Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
24 – 27 August 2021
1 – 2 September 2021

Nursing and Midwifery Council
Forsyth House, Cromac Square, Belfast, BT2 8LA (24 – 27 August 2021)
Virtual Hearing (1 – 2 September 2021)

Name of registrant:	Norman Mylinn George Walker	
NMC PIN:	02H0041S	
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – August 2005	
Area of registered address:	County Down	
Type of case:	Misconduct	
Panel members:	Bryan Hume Jonathan Coombes David Boyd	(Chair, Lay member) (Registrant member) (Lay member)
Legal Assessor:	Gareth Jones	
Panel Secretary:	Xenia Menzl	
Nursing and Midwifery Council:	Represented by Matthew Kewley, Case Presenter	
Mr Walker:	Not present and not represented in absence	
Facts proved:	Charges 2c,d, e, 4, 5a, 5b, 7	
Facts not proved:	Charges 1, 2b, 6, 8a, b	
Fitness to practise:	**Impaired**	
Sanction:	**Striking-Off Order**	
Interim order:	**Interim Suspension Order, 18 Months**	

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Walker was not in attendance and that the Notice of Hearing letter had been sent to Mr Walker's registered email address on 22 July 2021.

Further, the panel noted that the Notice of Hearing was also sent to Mr Walker's representative on 22 July 2021.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mr Walker's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Mr Kewley, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr Walker has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Walker

The panel next considered whether it should proceed in the absence of Mr Walker. It had regard to Rule 21 and heard the submissions of Mr Kewley who invited the panel to continue in the absence of Mr Walker. He submitted that Mr Walker had voluntarily absented himself.

Mr Kewley referred the panel to an email, dated 24 august 2021, from Mr Walker's representative which stated:

> '*I can confirm that Mr walker* [sic] *is aware the hearing was commencing today and* […] [Mr Walker] *is content for the hearing to proceed in his absence*.'

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5

The panel has decided to proceed in the absence of Mr Walker. In reaching this decision, the panel has considered the submissions of Mr Kewley, the representations made on Mr Walker's behalf, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made;
- Mr Walker's representative has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure Mr Walker's attendance at some future date;
- Five witnesses are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in June 2018;

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Walker in proceeding in his absence, although the evidence upon which the NMC relies will have been sent to him, he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Walker's decisions to absent himself from the hearing, waiving his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Walker. The panel will draw no adverse inference from Mr Walker s absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kewley, on behalf of the NMC, to amend the wording of charges 2 (a), the body of charge 3, 3e), 3e)ii), 3e)v), and 8a).

The proposed amendment in charge 2a) was to delete it in its entirety. It was submitted by Mr Kewley that various witnesses do state that Mr Walker did announce that he was leaving the home. He submitted that the charge itself suggests that Mr Walker left the home without telling anyone, however that was not the case. Mr Kewley stated that removing the charge would not change the misconduct or the mischief of the allegations. He therefore invited the panel to remove charge 2a).

In relation to charge 3 Mr Kewley invited the panel to remove the first half of the stem of the charge. He submitted that amending the first part of the stem does not alter the charge itself and makes the charge clearer. He stated that amending the first part of the stem clearly still explains that charges 3a) to 3e) are in respect of taking Resident A out of the Home on 19 June 2018.

He therefore invited the panel to make the following amendment:

Original charge:

> 3) ~~In relation to the matters referred to in charge 2 above~~, failed to record/document, adequately, or at all, any of the following:

Amended Charge

> 3) **In respect of taking Resident A out of the Home on 19 June 2018**, failed to record/document, adequately, or at all, any of the following:

In relation to charge 3e) Mr Kewley submitted that whilst the charge states that Mr Walker failed to make notes in Resident A's records including the communication log, the staff communication diary, the handover document and the 24 hour report, these were not in fact Resident A's records. He therefore invited the panel to remove the words '*Resident A's records including*'

Original Charge

> e) notes relating to the trip ~~in Resident A's records including~~:

Amended Charge:

> e) notes relation to the trip.

In relation to charge 3e) ii) Mr Kewley submitted that it is a duplication of charge 3e) v). He submitted that the communication log is the same as the 24 hour log in this case. He therefore invited the panel to remove charge 3e) ii).

Lastly, Mr Kewley submitted that charge 8a) is stating '*as requested*', however, he stated that the observations were requested and that the main misconduct in this charge relates to the observations being done in a timely manner. He therefore invited the panel to remove '*as requested and*' from the charge.

Original Charge:

8 a) undertake observations ~~as requested and/or~~ in a timely manner;

Amended Charge:

8 a) undertake observations in a timely manner;

Mr Kewley submitted that the changes are a particularisation of the charges and do not cause prejudice. He informed the panel that these amendments have been sent to Mr Walker's representative, who has chosen not to comment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that the amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Walker and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Kewley under Rule 31 to allow the hearsay evidence in relation to the following charges:

1) *On 19 June 2018, had sexual intercourse/activity with Resident A;*

6) *Your conduct at any and/or all of charges 2- 5 above was sexually motivated in that you were seeking to create a situation in which you could sexually abuse Resident A;*

Mr Kewley provided the panel with written submissions. The submissions set out the background of the case and explained why the NMC was not able to obtain a witness statement from Resident A and why she was not able to attend the hearing in person. In summary he submitted that the hearsay evidence is relevant to charges 1 and 6. Due to Resident A's mental health issues it would not have been appropriate for the NMC to have approached her in view of obtaining a witness statement for the purposes of these proceedings, however, if it were not for the mental illness of Resident A her evidence would have been admissible. Resident A's evidence is the sole and decisive evidence in respect of charges 1 and 6 and is wholly disputed. There is no evidence to corroborate Resident A's account and if the evidence were to be admitted there will be no opportunity to challenge or explore the account of Resident A. Mr Kewley submitted that the only accounts from Resident A come from short bursts for information that were said to others.

Mr Kewley further submitted that Resident A never named Mr Walker and there were no identification procedures during the police investigation in which Resident A was asked to identify Mr Walker. He further submitted that with regards to the evidence being demonstrably reliable, that the current Home Manager stated that '*Resident A can get mixed up between reality and delusion*'. Further, he acknowledged that there are further internal inconsistencies with Resident A's accounts.

Mr Walker's representative, provided the panel with written submissions with regard to the NMC's hearsay application. In summary, the submissions acknowledge that the hearsay evidence is relevant to charges 1 and 6. It was noted that Mr Walker was not convicted of any criminal offence. Further, due to Resident A's health conditions her reliability is questionable and there will be no opportunity to test the reliability of her evidence. It was therefore submitted, on Mr Walker's behalf, that there is no further evidence to corroborate

Resident A's account. Additionally, it was submitted that there are inconsistencies in Resident A's account. The panel was therefore invited to not admit the hearsay evidence.

The panel heard and accepted the legal assessor's advice which included reference to the cases of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin).

The panel determined that Resident A's evidence is the sole and decisive evidence with regard to charges 1 and 6. The panel acknowledged the NMC's efforts to obtain a witness statement from Resident A, however understood that her mental health would not allow for a statement to be obtained or that her attendance at the hearing could be secured.

The panel further had regard to an email from Resident A's doctor, dated 19 August 2020, which states:

> '[Resident A] *suffers from Schizophrenia. Her condition is at the severe end of the spectrum which is why she requires the level of care she is currently receiving. One of the most obvious symptoms of her condition is a symptom called Thought Disorder. This causes her thoughts, and as a consequence her speech, to constantly jump from one unrelated idea to another. This makes it very difficult for her to express her thoughts clearly or to give a coherent narrative*.'

The panel further noted that Resident A '*can get mixed up between reality and delusion*'.

The panel also noted that there was no other evidence corroborating the allegations. It noted that Resident A has not named Mr Walker and that the reference to '*the big man*' could not be confirmed by a number of witnesses. The panel therefore determined that there are inconsistencies between the witness evidence.

The panel was of the view that the hearsay evidence was weak and not reliable, there was no opportunity to test the evidence and Mr Walker denies the allegations. The panel noted

that the allegations are serious and could result in serious consequences if found proved. Further, the reliability of Resident A is questioned due to her ongoing mental illness.

In these circumstances the panel refused the application.

Details of charge (as amended)

That you, a registered nurse:

1) On 19 June 2018, had sexual intercourse/activity with Resident A; **[not proved]**

2) On 19 June 2018, escorted/took Resident A out of the Home without:
    a) […]
    b) clinical justification; **[not proved]**
    c) permission; **[proved]**
    d) completing a risk assessment; **[proved]**
    e) using an appropriate mode of transport, in that you used a private vehicle; **[proved]**
    f) using the entry and/or exit fob system; **[proved]**
    g) an additional person present; **[proved]**

3) **In respect of taking Resident A out of the Home on 19 June 2018** you failed to record/document, adequately, or at all, any of the following:
    a) your rationale/reasoning for taking Resident A out of the Home on 19 June 2018; **[proved]**
    b) a risk assessment; **[proved]**
    c) Resident A's departure from and/or return to the Home; **[proved]**
    d) Your departure from and/or return to the Home; **[proved]**
    e) notes relating to the trip in: **[proved in its entirety]**
        i) the care plan;
        ii) **[…]**
        iii) the staff communication diary;

iv) the handover document;
v) 24 hour report;

4) Inaccurately stated to Colleague A that you had permission to escort/take Resident A from the Home on 19 June 2018; **[proved]**

5) Your conduct at charge 4 above was dishonest in that you:
    a) knew that you did not have permission to escort/take Resident A from the Home on the date and/or in the circumstances in question; **[proved]**
    b) intended to create the misleading impression that you had permission to escort/take Resident A from the Home on the date and/or in the circumstances in question; **[proved]**

6) Your conduct at any and/or all of charges 2- 5 above was sexually motivated in that you were seeking to create a situation in which you could sexually abuse Resident A; **[not proved]**

7) Having left the Home with Resident A on 19 June 2018, compromised patient care at the Home; **[proved]**

8) On **the nightshift starting on** 07 February 2018, and in relation to Patient B who was found with an open wound on their head, failed to:
    a) undertake observations **in a timely manner**; **[not proved]**
    b) administer medication as prescribed/in a timely manner. **[not proved]**

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Background

Mr Walker was referred to the Nursing and Midwifery Council on 21 June 2018.

The allegations arose whilst Mr Walker was employed as a registered nurse at Lecale Lodge Care Home (the Home) in Downpatrick, Northern Ireland. The Home had a capacity of 54 residents across four separate units. The majority of the units are for residents with mental health needs.

On 19 June 2018 Mr Walker was the senior nurse in charge in the absence of the Manager, Colleague B. It is alleged that Mr Walker took Resident A out of the Home on his own for a period of time on the morning of 19 June 2018.

Resident A resided on a unit for residents with challenging mental health needs. She had a diagnosis of schizophrenia and would hear voices. Resident A had communication difficulties, she could verbalise but would essentially have two parallel conversations going on alongside each other.

It is alleged that there was no clinical justification for taking Resident A out of the Home that day. Resident A did not have a medical appointment to attend on that date. This allegedly occurred in the context of Resident A being at a high risk of absconding, thus rendering it inappropriate to have taken Resident A out of the Home without permission, risk assessment or appropriate documentation. It is alleged that Mr Walker told Colleague A that he had permission to leave the home with Resident A despite knowing he had not obtained such permission. It is alleged that by leaving the Home Mr Walker compromised patient care at the Home.

On the night shift starting on the 7 February 2018 Mr Walker was working as the nurse responsible for Patient B who was found with an open wound on their head. It is alleged that Mr Walker failed to undertake observations in a timely manner and to administer Patient B’s prescribed medication in a timely manner.

Amendment of charge 8

Before any finding on facts the panel noted that the stem of charge 8 states:

On 07 February 2018

However, the panel heard evidence that the alleged mischief occurred on the nightshift starting on the 7 February 2018 and the events alleged mostly happened after midnight, therefore occurring on the 8 February 2020. The panel therefore, invited Mr Kewley to make submissions.

Mr Kewley submitted that the original charge does not defer from the mischief in this charge and made no application to amend the charge. However, he acknowledged that it was in the panel's power to amend the charge should they wish to clarify the stem of the charge.

The panel heard and accepted the advice of the legal assessor.

The panel determined to amend the stem of charge 8 to clarify that the alleged misconduct occurred on the nightshift starting on the 7 February 2018, which also covers the 8 February 2018.

<u>Original charge:</u>

8) On 07 February 2018, and in relation to Patient B who was found with an open wound on their head, failed to:

<u>Amended charge:</u>

8) On **the nightshift starting on** 07 February 2018, and in relation to Patient B who was found with an open wound on their head, failed to:

Moving the Hearing to Virtual

Before handing down on the decision on facts the panel heard submissions form Mr Kewley to move the hearing to be heard virtually. He reminded the panel that the notice of hearing stated that the hearing would take place in person in Belfast at the Regus offices. However, over the weekend the NMC became aware of a Covid-19 related matter and decided not to proceed in person in Belfast to protect public safety.

Mr Kewley stated that Mr Walker's representative was contacted and asked if he had any objection with the hearing proceeding virtually on 31 August 202. It was indicated in writing that there was no objection to the hearing continuing virtually.

Mr Kewley invited the panel to consider the following factors:

- Whether it is satisfied that there is a good reason to proceed virtually;
- Whether it is practicable to proceed virtually;
- Whether it is fair to proceed in this way; and
- Whether proceeding virtually allows for an expeditious exposal of the case.

The panel heard and accepted the advice of the legal assessor.

The panel considered Mr Kewley's submissions and the fact that Mr Walker's representative had no objections to proceeding with the hearing virtually. It was of the view that proceeding virtually was in the interest of public safety, to prevent the risk of spreading the virus and to protect the participants health and safety. The panel was also of the view that it was practicable to proceed in that way. It noted that the NMC has been conducting virtual hearings since March 2020 and that it is common practice now to do so. The panel was of the view that it had the opportunity to see and hear the witnesses attending in person and was content that it was the most practicable way to proceed virtually. Further, the panel determined that there was no prejudice against Mr Walker in proceeding virtually. Lastly, the panel was of the view that this was the most practicable

way to dispose of the case expeditiously. The panel therefore determined to proceed with the case virtually.

Facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kewley and the written submissions by Mr Walker's representative. The panel noted that whilst the submissions on Mr Walker's behalf were solely on the issue of Mr Kewley's hearsay application they contained some explanations and admissions to the facts. The panel noted the admissions. However, as neither Mr Walker nor his representative were present and these admissions were not explicit, it determined to approach the fact finding process in the same way as if no admissions were made.

The panel has drawn no adverse inference from the non-attendance of Mr Walker.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Colleague A: Staff Nurse at Lecale Lodge at the time of the incidents;
- Colleague B: Nurse Manager at Lecale Lodge at the time of the incidents.
- Colleague C: Senior support worker at Lecale Lodge.

- Colleague D: Support Worker at Lecale Lodge.

- Colleague E: Staff Nurse at Lecale Lodge.

Charge 1

1) On 19 June 2018, had sexual intercourse/activity with Resident A;

This charge is found NOT proved.

The panel reminded itself of its decision not to allow the hearsay evidence of Resident A. It therefore noted that there was no evidence before it with regards to charge 1.

This charge is therefore not found proved.

Charge 2b)

2) On 19 June 2018, escorted/took Resident A out of the Home without:
    b) clinical justification;

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral witness evidence of Colleague A and Colleague B.

The panel noted that the stem of Charge 2 was not contested. Mr Walker accepts that he had taken Resident A out of the Home on 19 June 2018. This was confirmed in the written hearsay application submissions by Mr Walker's representative.

The panel noted that Colleague A stated in his written statement that Resident A had an unsettled night. He confirmed this in his oral evidence, where he also stated that Resident A was agitated and that the usual methods of settling her down, including her 'pro re nata' (PRN) medication were not working. Colleague A stated that Resident A was in an agitated state and that Mr Walker stated that he would take her out to calm her down:

> '[Mr Walker] *approached me and said that he would take Resident A out in his car. He said that it was a convertible and he would take the roof down so it would help her to settle and then she would be able to sleep when she returned.*'

Upon questioning by the panel if that was a reasonable measure, Colleague A stated that in his opinion taking Resident A out would distract her and this could calm her down. He stated that it was a reasonable measure. Colleague A stated that Mr Walker was senior to him in this situation and that taking her to go out of the unit would have been appropriate.

Colleague B in her oral evidence stated that usual methods of calming Resident A would include Management of Actual or Potential Aggression (MAPPA) techniques, creating a calm atmosphere in a known environment. Colleague B stated that taking Resident A out in a car could have caused further stimulation which could have led to her being more agitated. Colleague B stated in her oral evidence that taking Resident A out of her familiar environment to calm her down would have been unusual and not common practice.

The panel noted Colleagues B professional opinion on the techniques used to calm Resident A down. It noted that according to Colleague A all known techniques had been used to calm Resident A down, including medication, however, these were not successful. The panel further noted that Colleague B was not present that day and was not able to assess the situation and if there was a clinical justification to take Resident A out of the unit. The panel concluded that whilst it was unusual and not common practice to take Resident A out of the Home in an agitated state, Mr Walker did give a reason as to why he had taken her out. The panel concluded that the clinical justification for his decision was that he intended to calm her down from her agitated state. The panel therefore determined that there was a clinical justification for his action.

This charge is therefore found not proved.

Charge 2c)

2) On 19 June 2018, escorted/took Resident A out of the Home without:
    c) permission;

This charge is found proved.

In reaching this decision, the panel took into account the written and oral witness evidence of Colleague A and Colleague B.

The panel noted that Colleague A stated in his written statement:

> '[Mr Walker] *told me that he had checked with* [Colleague B] *and she was satisfied that he could run the errand and take her with him. He came straight out saying he had received authorisation and I had no reason to not believe this.*'

Colleague B stated that she was not in the Home at the 19 June 2018 due to an appointment. She stated in her written statement:

> '*I am aware that* [Mr Walker] *told* [Colleague A] *that he was taking Resident A out of the unit with my permission but all members of staff would need to know where a resident was. Just to reiterate* [Mr Walker] *did not ever tell me he was removing Resident A from the building, I would not have allowed this.*'

Colleague B confirmed this in her oral evidence and explained that she would not have allowed this due to several factors:

- Resident A was always accompanied by two members of staff due to the risk of absconding;

- Mr Walker was the senior nurse on that shift with responsibility for the senior file, he was the point of contact for all other nurses in case of emergency;
- All members of staff would need to know where a Resident was, even outside of the Home;
- Colleague B had not given Mr Walker permission to leave the home to run errands that day and no other cover was put in place to cover any period he would have not been in the Home;
- Colleague A was the only other staff nurse on shift that day, all other nurses were agency nurses.

Colleague B also confirmed that it was highly unusual that a nurse would take a Resident out of the unit and that there was special staff, Patient Advice and Liaison Service (PALS) and support workers who would do this. She told the panel that unless it was a clinical appointment, there was no reason for a nurse to take a resident out of the Home.

The panel noted that Mr Walker had been working at the Home for approximately a year and a half before the incident and would have been very familiar with best practice and the Home's protocol. It noted that Colleague B very clearly stated that she had, for the above stated reasons, not given Mr Walker permission to take Resident A out of the Home. Further, the panel noted that Mr Walker clearly stated to Colleague A that he had permission to take Resident A out of the Home. The panel therefore concluded that Mr Walker knew that permission was needed to take resident out of the Home.

The panel found Colleague B to be to be credible and reliable and therefore preferred her evidence.

The panel was therefore satisfied, on the balance of probabilities, that it is more likely than not that on 19 June 2018 Mr Walker escorted/took Resident A out of the Home without permission.

Charge 2d)

2) On 19 June 2018, escorted/took Resident A out of the Home without:
    d) completing a risk assessment;

This charge is found proved.

In reaching this decision, the panel took into account the written and oral witness evidence of Colleague B and the Home's Escort Policy.

The panel noted that the Home's Escort Policy requires any nurse to complete a risk assessment before taking a resident out of the Home and that this should be recorded in the resident's care plan.

> *'8.1 Following an assessment of any risks, the Person in Charge should determine the number and grade of staff to provide the escort, and ensure they are available. There should also be adequate staff left to cover the unit. Where this is not possible, the on-call manager should be contacted for advice.'*

The panel also noted that it heard from several witnesses that Resident A was well known to abscond and that therefore a risk assessment was necessary before taking her out of the Home safely.

The panel noted that there is no evidence before it to show that a risk assessment had been carried out. Colleague B confirmed that there was no record at all of Mr Walker taking Resident A out of the Home on the 19 June 2018. It therefore concluded, that in the absence of a risk assessment having been carried out, that Mr Walker did not carry out a risk assessment before taking Resident A out of the Home.

The panel was therefore satisfied, on the balance of probabilities, that on 19 June 2018 Mr Walker escorted/took Resident A out of the Home without completing a risk assessment.

Charge 2e)

2) On 19 June 2018, escorted/took Resident A out of the Home without:
    e) using an appropriate mode of transport, in that you used a private vehicle;

This charge is found proved.

In reaching this decision, the panel took into account the written and oral witness evidence of Colleague A, Colleague B and the Home's Escort Policy.

The panel noted that the Home's Escort Policy states:

'*Based on an assessment of the Person's mental and physical state, and risk presented, the Person in Charge must consider the following:*

- *the most suitable form of transport to convey the Person, e.g. fully insured* ***company or private vehicle****, mini cab, wheelchair taxi or ambulance*'

Colleague A stated in his written and oral statement that Mr Walker had taken out Resident A in his private vehicle, a convertible.

Colleague B accepted in her oral evidence that a private car may be used in some circumstances but that this decision should be based on an assessment of the resident's mental and physical state and the risk presented. The panel noted that Colleague B stated that it was highly inappropriate to use a private vehicle when transporting Resident A due to her mental state on the 19 June 2018, the fact that she was under the influence of PRN medication. Resident A continued to have unpredictable outbursts even after PRN mediation was administered and there was no other person in the vehicle who could have intervened in the event of a further outburst from Resident A whilst Mr Walker was driving. The panel further noted that Resident A was at risk of absconding, the panel therefore accepted Colleague B's view that a private vehicle driven by Mr Walker, without another member of staff present, was not an appropriate mode of transport on any occasion.

The panel was therefore of the view that, on the balance of probabilities, it is more likely than not that on 19 June 2018 Mr Walker escorted/took Resident A out of the Home without using an appropriate mode of transport, in that he used a private vehicle.

Charge 2f)

2) On 19 June 2018, escorted/took Resident A out of the Home without:
    f) using the entry and/or exit fob system;

This charge is found proved.

In reaching this decision, the panel took into account the written and oral witness evidence of Colleague B, and the Lecale Lodge TA Date Report dated 16 to 24 June 2018.

The panel noted that the fob system was recorded on the Lecale Lodge TA Date Report. Colleague B confirmed that these times were recorded for the purposes of payroll and also to have a record of staff present at the Home in case of emergencies such as fire. The entry in the Lecale Lodge TA Date Report dated 19 June 2018 clearly shows that Mr Walker entered the Home on 19 June 2018 at 7:11 and left the Home at 20:04.

The panel determined that there is no evidence before it to show that Mr Walker used the fob system when he left the Home with Resident A.

The panel was therefore satisfied, on the balance of probabilities, that on 19 June 2018 Mr Walker escorted/took Resident A out of the Home without using the entry and/or exit fob system.

Charge 2g)

2) On 19 June 2018, escorted/took Resident A out of the Home without:
    g) an additional person present;

This charge is found proved.

In reaching this decision, the panel took into account the written and oral witness evidence of, Colleague B and the Home's Escort Policy.

The panel noted that the Home's Escort Policy states:

'*Based on an assessment of the Person's mental and physical state, and risks presented, the Person in Charge must consider the following:*

[…]

- *how many staff should provide an escort and what skills they will require?*'

The panel accepted Colleague B's evidence that it was highly inappropriate in Resident A's case to take her out of the Home with less than two members of staff due to her high risk of absconding. The panel notes that Mr Walker accepts that there was no additional person present.

The panel was therefore satisfied, on the balance of probabilities, that it is more likely than not that on 19 June 2018 Mr Walker escorted/took Resident A out of the Home without an additional person present.

Charge 3

3) In respect of taking Resident A out of the Home on 19 June 2018 you failed to record/document, adequately, or at all, any of the following:
    a. your rationale/reasoning for taking Resident A out of the Home on 19 June 2018;

b. a risk assessment;
c. Resident A's departure from and/or return to the Home;
d. Your departure from and/or return to the Home;
e. notes relating to the trip in:
    vi) the care plan;
    vii)
    viii) the staff communication diary;
    ix) the handover document;
    x) 24 hour report;

This charge is found proved in its entirety.

The panel considered charge 3 in its entirety, including all sub-charges.

In reaching this decision, the panel took into account the written and oral witness evidence of Colleague A, Colleague B and the Home's Escort Policy.

The panel noted that in addition to the already mentioned segments of the Home's Escort policy it also states:

'*10.0 After Escorting*

10.1 On return to the unit, the staff who escorted the Person must make an entry in the Person's record, identifying the reason for the escort, the Person's behaviour, and the outcome of the escort.

10.2 The Person in Charge must be informed of the outcome of the visit and/or any accidents or incidents that occurred during that time. It must be recorded in the Person's Care Plan. A Datix report must be completed if indicated.'

The panel noted Colleague B's evidence in which she stated that she had reviewed all of the relevant notes including Resident A's care plan, electronic notes, staff communication diary, handover report and 24 hour report, however, has not found any evidence of Mr Walker having made any entry regarding taking Resident A out of the Home.

The panel concluded that Mr Walker had a duty to record taking Resident A out of the Home. It noted the absence of any entries in the above named records. It noted that Mr Walker stated that he '*did not consider notes were required*', however, the panel was of the view that this was highly unlikely due to the nature of the Home and the fact that all residents are vulnerable and at risk with substantial long standing mental health issues.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that on 19 June 2018 In respect of taking Resident A out of the Home Mr Walker failed to record/document, adequately, or at all, his rationale/reasoning for taking Resident A out of the Home, a risk assessment, Resident A's departure from and/or return to the Home; Mr Walker's departure from and/or return to the Home and notes relating to the trip in the care plan, the staff communication diary; the handover document and the 24 hour report.

Charge 4)

4) Inaccurately stated to Colleague A that you had permission to escort/take Resident A from the Home on 19 June 2018;

This charge is found proved.

In reaching this decision, the panel took into account the written and oral witness evidence of Colleague A and Colleague B.

The panel reminded itself of its findings in charge 2c). Colleague B clearly stated that she had not given Mr Walker permission to take Resident A out of the Home. It also noted that

Colleague A very clearly stated that Mr Walker told him that he had permission to take Resident A out of the Home. The panel was of the view that even if Colleague A did not understand the serious nature of Mr Walker's actions Colleague A was very fair towards him while giving oral evidence.

The panel further noted that in the written submissions provided by Mr Walker's representative stated that there was miscommunication between Mr Walker and Colleague A. However, the panel noted that, despite the high pressure environment of the Home, Colleague A was very clear that Mr Walker stated that he had permission and could recall who Mr Walker stated the permission was from. The panel was of the view that should Mr Walker have thought there was no need to have permission to take Resident A out of the Home there would have been no need to make such a statement to Colleague A at all.

The panel was therefore satisfied, on the balance of probabilities, that it is more likely than not that Mr Walker inaccurately stated to Colleague A that he had permission to escort/take Resident A from the Home on 19 June 2018.

Charge 5)

5) Your conduct at charge 4 above was dishonest in that you:
    a) knew that you did not have permission to escort/take Resident A from the Home on the date and/or in the circumstances in question;
    b) intended to create the misleading impression that you had permission to escort/take Resident A from the Home on the date and/or in the circumstances in question

This charge is found proved, including all sub-charges.

In reaching this decision, the panel took into account the written and oral witness evidence of Colleague A and Colleague B.

The panel reminded itself of its findings with regard to charges 2c) and 4.

The panel noted that Mr Walker had been working for the Home for a year and half before the incident and that he should have been aware of all policies and good practice. The panel was therefore of the view that Mr Walker should have been aware that he had a duty to ask for permission to take Resident A out of the Home.

The panel determined that an ordinary and decent person would consider Mr Walker stating that he had permission to leave the home with Resident A when he had not was dishonest. Further, the panel determined that an ordinary and decent person would consider that Mr Walker's intention when stating to Colleague A that he had permission when he had not had the intention to mislead Colleague A and give the impression that he had permission to leave the home with Resident A when he had not.

The panel was therefore satisfied that, on the balance of probabilities, it is more likely than not that Mr Walker's conduct in Charge 4 was dishonest in that he knew that he did not have permission to escort/take Resident A from the Home on the date and/or in the circumstances in question and intended to create the misleading impression that he had permission to escort/take Resident A from the Home on the date and/or in the circumstances in question.

Charge 6

6) Your conduct at any and/or all of charges 2- 5 above was sexually motivated in that you were seeking to create a situation in which you could sexually abuse Resident A;

This charge is found NOT proved.

The panel reminded itself of its decision not to allow the hearsay evidence of Resident A. It therefore noted that there was no evidence before with regards to charge 6.

This charge is therefore not found proved.

Charge 7

7) Having left the Home with Resident A on 19 June 2018, compromised patient care at the Home;

This charge is found proved.

In reaching this decision, the panel took into account the written and oral witness evidence of Colleague A and Colleague B, the Staff and Senior Nurse Rota for the 19 June 2018 and the description of the role of the person on senior cover.

The panel noted that Mr Walker was on shift and that he was also noted as the person on senior cover on the 19 June 2018. It noted the Role of Senior Cover description which states:

'*The home must always have a designated person in charge*.'

The panel noted that Colleague A was new to the home and stated that he has not had an induction to be the senior nurse. Colleague B confirmed this in her oral evidence. The panel also noted that Colleague B stated that the Unit that Resident A resided in was a particularly difficult unit and always had a requirement for two registered nurses to provide safe and effective care. Colleague B told the panel that, as she knew that she was not going to be at the Home that day, she staffed the Home so that Mr Walker would work with Colleague A on the more demanding Unit. The panel accepted that Colleague B moved Mr Walker to the downstairs unit to take charge as the senior nurse and cover senior responsibilities in her absence on that day. The panel found that Colleague B was very

clear that the senior nurse in charge was the designated person for other nurses and staff to approach during an emergency and was therefore to remain at the Home at all times.

The panel found that Mr Walker leaving the Home without permission and without designating a person in charge of the Home while he was away could have led to serious complications in case of an emergency. Colleague A stated that none of the other nurses that day were trained to be the senior nurse in charge and Colleague B confirmed that he understood that in Mr Walker's absence he would be responsible for the Unit, but not the whole Home. The panel was of the view that leaving the Home whilst having that responsibility left other staff to potentially make decisions that they were not qualified to do, not only putting patients at risk but also colleagues at risk of their registration.

The panel was therefore satisfied, on the balance of probabilities, that it is more likely than not that having left the Home with Resident A on 19 June 2018, Mr Walker compromised patient care at the Home.

Charge 8a)

8) On the nightshift starting on 07 February 2018, and in relation to Patient B who was found with an open wound on their head, failed to:
    a) undertake observations in a timely manner;

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence by Colleague D and Colleague E, Resident B's electronic Patient Notes and Datix entry.

The panel noted Mr Walker's entry in Resident B's patient notes, dated 8 February 2018 at 06.05 which states:

'*Resident B became agitated at 1am, hitting his head of the wall. Datix completed,* […] *Resident B then began to complain of breathing difficulties, physical ob's checked and recorded.*'

Colleague D states in her written statement:

'*I said to* [Mr Walker] *"Are you not going to take* [Resident B's] *observations?" Norman said "I am" and then he went to get the oximeter.*'

The panel noted that observations of Resident B were noted in his patient notes between 1am and 2.40pm. The panel was therefore of the view that Mr Walker had taken observations of Resident B shortly after the incident. The panel also noted that several witnesses confirmed that there was a handwritten document on which observations were noted down. However, the panel had no documentation before it to show that such a document existed for the observations taken for Resident B on the 8 February 2018. The panel also noted that Colleague E stated that there may have been a policy regarding observations been in place at the Home at the time of the incident, however, the panel noted that no such policy was put before them.

The panel was therefore satisfied that it is more likely than not that on the nightshift starting on 7 February 2018, in relation to Patient B who was found with an open wound on their head, Mr Walker had not failed to undertake observations in a timely manner.

Charge 8b)

8) On the nightshift starting on 07 February 2018, and in relation to Patient B who was found with an open wound on their head, failed to:
    b) administer medication as prescribed/in a timely manner;

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence by Colleague D and Colleague E, Resident B's electronic Patient Notes and Datix entry.

The panel noted that Colleague E stated that there was medication prescribed to Resident E to settle him in case he was agitated. She also stated that Mr Walker had not yet given this medication to Resident B when she joined the unit to help but that Mr Walker had already called the doctor at that point.

The panel was of the view that, without more detailed notes and without seeing the patient, it is difficult to ascertain whether medication was either necessary or needed. It was of the view that there could have been a clinical justification not to give the medication prescribed to obtain more accurate observations. It was of the view that this would be something that would be in the professional judgement of the clinician looking after Resident B.

The panel noted that Mr Walker phoned the doctor at 1.20 am, but there is no note to say what the doctor stated. The panel was of the view that the doctor in this case was better qualified to ascertain whether mediation needed to be given.

Further, the panel noted that medication was given at 3pm.

The panel was of the view that there was insufficient evidence to show that the medication was not given in a timely manner. It concluded that there were too many unknown variables before it to demonstrate that the timeframe in which the medication was given was not appropriate at the time.

The panel therefore determined that this charge is not found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Walker's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Walker's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Kewley invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr Kewley identified the specific, relevant standards where Mr Walker's actions amounted to misconduct. He submitted that Mr Walker was working as a senior nurse at the time concerned whilst Resident A was a vulnerable resident due to her mental health needs.

He reminded the panel that she was deprived of her liberty and was not free to leave the unit and that her risk of absconding was well known and documented. Mr Kewley submitted that it was Mr Walker's duty to protect and safeguard Resident A, but by taking her out of the Home in the manner he did, Mr Walker had put her at an increased risk of harm. Mr Kewley submitted that the situation was made more serious as by leaving his senior nursing responsibilities Mr Walker created a risk for the other residents at the Home.

Mr Kewley further submitted that honesty and integrity is a basic requirement for any healthcare professional. He submitted that Mr Walker's dishonesty was connected to his clinical practice born out his explanation of the decision to remove Resident A from the safety of the Home. He submitted that this is not completely unconnected with Mr Walker's professional responsibilities and that the dishonesty goes to the core issue Mr Walker's integrity and responsibility.

Mr Kewley therefore submitted that Mr Walker's actions fell far short of what would have been expected of a registered nurse and what would have been proper in the circumstances.

Submissions on impairment

Mr Kewley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kewley invited the panel to consider whether there is any evidence before it to show that Mr Walker has in the last three years taken a step back to consider what went wrong, recognised any misconduct, accepted his responsibility or appreciated how things could

have gone differently. He submitted that there is nothing before the panel to show that Mr Walker has any insight. He acknowledged that Mr Walker has sent some submissions prior to the hearing, however, these only contain bare assertions and no acceptance.

Mr Kewley stated that the same issue arises with remediation. He submitted that there is nothing before the panel to show that Mr Walker has kept up to date with current nursing knowledge, let alone any remediation regarding the regulatory concerns of this case. Further, Mr Kewley submitted that there is no admission or recognition by Mr Walker about the dishonesty in this case.

Mr Kewley submitted that, due to the lack of insight and remediation, there is a high risk of repetition in this case. He submitted that based on the risk of repetition there is an ongoing risk of harm to patients should Mr Walker return to practise unrestricted.

Additionally, Mr Kewley submitted that there is also a requirement to find current impairment in order to maintain public confidence in the profession and maintain proper standards. He submitted that serious findings arise from the care of a vulnerable resident that are not only clinical in nature but also concern Mr Walker's honesty and integrity.

Mr Kewley therefore invited the panel to find current impairment on the ground of public protection and submitted that a finding of impairment is also otherwise in the public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mr Walker's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Walker's actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that taking out a vulnerable person that was well known to abscond, without a risk assessment, a second member of staff and in an inappropriate vehicle put Resident A at serious risk of harm and was far below the standard expected of a nurse. The panel concluded that not only should there have been a second person accompanying Resident A, but both members of staff should have been junior staff, so that Mr Walker could have resumed his senior nurse responsibilities.

The panel noted that Mr Walker was not only the senior nurse in charge but also the fire officer, he was well aware of his responsibilities and no other member of staff that day was trained to the required standard to hold senior nurse responsibilities. The panel was of the view that not only did this put all other residents at the Home at risk, but left staff who were not trained for this task in a position of responsibility which was not in their scope of practice. The panel concluded that in case of an emergency this could have resulted in a serious risk of harm to patients but also to other members of staff, leaving colleagues at risk of their registration.

The panel noted that Colleague A stated that this would have been not much different from Mr Walker leaving his duties to go on lunch break. However, the panel was of the view that taking a lunch break in the Homes ‘bistro’ was not comparable to leaving the

home entirely, without permission, and without any way of being contacted in case of an emergency.

The panel was of the view that this was a serious departure of the standards expected of a registered nurse and was of the view that this amounted to misconduct.

Further, the panel concluded that Mr Walker's dishonesty alone amounted to misconduct. Additionally, the panel was of the view that Mr Walker well knew that he was not given permission to leave the Home with Resident A and that this was not a matter of miscommunications or misunderstanding. The panel concluded that this was a deliberate act of dishonesty which puts the misconduct at the upper end of seriousness.

The panel therefore found that Mr Walker's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Walker's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel found that patients were put at risk and that there was potential for physical and emotional harm as a result of Mr Walker's misconduct. Mr Walker's misconduct breached the fundamental tenets of the nursing profession and brought its reputation into disrepute.

It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that it had no information at all before it to show that Mr Walker has insight into his actions, the risks involved in taking out Resident A without permission, without a second member of staff, and in an inappropriate vehicle. He has not demonstrated that he understood the implications his actions had on the other patients and his colleagues at the Home had an emergency occurred in his absence. The panel was of the view that he was in charge of a very vulnerable person and was concerned that Mr Walker has not shown any insight, remorse or has given an explanation for his actions. The panel was therefore of the view that Mr Walker has no insight.

The panel was satisfied that the misconduct in this case is capable of remediation, but acknowledged that the dishonesty in this case would be difficult to remediate. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Walker has remedied his practice. However, the panel had again no information before it to demonstrate that Mr Walker has remediated his practice.

Therefore, the panel is of the view that there is a high risk of repetition based on the lack of insight and remediation. The panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in a case where a nurse took a vulnerable resident, at risk of absconding, out of the safety of a Care Home without seeking permission,

assessing risks involved, without proper support and in an inappropriate vehicle. It therefore also finds Mr Walker's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Walker's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Walker off the register. The effect of this order is that the NMC register will show that registrant has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Kewley outlined the aggravating and mitigating factors of the case to the panel. He submitted that to take no further action, a caution order and a conditions of practice order would not protect the public nor would it meet the public interest in this case. Mr Kewley submitted that the misconduct and the dishonesty in this case are at the top end of the spectrum and that there is a high risk of repetition. He submitted that the findings are too serious to be dealt with by way of no action, caution order or conditions of practice order.

Mr Kewley then addressed the panel on a suspension order. He submitted that the concerns raised were not only in regard to Mr Walker's clinical practice but also concerned his honesty and integrity. He submitted that there has been a total lack of meaningful engagement with the NMC process in the past three years. He submitted that there was no evidence before the panel that Mr Walker was committed to learn or work on his

practice in the future. He stated that there was no indication that a maximum suspension of 12 months would be used purposefully by Mr Walker.

Mr Kewley submitted that the lack of insight, remediation and remorse as well as the risk of repetition make it impossible for Mr Walker to remain on the register. He therefore invited the panel to impose a striking off order.

Decision and reasons on sanction

Having found Mr Walker's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- A lack of insight into his failings;
- Resident A was a vulnerable adult in care;
- Mr Walker's actions had the potential to put patients at serious risk of harm;
- Mr Walker's actions left his colleague in a vulnerable position; and
- Mr Walker misused his power as a senior nurse in charge of the Home and breached the trust of his colleagues with his actions.

The panel noted that there were no previous regulatory concerns.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Walker's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Walker's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Walker's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and the dishonesty identified was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Walker's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of repetition of behaviour since the incident;*

The panel was of the view that whilst the dishonesty and misconduct were on the upper end, Mr Walker's actions were remediable. However, the implications and potential risk of Mr Walker's misconduct put it at the upper end of seriousness. The panel was concerned that an experienced registered nurse took a vulnerable resident out of the Home without risk assessment and adequate safeguarding whilst being dishonest with his colleagues

and leaving a position with senior responsibilities. The panel was particularly concerned as the Home houses predominantly vulnerable residents who have a long standing history of mental health issues. Mr Walker had received specific training to be able to perform the role of senior nurse, and was clearly aware of his responsibilities and the risk that could arise. The panel was of the view that Mr Walker was in a leadership position, a position of trust which he abandoned without adequate risk assessment, support and safeguarding measures in place.

Further, the panel considered whether a period of suspension would be sufficient for Mr Walker to demonstrate insight, remorse and remediation. However, the panel noted that Mr Walker has not meaningfully engaged with the NMC in any way in the past three years. The panel was particularly concerned that Mr Walker, despite being represented, had not provided the panel with any evidence of remorse, insight or remediation. It was of the view that this suggests attitudinal issues and concluded that even the maximum period of a 12 months suspension order would not be enough time for Mr Walker to demonstrate remorse, that he gained insight, and started to remediate his misconduct.

The panel concluded that the conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Walker's actions is fundamentally incompatible with Mr Walker remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Mr Walker's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Walker's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Walker's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Mr Walker in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Walker's own interest

until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Kewley. He submitted that an interim order is necessary to protect the public for the reasons identified earlier by the panel in their determination until the striking off order comes into effect. He therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, and would be inconsistent due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after Mr Walker is sent the decision of this hearing in writing.

That concludes this determination.