

# Section 29 Case Meeting

9 July 2021

157-197 Buckingham Palace Road, London SW1W 9SP



## Melanie Jayne Hayes

### *Members present*

Alan Clamp (in the Chair), Job title, Professional Standards Authority  
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority  
Kisha PUNCHIHEWA, Job title, Professional Standards Authority

### *In attendance*

Alexis Hearnden, Counsel, 39 Essex Street Chambers

### *Observers*

Michael Hannah, Scrutiny Officer, Professional Standards Authority  
Rachael Martin, Team Coordinator, Professional Standards Authority

**This meeting was held virtually in light of the current pandemic.**

## 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*<sup>1</sup>).

#### **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 16 July 2021.

#### **6. The relevant decision**

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 10 May 2021.

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 10 May 2021
- The Authority's Detailed Case Review
- Transcript of the hearing dated 10 May 2021
- Counsel's Note dated 7 July 2021
- CPD Exhibits
- CE Decision Letter sent to Registrant
- CE Masters
- CPD Provisional Agreement – signed
- Regulatory concerns response form
- Hearing Decision letter sent to Registrant

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<sup>1</sup> CRHP v Ruscillo [2004] EWCA Civ 1356

- On table document
- Witness statement bundle
- Referral letter from NMC dated 20 May 2021
- Further letter from NMC dated 3 June 2021
- 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 This was a substantive hearing disposed of by way of a consensual panel determination (CPD). The Registrant, a mental health nurse had been on the register for 9 years did not attend the hearing. She was represented but her representative did not attend the hearing.

8.2 The allegations concerned two instances where the Registrant had used racist language in 2012 and May 2018 whilst at work. Two of the racist comments were made in relation to work colleagues, though the NMC did not allege that the language used was racist or that the Registrant's actions were racially motivated. The third comment was a threat made towards a patient.

8.3 The comments made by the Registrant in May 2018 were made on the Registrant's last day of work with the Trust.

8.4 On 8 May 2018 a colleague, wished the Registrant good luck in her new role. The Registrant responded with the racist comments which formed charge 3.

8.5 The colleague reported the incident and an internal investigation commenced. The Specialist Lead Nurse was asked to conduct the internal investigation but refused as she said she had worked with the Registrant in a previous role in 2012 and had witnessed her making racist comments and could not be objective. These incidents formed charges 1 and 2 and concerned racist language used by the Registrant in 2012.

8.6 The Registrant did not engage with the Trust investigation and denied the concerns prior to the case being put before the NMC Case Examiners. The only substantial engagement with the NMC appears to be the Registrant's agreement to resolve the case by consent to a six-month suspension order with review.

8.7 The case was considered by the Case Examiners on 5 October 2020 who found a case to answer. It is noted in the decision that the concerns gave rise to the Registrant's attitude and professionalism and concerns that she may hold underlying discriminatory attitudes towards others based on race.

8.8 The draft CPD was signed by the Registrant on 5 May 2021.

- 8.9 The Panel accepted the CPD noting in their decision on impairment that there was no evidence of ‘further’ remediation and a ‘much greater degree of insight remains to be demonstrated’.
- 8.10 In accepting the proposed 6-month suspension order the Panel reasoned that a strike off would not be proportionate ‘considering all the information before it and the mitigation provided’. The Panel did not consider the Registrant’s behaviour fundamentally incompatible with continued registration ‘in the particular circumstances of the case’.
- 8.11 The NMC wrote to the Authority on 20 May 2021 following a meeting of its Decision Review Group (‘DRG’) expressing concern that neither the CPD nor the determination properly considered the seriousness of the issues.
- 8.12 On 24 May 2021 the NMC received a letter from the BAME Chief Nurses Group expressing concern regarding the decision following an article in the Daily Mail on 13 May 2021. The NMC agreed to meet with the Chief Nursing Officer for England and the NMC appear to have issued a public statement shortly thereafter. A further letter was sent to the NMC by the London Southbank University Institute for Health and Social Care also raising concerns. The NMC wrote to the Authority again on 1 June 2021 outlining the concerns it had received regarding the decision.

## **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:

### ***Decision to dispose of case as a CPD and the evidence before the Panel***

- 9.3 The Members considered whether the case was suitable to be resolved by consent given the seriousness of the allegations and the lack of information from the Registrant. The Members noted that there was limited evidence from the Registrant, she made no witness statement and there was no evidence of remediation. The only material before the Panel from the Registrant was 5-character references and a CV. The Members noted that although noted as an appendix in the CPD, there was no evidence of any training undertaken by the Registrant or reflections on any training before the Panel.
- 9.4 Furthermore, the suggestion in the CPD agreement that the Registrant had undertaken further training which had improved her understanding of racism in the workplace did not appear to have an evidential basis as there was nothing to support this or the Registrant’s learning from the training.
- 9.5 The Members were concerned by the limited evidence before the Panel in terms of the Registrant’s understanding of her misconduct or any changed views or circumstances which would indicate that repetition was unlikely or that the conduct was in fact remediable. The Panel had observed that there was limited evidence to confirm insight or remediation and that there was no evidence that the Registrant had addressed charge 2 (the threat made towards

a patient): the Members considered that this indicated that public protection concerns remained.

- 9.6 The Members considered that the decision to dispose of the case as a CPD was questionable on the basis that there was limited evidence from the Registrant, the lack of any explanation from her for her decision to initially deny the misconduct during her employer's investigations and her decision to engage on a limited basis with the Trust investigation. The Members considered that cumulatively these factors should have indicated to the NMC that the case was not an ideal case for disposal as a CPD.

### *Panel's approach*

- 9.7 The Members considered whether the Panel had fully grappled with the seriousness of the allegations. The Members considered that (i) the draft document presented to the Panel with the summary and reasoning for the suggested sanction and (ii) the Panel's final decision indicated that both the NMC and the Panel had failed to undertake sufficient analysis of the evidence. For instance, neither properly considered whether the Registrant's conduct demonstrated a deep-seated attitudinal problem, that is whether she is racist and/or would encourage violence against patients. The Members also considered that the Panel failed to give consideration to whether the Registrant's behaviour could indeed be changed and if so how.
- 9.8 The Members were further concerned by the lack of consideration by the Panel as to how such discriminatory beliefs may impact on the Registrant's actual conduct and treatment of patients. The racist comments made by the Registrant occurred six years apart and the Members considered that the Panel failed to adequately consider whether this indicated that the Registrant's attitude might affect her dealings with patients.
- 9.9 The Members also noted that the SG did not provide any assistance to the Panel since the matter of racism is not specifically addressed.
- 9.10 The Members concluded that the Registrant's conduct which involved offensive and racist comments as well as a threat of violence towards a patient was extremely concerning. As was the Panel's decision to suspend the Registrant on the basis that her conduct was potentially remediable particularly in light of the limited evidence and lack of any evidence to indicate that remediation was a possibility. The Members considered that there was a lack of reasoning by the Panel for its decision given the seriousness of the misconduct.
- 9.11 The Members noted that whilst the Panel did ask itself whether the misconduct was fundamentally incompatible with continued registration, it failed to explain its conclusion and did not appear to consider the issue sufficiently. The Members considered that there were indicators that the conduct was fundamentally incompatible with continued registration given the lack of insight or remediation and the lack of evidence to confirm that repetition was unlikely.

### *Sanction imposed*

- 9.12 The Members considered whether the Panel was right to accept the CPD and impose a suspension order for 6-months with a review on the basis that the misconduct was remediable.

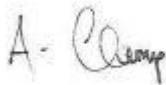
- 9.13 The Members considered that the decision was lacking in reasons as to why the Panel felt it was appropriate to give the Registrant another chance given the limited evidence before it and that the misconduct was not isolated. Furthermore, the Members were concerned that the Panel failed to properly apply the sanctions guidance for suspension. The aggravating factors that applied to this case suggested that, without sufficient explanation, this was not a case where suspension was appropriate. The Members also considered the judicial guidance in the case of Bolton was appropriate here. The Members were concerned that the Panel had not properly considered the impact of this decision on the wider public interest.

#### Conclusion on insufficiency for public protection

- 9.14 The Members concluded that the Panel's decision to accept the CPD and impose a 6-month suspension with a review was insufficient for public protection in that the Panel was wrong in its assessment of the seriousness of the misconduct and failed to take into account what might be deep-seated attitudinal issues on the part of the Registrant, as well as her lack of insight. Furthermore, the Panel failed to give adequate consideration to public confidence issues and did not give adequate consideration of whether the conduct was fundamentally incompatible with continued registration.

#### 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 and Wales.



**Alan Clamp (Chair)**

**20/8/21**

**Dated**

## 11. Annex A – Definitions

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

<b>The Authority</b>	The Professional Standards Authority for Health and Social Care
<b>The Panel</b>	A Fitness to Practise Committee of the Nursing and Midwifery Council
<b>The Registrant</b>	Melanie Jayne Hayes
<b>The Regulator</b>	Nursing and Midwifery Council
<b>NMC</b>	Nursing and Midwifery Council
<b>The Act</b>	The National Health Service Reform and Health Care Professions Act 2002 as amended
<b>The Members</b>	The Authority as constituted for this Section 29 case meeting
<b>The Determination</b>	The Determination of the Panel sitting on 10 May 2021
<b>The Court</b>	The High Court of Justice of England and Wales
<b>The ISG</b>	Regulator's Indicative Sanctions Guidance