Section 29 Case Meeting

30 November 2021

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Susan Nyakwangwa

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny and Quality, Professional Standards Authority
Rebecca Senior-Carroll, Senior Legal Reviewer, Professional Standards Authority

In attendance
Peter Mant of counsel 39 Essex Chambers

Observers
Michael Hannah, Scrutiny Officer, Professional Standards Authority
Collette Byrne, Accreditation 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 Counsel 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 3 December 2021.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 29 September 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:

- The Authority's Detailed Case Review
- Counsel's Note dated 26 November 2021
- Determination of the panel dated 29 September 2021
- Transcripts of the hearing dated 23 September 2021 to 29 September 2021
- Case Examiner Investigation completion report dated 16 July 2019
- Case Examiner decision letter dated 30 December 2019
- The NMC's Code dated 2015
- The NMC's Indicative Sanctions Guidance 2012 (revised 2016)
- The Authority's Section 29 Case Meeting Manual

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

7.2 The Members 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 after they reached a conclusion on the sufficiency on the outcome.

8. Background

8.1 The Registrant was employed as a registered nurse at Thistle Hill Care Home (the Care Home).

8.2 The misconduct took place on 26 February 2016, her first shift at the Care Home. Scarborough and Ryedale Clinical Commissioning Group referred the registrant to the NMC in relation to the care she provided to Patient A, who suffered from multiple health issues. Patient A's condition showed a deterioration that morning and the Registrant was asked to contact the GP Practice for advice.

8.3 The allegation was that the Registrant acted dishonestly because she knew she had not telephoned the GP Practice prior to 1pm. The dishonesty occurred when:

a. on 26 February 2016 when she told Colleagues A and B that she had telephoned the GP practice prior to 1pm

b. on September 2016 during a police interview when she stated that she had telephoned the GP surgery about Patient A prior to 1pm on 26 February 2016

c. giving oral evidence at an inquest into the death of patient A

8.4 The Panel found all the charges proved and that the facts proved amounted to misconduct. It imposed a Suspension order for 12 months, which will be reviewed before it expires.

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:

Whether the Panel failed to appreciate the gravity of the misconduct and/or erred in finding that the conduct was not fundamentally incompatible with continued registration

9.3 The Members noted that it was not clear to what extent the Panel considered the discrete issue of the Registrant being dishonest while giving evidence under oath at the Inquest into Patient A's death. This was a serious aspect of the conduct which did not feature significantly in the decision.

9.4 The Members also had concerns about the Panels analysis of the Registrant's dishonesty as a single act given that it had taken place over a number of months and in respect of different enquiries.

9.5 However, the Members also had regard to the Panel's overall assessment at the misconduct and impairment stage. The members concluded that overall the Panel found that the misconduct was serious.

Whether the Panel erred in departing from the NMC Sanctions Guidance without cogent reasons

9.6 The Members noted the factors outlined in the NMC Sanction Guidance on Suspension Orders. The members considered it questionable whether some of the factors which indicated that suspension was appropriate were present. The members also identified other factors from the guidance which appeared to be engaged suggesting that strike off may be appropriate.

9.7 In particular, the Members noted that the misconduct was not a single event. The Registrant had been dishonest on different occasions and maintained her dishonesty for more than five years. The members considered whether this may suggest an attitudinal problem.

9.8 The Members considered that the Panel's finding that the Registrant had limited insight came solely from her representative's submission that misconduct was accepted. The Members discussed whether accepting to misconduct via a representative can amount to insight.

9.9 The Members considered that the Registrant had a long time to reflect on the incident before the hearing. The Members noted that the Registrant had denied the allegations, her case being that the call was made. When the findings of fact were made the Members noted that there was a short period of time between the fact-finding stage and the grounds stage of the hearing. Therefore, the Registrant had a very short period before the misconduct and impairment stage to reflect and develop insight into the findings.

9.10 In applying the NMC Sanctions Guidance, the Members considered that the Registrant's dishonesty was repeated, related to care provided to a vulnerable patient and impacted on the accuracy of information provided to other healthcare providers. However, the Members noted that the NMC Sanctions Guidance (in particular 'Considering Sanctions for Serious Cases') stated that where a nurse engages with the fitness to practise committee to show that they feel remorse, that they realise they acted in a dishonest way and tell the panel it will not happen again, they may be able to reduce the risk that they will be removed from the register. In this case, the Registrant had engaged in the proceedings and accepted misconduct via her legal representative. The members discussed whether this may be indicative of the beginnings of a journey of reflection for the Registrant.

9.11 The Members considered whether nothing other than a striking-off order would protect the public in this case. The members acknowledged that the suspension order is to be reviewed before its expiration and that this would provide a layer of public protection.

9.12 The Members concluded that all the factors which they discussed in relation this concern were relevant considerations for the Panel, who were required to make an evaluative judgement. The facts were clearly serious and suggested that a

strike off ought to have been given serious consideration. However, the Panel was also entitled to consider the Registrant's engagement and acceptance of misconduct. The panel also considered a strike off and gave some reasons for not choosing to strike off. The Panel had taken the view that the Registrant was at the early stage of developing insight. The members considered that it would be difficult to challenge this evaluative judgement and say that the Panel were wrong to come to this assessment.

Whether the Panel erred in placing undue weight on matters of personal mitigation; and, whether the other mitigating factors relied on by the Panel reasonably justified the sanction imposed

9.13 The Members considered the mitigating factors. The Members considered that the fact it was the Registrants first day at the home should not have carried much weight. However, the Members considered that most of the other factors were appropriately captured and the Panel were entitled to take them into account. However, the Members considered that whilst the initial dishonest act may be regarded as "spur of the moment", the continuing dishonesty was significantly more serious.

9.14 The Members considered whether the Panel gave too much weight to personal mitigation compared with the aggravating factors. The Members also examined whether the panel had given adequate regard to the serious nature of the conduct. They considered that it was not entirely clear how the Panel had weighed the aggravating and mitigating factors. The Members could not conclude whether any or all the mitigating factors had steered the Panel away from a striking-off order.

9.15 The Members noted that the Panel's finding that the Registrant was developing insight seemed to play a significant role in its view that a striking off order would be disproportionate.

Whether the Panel erred in its analysis of the Registrant's insight and/or erred in justifying suspension on the grounds that it would provide time for the Registrant to develop insight

9.16 The Members considered that the Registrant had minimal insight but noted that the Panel had had the opportunity to see the Registrant. The Members considered that in practice it would not have been possible to develop significant insight in the short period of time between the facts-finding stage and the misconduct stage.

9.17 The Members considered whether it can be said that a suspension order with a review, as opposed to a striking-off order, does not protect the public. It was considered that this was a case with finely balanced factors. The Members concluded that a review hearing was a significant part of the sanction in this case. It was further considered that none withstanding a finding of limited insight, it was not unreasonable for the Panel to have imposed a long suspension order, rather than a striking-off order.

Conclusion on insufficiency for public protection

9.18 The Members reiterated that this was a case which was finely balanced. While the conduct was very serious and a strike off was within the band of reasonable outcomes, the Members considered that the assessment of developing insight suggested that a suspension with review may be proportionate. The Members considered that it may be difficult to interfere with this finding. The public would be protected during the suspension and a subsequent Panel could review whether insight had been developed or not. On this basis, the Members decided that the decision was not one which no reasonable Panel could have made. In all the circumstances it was not considered 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.

13/12/21

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 and Midwifery Council
The Registrant	Susan Nyakwangwa
The Regulator	The Nursing and Midwifery Council
NMC	The Nursing and 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 23 September 2021 – 29 September 2021
The Court	The High Court of Justice of England and Wales
The Code	Professional standards of practice and behaviour for nurses and midwives (2015)
The ISG	The Nursing and Midwifery Council's Indicative Sanctions Guidance