issues regarding the training the nurses would have received as mental health nurses.

9.6 The Members therefore concluded that [redacted]'s statement was not an appropriate replacement for the report of [redacted]. They disagreed with NMC's view that [redacted] was better placed to assist the Panel and with its view on when it might choose to obtain expert evidence, as the Members considered an independent opinion to be crucial for the Panel's consideration. It also considered that the NMC could have requested that [redacted]'s report be reformulated for the purposes of the regulatory proceedings.

9.7 The Members therefore concluded that there had been a serious procedural error on the NMC's part in not including the expert report in evidence to the Panel. In terms of the failure to produce the coroner's report, the Members conceded that this highlighted concerns about the conduct of the nurses but its conclusions were not admissible as evidence before the panel.

### *Undercharging*

9.8 The Members discussed whether the allegations sufficiently encompassed the extent of the registrants' failings throughout the day in question, particularly in relation to [redacted]. They noted that there was no specific allegation about whether Patient A's death could have been prevented if prompt action had been taken. The Members took into consideration the NMC's response which stated that its policy principles and guidance make clear that it will only investigate whether a clinical failing caused or contributed to death or serious harm where there is evidence that the registrant '*was aware that something they were about to do could put the safety and wellbeing of others at risk, was aware that it was unreasonable to take the risk and chose to take the risk'*. The NMC did not consider there was evidence in these cases to suggest either nurse took such a risk.

9.9 The Members considered the expert's assessment of the degree and severity of the failings, which specifically made reference to the NMC Code, but noted that there was no evidence before them that was capable of supporting an allegation that the failings represented the loss of an opportunity to prevent the death of Patient A.. They also considered that the allegations against [redacted] should have identified that she knew or ought to have known that Patient A may have suffered a head injury as a result of his seizure and fall, and that in the NMC failing to ensure the allegations against [redacted] captured the nature and full extent and seriousness of her misconduct, the Panel were denied the opportunity to comprehensively assess this. The Members considered that in the absence of such allegations, these factors could have been considered as aggravating features which ought to have been considered carefully at sanction stage.

### *The Panel's consideration of the nurse's training*

9.10 The Members noted that the Panel, in its assessment of the significance of [redacted]'s failure to escalate symptoms of Patient A's deteriorating condition, appeared to be unclear as to the standard of training applicable to a registered Mental Health Nurse in relation to the significance of blood pressure readings and that the Panel appeared to have made assumptions on this issue. The Members bore in mind the comments of [redacted], who confirmed that he was familiar with the training provided to mental health nurses, that *these were basic nursing skills that are covered in the first year of University. …. these failings were basic and were deemed to be, in my opinion, grossly negligent. At its most basic, this gentleman was left without fluid and food for the entire period that he was left in bed. This is as basic as a nurse's role could get.*

9.11 The Members therefore considered that the Panel should have taken steps to ensure that it fully understood the extent of training which these mental health nurses would have received in relation to blood pressure readings.

### *Substantive Meeting vs hearing*

9.12 The Members queried why the NMC had chosen to hear the cases at a substantive meeting rather than a hearing. They considered that the meeting format, which lacks a case presenter, may have limited the Panel, and that the lack of transcript made it difficult to see how and whether the Panel had properly engaged with all the issues at hand.

### *Decisions on sanction*

9.13 The Members considered whether the sanctions imposed were sufficient for public protection. In relation to [redacted], the Members considered that the Panel failed to explain how it weighed the aggravating and mitigating features and failed to properly characterise the seriousness of the misconduct. In [redacted]'s case, the Members considered the Panel failed to give adequate consideration to the degree to which her serious neglect of Patient A was fundamentally incompatible with registration as a nurse, given her failure to remediate her misconduct and her lack of engagement with the proceedings.

9.14 Further, the Members did not consider the Panel had paid due regard to the Sanctions Guidance in considering whether suspension was appropriate for either registrant, notably by failing to place weight on the registrants' total lack of insight by omitting the reference in the sanctions guidance that Panels should be satisfied that insight is evident when choosing suspension. Further, the reference to a lack of repetition did not strike the Members as relevant, since it was not clear that [redacted] at least had been practising since the incident. It was not therefore entirely clear to the Members why the Panel had considered suspensions to be sufficient for upholding public confidence and maintaining the reputation of the profession.

9.15 The Members had concerns about the registrants' lack of insight and remediation, and the absence of information about what they had been doing since the incident, in addition to their lack of engagement with the NMC. They considered that these aspects, especially when bearing in mind the NMC's

sanctions guidance, and the sheer level of the registrants' failings in basic areas of nursing, pointed towards striking off as a reasonable sanction. The Members accepted however, that there was no evidence of harmful deep-seated attitudinal issues in relation to either registrant.

9.16 The Members bore in mind that suspension is a serious sanction, which protects the public, although they were concerned at the Panel's lack of explanation for choosing to impose a shorter suspension of three months on [redacted]'s registration. It appeared to the Members that the language used by the Panel indicated it had treated [redacted]'s conduct less seriously, potentially because he made early admissions, and due to the inadequate handover he had received, but the Members considered the registrants' conduct were equally poor and that the inadequate information at handover was no mitigation for [redacted]'s failings.

9.17 The Members, however, accepted that there were some differences in the cases and that it was not entirely unreasonable for the Panel to have reached a different view on sanction length for each registrant.

9.18 Having taken all the above into consideration, the Members concluded that the Panel could have come to a different outcome in relation to [redacted] if it had been provided with the expert report of [redacted], albeit that this may have led to a longer period of suspension rather than a striking off order. Similarly, the Members considered it unlikely that these considerations would have led to a harsher outcome in [redacted]'s case.

### Conclusion on insufficiency for public protection

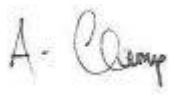
9.19 The Members were concerned with the under-prosecution in this case, the Panel's lack of reasoning and the NMCs failure to bring additional allegations against [redacted]. Nevertheless, since suspensions were imposed in each case which will be reviewed, and that the reviewing Panel will expect to see that the registrants have followed the recommendations of the previous Panel before allowing them back to practice, 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.



**10/08/20**

**Alan Clamp (Chair)** **Dated**

## 12. Annex A – Definitions

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

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| **The Authority** | The Professional Standards Authority for Health and Social Care |
| **The Panel** | A Fitness to Practise Panel of the NMC |
| **The Registrants** | [redacted] and [redacted] |
| **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 [redacted] |
| **The Court** | The High Court of Justice of England and Wales |
| **The SG** | Regulator's Indicative Sanctions Guidance in force at sanction stage |