

# Section 29 Case Meeting

15 September 2023

16-18, New Bridge St, Blackfriars, London, EC4V 6AG



## ***Members present***

Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority  
Graham Mockler, Director of Regulation and Accreditation, Professional Standards Authority  
Christine Braithwaite, Director of Standards and Policy, Professional Standards Authority

## ***In attendance***

Michael Standing, 39 Essex Chambers, Legal Advisor

## ***Observers***

Amrat Khorana, Board Member  
Georgina Devoy, Senior Scrutiny Officer, Professional Standards Authority  
Simon Wiklund, Head of Legal, Professional Standards Authority

## **1. Definitions**

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the PSA, 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 PSA's decision whether or not to refer the case to the court under Section 29 of the Act.

## **3. The PSA's powers of referral under Section 29 of the Act**

3.1 The PSA 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 PSA 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 21 September 2023.

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

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on [REDACTED]

#### **7. Documents before the meeting**

7.1 The following documents were available to the Members:

- Determination of the panel dated [REDACTED]
- The PSA's Detailed Case Review
- Transcripts of the hearing dated [REDACTED]
- Counsel's Note dated 14 September 2023
- NMC Exhibits
- Case Examiners' report and bundle
- The PSA'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 PSA's Notification of s.29 Meeting.

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

## 8. Background

- 8.1 The Registrant was employed as a Bank Nurse at a brain injuries rehabilitation unit at the time of the incident.
- 8.2 The registrant admitted to the allegation that [REDACTED], on [REDACTED], was convicted of committing an act/series of acts with intent to pervert the course of public justice at [REDACTED] Crown Court. The conviction arose following an incident that occurred at the Unit during a night shift on [REDACTED].
- 8.3 The case before the NMC panel was heard alongside that of Registrant A, a Registered Mental Health Nurse also involved in the incident. Registrant A was convicted of the same offence as the Registrant.
- 8.4 The incident involved Patient A, who required checks to be carried out on him every 15 minutes. The Registrant carried out a check on Patient A at 9:15pm and noted that he was in the room and was alive.
- 8.5 Registrant A arrived at approximately 9:45pm, when he was informed by a support worker that she had found Patient A hanging in his room. Registrant A attended the room and saw Patient A hanging from a ligature around his neck. Registrant A did not immediately commence CPR but went to the office where he dialled 999. This 999 call was subsequently taken over by the Registrant. During the call, Registrant B was asked if CPR had commenced, and she replied that it had not.
- 8.6 Paramedics attended, but were unable to resuscitate Patient A. Both Registrants and the support worker all told that police that CPR attempts on Patient A had been commenced as soon as Patient A was found. The police were suspicious of this account, given the conflict with what Registrant B had said during the 999 call.
- 8.7 The police launched an investigation, and the Registrant, Registrant A and the support worker all gave statements to the police confirming that CPR attempts on Patient A had been commenced as soon as Patient A was found. A few days after her initial interview on [REDACTED], where the Registrant gave an untruthful account, she contacted the police through her solicitor asking to be re-interviewed. In a second interview on [REDACTED] interview, she stated that her previous account was not true and that she had lied at Registrant A's behest. She stated that Registrant A feared the consequences for him and his family, were it to be discovered that he had not immediately attempted to resuscitate Patient A.
- 8.8 Both Registrants were charged with perverting the course of justice.
- 8.9 The Registrant pleaded guilty on [REDACTED] at [REDACTED] Crown Court and was sentenced on [REDACTED] to four months imprisonment, suspended for 12 months, with 150 hours of unpaid work.
- 8.10 The Panel found the Registrant's fitness to practise was not currently impaired by the conviction. As such, they did not take any further action.

## 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:

### *Impairment on public interest grounds*

- 9.3 First, the Members discussed the narrow issue of whether the Panel was wrong to decide that no finding of impairment was required on public interest grounds. The Members noted that this included, marking the profound unacceptability of the registrant's behaviour, emphasising the importance of the breach of a fundamental tenet of the profession, and reaffirming proper standards of behaviour in order to maintain public confidence in the practitioner and in the profession.
- 9.4 In doing so, the Members discussed whether the panel placed excessive weight on personal mitigation factors such as the Registrant's insight, remediation and remorse, rather than the public interest factors. The Members considered the Panel's reasoning in respect of the public interest to be short and lacking in detail, and that although the Panel appeared to go through a balancing exercise, this was not overtly carried out. They noted that although the Panel's assessment of factors to be assessed on each limb should be different, there was no indication these had been separated out, and that there had been only a cursory reference to Grant. The Members, therefore, found it difficult to assess the level of weight given to the various factors and that these were somewhat blurred.
- 9.5 The Members also discussed whether the Panel had failed to recognise or give sufficient weight to the factors which would undermine the public's confidence in the profession, namely the very serious nature of the misconduct in lying to the police about the care provided to a patient in the aftermath of the patient's death, and the fact that it resulted in a criminal conviction and a sentence of imprisonment (albeit suspended). The Members considered that the panel's decision failed to mark this seriousness or fully explain its decision, and that this was required in order to sufficiently declare and uphold standards. They noted however that there is no automatic rule that a conviction will result in a finding of impairment.
- 9.6 Next, the Members discussed the advice provided by the legal advisor. They considered this to be muddled and inaccurate, and that it conflated the factors relevant to personal impairment and public interest impairment, meaning it would be difficult for a lay member to grasp. They considered it to be insufficient with regards to the approach to the analysis of upholding standards and public interest impairment, and that it directed the panel on an unhelpful route which may have contributed to its ultimate lack of strong reasoning within the decision.

### Conclusion on insufficiency for public protection

- 9.7 The Members were concerned with the panel's lack of reasoning in respect of its finding of no impairment on public interest grounds. Nevertheless, they concluded that, despite the terrible breach of professional standards and duty of candour displayed by the Registrant, the decision of the Panel was not one which no properly directed panel could have reached, nor could it conclude that the inaccurate legal advice ultimately led to a decision which was unreasonable.
- 9.8 In reaching this conclusion, they took into account the Registrant had told the truth very soon after the initial lie to the police, had cooperated with the authorities, was sentenced to a suspended sentence of four months imprisonment, completed 150 hours of unpaid work, and had developed full insight, remorse and had strengthened their practice. The Members also took into account that the Panel was assessing the Registrant's current fitness to practise, and that the passage of time that has elapsed since the incident may have benefited the Registrant through the lack of any repetition.
- 9.9 The Members therefore reached a conclusion that the risk of repetition was very low and that the public confidence aspect could still be satisfied by the mitigating factors outlined above. In all the circumstances, therefore, the decision of the Panel 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 PSA's power under Section 29 to refer the case to the relevant court.



**Alan Clamp (Chair)**

**05/10/23**

**Dated**

**11. Appendix A – Definitions**

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

<b>The PSA</b>	The Professional Standards Authority for Health and Social Care
<b>The Panel</b>	A Fitness to Practise Committee of the NMC
<b>The Registrant</b>	[REDACTED]
<b>The Regulator</b>	The Nursing and Midwifery Council
<b>Regulator’s abbreviation</b>	NMC
<b>The Act</b>	The National Health Service Reform and Health Care Professions Act 2002 as amended
<b>The Members</b>	The PSA as constituted for this Section 29 case meeting
<b>The Determination</b>	The Determination of the Panel sitting [REDACTED]
<b>The Court</b>	The High Court of Justice of England and Wales