Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

18-22 October 2021
25-27 October 2021

Resuming hearing

4-7 January 2022

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Patrick McKee
NMC PIN:	90E0006E
Part(s) of the register: Nursing	RN3 Registered Nurse – Mental Health
Area of registered address:	England
Type of case:	Misconduct
Panel members:	Anthony Mole (Chair – Lay member) Carla Hartnell (Registrant member) Derek McFaull (Lay member)
Legal Assessor:	Ben Stephenson
Panel Secretary:	Vicky Green
Nursing and Midwifery Council:	Represented by Hannah Smith, Case Presenter
Mr McKee:	Not present and not represented in his absence
Facts proved:	All
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim suspension order – 18 months

Decision and reasons on service of Notice of Hearing

At the outset of the hearing the panel was informed that Mr McKee was not in attendance and that the Notice of Hearing letter (the Notice) had been sent to his registered address by recorded delivery and by first class post on 16 September 2021.

The NMC instructed a third party to undertake a trace in an attempt to obtain a current address for Mr McKee. The NMC was provided with a Trace Report in which it was stated that Mr McKee resided at a different address.

On 16 September 2021 the NMC sent another Notice to the address identified by the Trace Report by recorded delivery and by first class post. The Notice was also sent to Mr McKee by email.

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 McKee's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Ms Smith, 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 McKee has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address. Nevertheless, the panel was of the view that the NMC had gone above and beyond in its efforts to

ensure that the Notice was served on Mr McKee by sending it to two addresses and by email.

Decision and reasons on proceeding in the absence of Mr McKee

The panel next considered whether it should proceed in the absence of Mr McKee. It had regard to Rule 21 and heard the submissions of Ms Smith who invited the panel to continue in the absence of Mr McKee. She referred the panel to a handwritten letter dated 13 January 2015 from Mr McKee in which he stated that he will not be working as a registered nurse again and that he would not be attending any future proceedings.

Ms Smith submitted that it is clear that Mr McKee has not had any intention of engaging with these proceedings and that he has waived his right to attend. She submitted that Mr McKee has not kept the NMC informed about his change of address which has made it difficult for the NMC to discharge its statutory duty to keep him informed about his case. Ms Smith submitted that given Mr McKee's lack of engagement, and his stated intention to disengage with the NMC proceedings in his letter in January 2015, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

Ms Smith submitted that given that the charges arose in 2014, any further delay in hearing this case could impact on the recall of witnesses, six of whom have agreed to attend the hearing this week in person. She reminded the panel of the public interest in the expeditious disposal of hearings and submitted that, in view of Mr McKee's deliberate absence, and the limited capability of holding physical hearings due to the ongoing COVID-19 pandemic, there is no good reason to adjourn this hearing.

Ms Smith submitted that any prejudice caused to Mr McKee by proceeding in his absence would be mitigated and reduced by the significant information in the bundle which contains his responses to the charges.

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'*.

The panel decided to proceed in the absence of Mr McKee. In reaching this decision, the panel has considered the submissions made by Ms Smith and the advice of the legal assessor. It has had particular regard to the factors set out in the case of *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 by Mr McKee.
- Mr McKee has not had any contact with the NMC since January 2015 and he has not responded to any of the letters sent to him about this hearing.
- Given Mr McKee stated in January 2015 that he would not be engaging with the NMC, and he has not engaged since, there is no reason to suppose that adjourning would secure his attendance at some future date.
- Two witnesses have attended today to give live evidence and four other witnesses are due to attend this week.
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services.
- The charges relate to events that occurred in 2014.
- Further delay may have an adverse effect on the ability of witnesses accurately to recall event.
- There is a strong public interest in the expeditious disposal of the case.
- There is limited capability in holding psychical hearings due to the ongoing COVID-19 pandemic.

There may be some disadvantage to Mr McKee in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered

address, 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 McKee's decision to absent himself from the hearing, waive 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 McKee. The panel will draw no adverse inference from his absence in its findings of fact.

Details of charge

That you, a registered nurse:

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:
        i. You did not identify whether you or Colleague 1 would lead the assessment; **[Proved]**
        ii. You did not consider, sufficiently or at all:
            1. Social circumstances
            2. Psychological factors
            3. Medical issues
            4. Mental health assessment
            5. Recognition of changes since last seen
            6. Identifying and exploring areas of clinical risk
            7. Safety and protective factors in the community **[Proved]**
        iii. You did not fully take into account that their care plan provided for short-term admissions; **[Proved]**

iv. You did not fully take into account that their two care coordinators and psychotherapist were recommending short-term admission and their reasons; **[Proved]**
v. You did not take into account that they had described wanting to a put a bag over their head; **[Proved]**
vi. You did not take into account that they had been found with a bag over their head earlier in the day; **[Proved]**
vii. You did not assess the possible impact of their consumption of nitrazepam on their presentation; **[Proved]**
viii. The alternative care plan to admission you identified did not adequately protect them; **[Proved]**
ix. You placed undue reliance on previous assessments; **[Proved]**
x. You did not seek a second opinion from a psychiatrist; **[Proved]**

b. Told them the reason for not admitting them was a lack of bed space; **[Proved]**
c. Did not further risk assess them when they banged their head against a wall after the initial clinical / gatekeeping assessment; **[Proved]**
d. Did not further risk assess them when they self-ligatured after the initial clinical / gatekeeping assessment; **[Proved]**
e. Said “leave her, she’ll faint before she dies” or words to that effect when they had self-ligatured; **[Proved]**
f. Did not further risk assess them after they had been restrained in relation to the self-ligature after the initial clinical / gatekeeping assessment; **[Proved]**
g. When the police attended Miranda House:
    i. Said words to the effect of:
        1. She is just a member of the public now; **[Proved]**
        2. She has been assessed and we want her out of the building; **[Proved]**
    ii. Discussed Patient A in the car park; **[Proved]**
    iii. Raised your voice to the police; **[Proved]**
h. Decided they should not be admitted; **[Proved]**
i. Did not make an adequate record in that:

i. You did not record your discussions with other clinicians about their admission before their attendance at Miranda House; **[Proved]**
ii. You did not make a contemporaneous note during their appointment; **[Proved]**
iii. You did not include a structured risk / clinical assessment; **[Proved]**
iv. You did not record their presenting features; **[Proved]**
v. You did not adequately record their needs; **[Proved]**
vi. You did not record a rationale for providing them with community-based care; **[Proved]**
vii. You did not adapt the care plan to provide community-based care; **[Proved]**
viii. Your action plan “to await contact” was insufficiently detailed; **[Proved]**
ix. You did not record a rationale for not admitting them; **[Proved]**

2. Your decision to refuse admission contributed to Patient A’s death **[Proved]**

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

Application to hear the evidence of Ms 3 without observers being physically present

On the second day of the hearing and before Ms 3 gave evidence, Ms Smith made an application to hear her evidence without having observers physically present in the hearing room.

Ms Smith submitted that prior to the hearing Ms 3 was informed that there would be observers watching the hearing remotely but that there would be no observers attending in person. There are observers who are attending in person, [PRIVATE]. Ms Smith submitted that Ms 3 is a key witness and it is therefore important that the panel hears the best evidence from her. She submitted Ms 3 would feel more comfortable if the observers watched the hearing by video link from another room.

As part of this application Ms Smith indicated that there were matters relating to Ms 3's health that needed to be taken into consideration.

Application pursuant to Rule 19

Ms Smith made an application for matters relating to the health of Ms 3 to be heard in private. This application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there would be reference to the health of Ms 3, the panel determined to hear these parts of the hearing in private.

Application to hear the evidence of Ms 3 without observers being physically present [continued]

[PRIVATE]

Ms Smith invited the panel to take all of the above into consideration and invited it to hear Ms 3's evidence without the observers in the room.

The panel accepted the advice of the legal assessor who referred it to Rule 31 of the Rules.

The panel noted that the evidence of Ms 3 is clearly relevant as she is a key witness and the only witness who was present in the room with Patient A and Mr McKee during the assessment. The panel was therefore of the view that it is of great importance that Ms 3 is able to give the best evidence possible without causing her any further anxiety. The panel noted that the observers in the room agreed to remote observing to facilitate hearing the evidence of Ms 3.

The panel was of the view that whether the observers were present physically or virtually had no bearing on the question of fairness to Mr McKee.

The panel therefore determined to hear the evidence of Ms 3 without any observers being physically present in the room.

[The hearing resumed on 4 January 2022]

Service of notice of the resuming hearing and decision and reasons on continuing to proceed in the absence of Mr McKee

When the hearing resumed Ms Smith informed the panel that the two notices of the resuming hearing has been served on Mr McKee in accordance with the Rules. She submitted that the two notices of the resuming hearing have been sent to Mr McKee, the first was sent notifying him of a three day resuming hearing and follow up notice was sent when an additional date had been listed. The most recent notice of the resuming hearing was sent to Mr McKee on 2 December 2021 to his registered email address.

Ms Smith drew the panel's attention to an email dated 9 December 2021 from a member of Mr McKee's family in which the following is stated:

> *'Mr Mckee does not wish to engage I'm* [sic] *this circus.'*

Ms Smith submitted that it is clear that Mr McKee does not wish to engage with these proceedings and that nothing has changed since the panel's original consideration of whether to proceed in his absence. Ms Smith submitted that an adjournment would serve no useful purpose as he has continued to disengage with these proceedings despite the adjournment in October 2021. Furthermore, Ms Smith submitted that the passage of time since the charges arose is significant and to delay these proceedings further would not be in the public interest. She therefore invited the panel to continue to proceed in Mr McKee's absence.

The panel accepted the advice of the legal assessor.

The panel noted that the notice of the resuming hearing has been served on Mr McKee and that a family member appears to have responded on his behalf. The panel was satisfied that the NMC had attempted to make Mr McKee aware of these proceedings and he has continued to voluntarily absent himself. The panel determined that there has been no change since its decision to proceed in the absence of Mr McKee at the outset

of this hearing. The panel therefore determined, for the same reasons set out previously, to proceed in the absence of Mr McKee.

Consideration of new information and decision and reasons on whether to proceed in the light of this new information

In October 2021, this hearing adjourned due to lack of time and a date was agreed for the panel to resume to continue its deliberations on facts and to conclude the hearing. In the intervening period, the NMC became aware of a letter from Her Majesty's Senior Coroner (the Coroner), regarding the inquest into the death of Patient A, dated 8 December 2021 in which it was stated that following a successful application to the High Court, the decision from the original inquest into Patient A's death was quashed and a new inquest has been ordered.

Before the panel had reached its decision and reasons on facts, the NMC made a request for the panel to reconvene to consider the impact of the information about a new inquest contained in the above mentioned letter.

Ms Smith drew the panel's attention to some parts of the Coroner's letter, in particular:

> *'Quite clearly, additional evidence will need to be obtained and this will centre upon obtaining disclosure of material that was disclosed to me on a "for my eyes only" basis, but moreover, as one of the core issues which prompted the application under Section 13 concerned a "car park" conversation between two members of the Mental Health Trust, it will clearly be necessary for statements to be obtained from these individuals in respect of the content and nature of this conversation.'*

Ms Smith informed the panel that the "car park" conversation that the Coroner refers to involved Ms 3 and Dr 12.

Ms Smith submitted that the panel will need to consider two questions which arise from the decision to quash the conclusion from the original Coroner's inquest.

Firstly, she submitted that the panel should consider whether this decision has any bearing on the reliability or credibility of Ms 3's evidence. Ms Smith submitted that there is no information regarding the decision to quash the original conclusion that undermines Ms 3's position as a witness of truth in relation to the allegations against Mr McKee. She further submitted that there is no indication within Ms 3's evidence provided during the original inquest that could have been a deliberate untruth or a misleading answer. Ms Smith drew the panel's attention to a further extract from the Coroner's letter, namely:

> *'My provisional view with regards to the conduct of the new Inquest would be to admit all evidence which had been heard at the original Inquest under the provisions of Rule 23 of the Coroners Inquest Rules. Furthermore, it would be my intention to also admit my findings of fact and exhibit my conclusion.'*

Ms Smith submitted that even in possession of the new information about the discussion which involved Ms 3, the Coroner raised no issues about the credibility of Ms 3's evidence.

The second question that Ms Smith submitted that panel should consider is how the panel should treat the inquest conclusion, which was included in evidence, now that that conclusion has been quashed. Ms Smith submitted that in accordance with the legal advice you received at the closure of the NMC's case on facts, a conclusion made by another body can be considered by the panel in reaching its decision on facts but it is not determinative.

Ms Smith submitted that the new information, ultimately, does not impact on what the panel needs to consider in relation to the charges against Mr McKee. Nevertheless, she submitted that how this case proceeds in the light of this new information is a matter for the panel.

The panel accepted the advice of the legal assessor.

In considering how to proceed in the light of this new information, the panel was mindful of the question of fairness to Mr McKee as well as having regard to the overarching objectives of the NMC.

The panel first considered the question of whether, in light of the High Court's decision to quash the conclusion of the original coroner's inquest and the new information, Ms 3's evidence can be safely relied upon. The panel noted that the evidence provided to it by Ms 3 was clear and concise and that the evidence she gave at the original inquest and during this hearing was consistent. Ms 3's evidence to the panel related to her interaction with Mr McKee whilst an assessment of Patient A was being undertaken. The panel was of the view that the new information does not undermine Ms 3's credibility as it has no relation to the charges against Mr McKee. It relates solely to a conversation that she had with Dr 12 after her interaction with Mr McKee had ceased. The panel therefore concluded that Ms 3's evidence can safely be relied upon in determining the charges against Mr McKee.

The panel then went on to consider how it should treat the inquest conclusion now that that decision has been quashed. Whilst the panel acknowledged that the conclusion of the coroner's inquest could be taken into account in its decision making, it considered that this evidence was not determinative in respect of any of the charges against Mr McKee. The panel was of the view that the other evidence presented by the NMC was sufficient in order for it to continue to make a determination on the charges.

The panel therefore determined that it was both fair and in the public interest for this hearing to proceed.

Decision and reasons on 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 Ms Smith on behalf of the NMC.

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

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:

- Mr 1 – Band 6 Community Psychiatric Nurse at Humber NHS Foundation Trust in Anlaby Clinic.
- Ms 2 – Band 6 Mental Health Nurse and Community Psychiatric Nurse at Humber NHS Foundation Trust in Anlaby Clinic.
- Ms 3 – Community Mental Health Nurse for Humber NHS Foundation Trust.
- Mr 4 – Policeman at Humberside Police.
- Mr 5 – Clinical Care Director and Consultant Nurse in Addiction.
- Mr 6 – Independent Investigator on serious and untoward incidents.

The panel was provided with witness statements from the following witnesses:

- Mr 7 – Patient A's Psychotherapist.
- Ms 8 – Service Manager for Community Mental Health Team (seconded as Assistant Care Group Director at the time the charges arose) in Hull within Humber NHS Foundation Trust.

Outline of NMC case

The charges arose whilst Mr McKee was employed as a Band 7 Senior Crisis Resolution Nurse and working in the Crisis Home Treatment Team (CRHTT) at Miranda House in Hull. The CRHTT acted as gate-keepers for all mental health hospital admissions (except those under deemed sectioned under the Mental Health Act). As a

gate-keeper, Mr McKee would carry out a pre-assessment of all potential patients, and determine whether they met the criteria for admission into Miranda House. The lack of a bed in Miranda House or in the local area would not be a reason to refuse admission. It would also not be the responsibility of the CRHTT to find a bed if the decision was made to admit.

Patient A was a young woman living with borderline personality disorder (BPD) which was considered to be severe. One of the features of BPD is self-harming behaviour and suicidality. Many of Patient A's risk factors were chronic and she was always at a high risk of self-harm and harm to others. She had received inpatient mental health treatment from her teenage years.

Patient A had spent periods of time as an inpatient, primarily for long stays, but it was accepted that inpatient admission did not always work for her, since she still engaged in self-harming behaviour, including overdosing, and posed a risk to those caring for her, including assaulting a psychiatrist, for which she was prosecuted. National Institute for Health and Clinical Excellence: Borderline personality disorder – Treatment and management (January 2009) (NICE Guidelines) also did not recommend long periods of admission for treatment of the condition.

In February 2014 after Patient A was released from a long inpatient period, a professionals' meeting took place, and it was identified that short-term admission (up to 72 hours) could be used as a tool to manage escalating risk. This was included as part of Patient A's care plan thereafter.

At the time of the charges Patient A had been under the care of two care co-ordinators for some time. Ms 1 was her original care co-ordinator and due to retire. A period of transition and handover was ongoing and Ms 2 was also acting as Patient A's care coordinator.

In early July 2014 Patient A had a short period of admission in line with her care plan. From around 22 July 2014 Patient A's risk-taking and self-harming behaviour began to escalate. She took a number of overdoses, called ambulances and self-presented at Accident and Emergency (A & E). Patient A had capacity and sometimes decided not to

engage with professionals who had to allow her to leave without treatment if she decided to decline an assessment and/or treatment.

In the early hours of 25 July 2014 Patient A self-presented at A & E and informed staff that she had taken an overdose and that she wanted to be admitted to an inpatient mental health unit called Mill View. The staff made enquiries and found that there were no available beds at Mill View. When this was communicated to Patient A she refused to be assessed for admission by the CRHTT, threatened violence against the CRHTT staff who had attended to assess her, and self-ligatured in the presence of hospital security. In the morning of 25 July 2014 Patient A called her psychotherapist (Mr 7) and she also tried to make contact with her care coordinators. Mr 7 called her back at around midday, he was concerned about her as whilst she had previously expressed potentially destructive emotions, she sounded exhausted and despairing. Relative A tried to make contact with the community mental health team including both care co-ordinators because she was so concerned. This was unusual because Patient A resisted attempts to involve her family in her care and she would not let the people involved in her care share information with her family.

Mr 1, a Band 6 Community Psychiatric Nurse was on duty for CMHT on 25 July 2014, spoke to a paramedic who had attended Patient A's home for a reported overdose. When Ms 2 and Ms 3 returned to the office Mr 1 informed them about Patient A and contacted CRHTT on their behalf to arrange a gatekeeping assessment for Patient A's admission into Miranda House. Ms 2 had spoken with Patient A who had reluctantly agreed to an assessment. Ms 2, Ms 3 and Mr 7 were all in agreement that the escalation of risk to Patient A meant that she should be admitted to an inpatient unit for a short period in accordance with her care plan.

Mr 1 spoke to Mr McKee who said that there were no beds available and that in-patient stays did not work for her. Mr 1 told Ms 2 what he had been advised and she called CRHTT. When Ms 2 spoke with Mr McKee he stood by his previous assertion that there were no available beds but he agreed to see Patient A for a gateway assessment at 15:30 at Miranda House.

Ms 3 attended Patient A's home to collect and take her for the gateway assessment at Miranda House. When Ms 3 arrived, there were paramedics and police present who had been called by Patient A who was distressed and had put a bag over her head. Ms 3 drove Patient A to Miranda House for her gateway assessment.

Mr McKee and Colleague 1 (a Band 6 registered nurse at CRHTT) undertook the gateway assessment of Patient A together in the presence of Ms 3. Colleague 1 was a Band 6 nurse so, as a Band 7, Mr McKee was the senior nurse involved in the assessment. During a discussion with Mr McKee and Colleague 1, Ms 3 highlighted the concerns about Patient A's escalated risk and that these concerns were echoed by Ms 2 and Patient A's psychologist (Mr 7). Mr McKee and Colleague 1 were informed that Patient A had taken a greater frequency of overdoses, she had engaged in more self-harming behaviour where she had placed a bag over her head and that there was a change in her demeanour. As a consequence, Ms 3, Ms 2 and Mr 7 considered that there was a real risk of harm if she was to remain in the community. It was therefore recommended that, in accordance with her care plan, Patient A should be admitted for a short period as an inpatient.

Both Mr McKee and Colleague 1 decided that Patient A did not require admission. Mr McKee communicated this to Patient A but said that the decision to not admit her was because there were no beds available at Miranda House. Patient A asked whether there were any other beds available out of the area and Mr McKee said that there were not. Upon hearing that she would not be admitted, Patient A became distressed and started to bang her head against the wall. Ms 3 tried to get Mr McKee and Colleague 1 to change their minds but she was unsuccessful. Mr McKee and Colleague 1 left the room. Patient A took a shoelace from her shoe and tied it around her neck, Ms 3 sought help and when Mr McKee returned he said *"she'll faint before she hurts herself"* and he otherwise did not intervene. An alarm was raised by Colleague 1 and a number of staff restrained Patient A and removed the ligature (shoe lace) from her neck.

After it was decided that Patient A was not going to be admitted, the Police were called and at 16:04 two police officers attended Miranda House, one of whom was Mr 4. When the police arrived they were told they had been called to escort Patient A from the

premises. Upon assessing the situation and seeing Patient A, the police officers asked Mr McKee and Colleague 1 to reconsider their decision to not admit her. Mr McKee and Colleague 1 stood by the decision to not admit Patient A. The police officers escalated their concerns to their Sergeant who attended and escalated to his inspector. When Mr 4 was in the car park calling his sergeant the Team Leader, Colleague 2 (a Band 7 mental health nurse) arrived. Mr 4 explained the situation to Colleague 2 and, having seen that this conversation was happening, Mr McKee and Colleague 1 also went to the car park. Mr McKee and Colleague 1 told Colleague 2 that Patient A did not meet the criteria for admission. Colleague 2 agreed with the decision to not admit Patient A and she was subsequently taken home by the police. Before Patient A was taken home by the police, Ms 3 said that she would see her on Monday, to which she replied that she would be dead by Monday.

Mr McKee wrote the notes of the assessment in Patient A's patient record later that day. The plan of care for Patient A was for her to call the CRHTT over the weekend if needed.

Later that evening Patient A called the emergency services requesting an ambulance as she said she had taken an overdose. The ambulance attended Patient A's home 99 minutes after she called when the paramedics found her with a bag on her head. CPR was attempted but she was pronounced dead at the scene. A post mortem was carried out and the medical cause of death was asphyxiation caused by and overdose in conjunction with a plastic bag.

There was a Coroner's inquest into the death of Patient A in which a wide range of factors that could have contributed to her death were considered. A written judgement and conclusion was handed down on 23 October 2015.

Charges

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered all of the witness and documentary evidence provided in this case.

The panel drew no adverse inference from Mr McKee's absence in its findings of fact.

The panel then considered each of the disputed charges and made the following findings.

Charge 1.a.

Before it considered the sub-sections set out within charge 1.a., the panel considered the question of *'adequacy'* and what would constitute as an adequate clinical / gatekeeping assessment. In determining these points, the panel had regard to the expert evidence of Mr 5 and Mr 6.

The panel had sight of the report produced by Mr 5 following his investigation (*Clinical Review of Standards: A report to support the fact-finding investigation into professional standards*).

> The panel had regard to the expert evidence of Mr 6 who stated the following in his witness statement:
>
> *'A comprehensive assessment would take one hour and would include full documentation of the following:*
>
> *i. The presenting complaint – current symptoms and issues of concern;*
> *ii. History of the presenting complainant;*
> *iii. Past psychiatric history;*
> *iv. Past medical history*
> *v. Present care and treatment plan, including current medications and therapy;*

vi. *Treatment history, previous medication and therapies;*
vii. *Family history, relationships and key issues for concern;*
viii. *Personal history, including childhood relationships, occupational and social history;*
ix. *Present social circumstances;*
x. *Drugs and alcohol use – past and current;*
xi. *Forensic history;*
xii. *Mental state examination including appearance, behaviour, speech, mood, thoughts, stressors, (suicide ideation, plans, methods, perception) cognitive function and insight.*
xiii. *Mental capacity;*
xiv. *Physical examination where appropriate;*
xv. *Diagnosis;*
xvi. *Care management plan.*

… As Patient A was known to the crisis team I would not expect an assessment of this detail, however I would have expected the assessment of Patient A to last at least half an hour.'

Once the panel has made its decision on each of the subsections within this charge, it will determine whether the subsections cumulatively amounted to an inadequate clinical / gatekeeping assessment.

Charge 1.a.i.

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:
        i. You did not identify whether you or Colleague 1 would lead the assessment;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to the notes of disciplinary investigation interview with Mr McKee on 23 July 2015, the evidence of Ms 3, Mr 5, Mr 6 and Ms 8.

The panel noted that Mr McKee and Colleague 1 were both present during the assessment of Patient A. The panel had regard to Mr McKee's response recorded in the notes of the interview that took place on 23 July 2015:

> ***'8. What was your role in the assessment?***
>
> *[Colleague 1] asked most of the questions as she knew Patient A and I didn't. I joined [Colleague 1] in the assessment as I had heard there were concerns about Patient A but neither of us could see any escalating concerns.'*

The panel took account of the evidence of Ms 8, an Assistant Care Group Director who carried out the disciplinary investigation into Mr McKee and Colleague 1's conduct in relation to Patient A. The panel had regard to Ms 8's witness statement in which she stated the following:

> *'…conflicting evidence was given over who was leading the assessment of Patient A. In my opinion, if there was confusion, [Mr McKee] should have taken the lead in the assessment by virtue of his seniority.'*

The panel was mindful that Ms 8 was not called by the NMC to give live evidence but it noted that her witness statement was corroborated by documentary evidence and supported by the evidence of Ms 3 and Mr 5, both of whom attended the hearing to give live evidence. The panel determined that the evidence of Ms 3 and Ms 5 was credible and reliable.

In her oral evidence Ms 3 told the panel that she did not know who was leading the gateway assessment, but that she assumed that Mr McKee was as he was the senior nurse.

The panel also had regard to the expert evidence of Mr 5 who, in his witness statement, stated the following:

> *… there appeared to be confusion about whether [Mr McKee] or [Colleague 1] was leading the assessment. Throughout the investigation it became apparent that [Colleague 1] asked the majority of the questions and [Mr McKee] recorded the response. In my opinion this is not a satisfactory method of carrying out an assessment…*
>
> *…As Clinical Lead of the crisis team and a band 7 nurse, I would have expected [Mr McKee] to have made a clear distinction of roles and responsibilities regarding who was going to lead the assessment and to have communicated that clearly to [Colleague 1] prior to beginning the assessment.'*

The panel had regard to the Humber NHS Foundation Trust Job Description for a band 7 Lead Nurse and noted that providing *'advanced/specialist advice, assessment and interventions'* was expected of Mr McKee.

Having regard to all of the above the panel determined that Mr McKee should have identified whether he or Colleague 1 would lead the assessment and he did not. The panel therefore found this charge proved.

Charge 1.a.ii.1-7.

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:
        i. You did not consider, sufficiently or at all:
            1. Social circumstances
            2. Psychological factors
            3. Medical issues
            4. Mental health assessment
            5. Recognition of changes since last seen

6. Identifying and exploring areas of clinical risk
7. Safety and protective factors in the community

This charge is found proved.

In reaching its decision the panel took into account all of the evidence before it. It had particular regard to the NICE Guidelines, Patient A's patient record and the expert evidence of Mr 5 and his report and Mr 6 and his report.

The panel acknowledged that the primary recognised source of evidence-based clinical guidance and advice utilised within the NHS is provided by NICE Guidelines.

The panel had regard to the witness statement of Mr 5 in which he stated the following:

> *'It became apparent, throughout the investigation, that the assessment carried out by [Mr McKee] and [Colleague 1] lasted approximately 15 minutes. When carrying out a clinical assessment of a patient's needs, I would expect a comprehensive assessment of the following:*
>
> *a. social circumstances;*
> *b. psychological factors;*
> *c. medical issues including use of prescribed medications and use of drugs/alcohol;*
> *d. mental health assessment including motivational factors for self-harm and suicidal intent;*
> *e. Recognition of changes since last seen;*
> *f. Any areas of clinical risk and an exploration of any that are identified; and*
> *g. A assessment of safety and protective factors in the community (the alternative to in patient care is sending the patient home).'*

The panel also had regard to the expert evidence of Mr 6 who set out a list of factors that Mr McKee should have considered during the assessment in accordance with the NICE Guidelines.

The panel had sight of Patient A's patient record and noted that whilst Mr McKee documented some interaction in the communication evaluation sheet on 25 July 2014, he did not include any of the recommended factors. Accordingly, the panel found this charge proved.

Charge 1.a.iii.

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:

        iii. You did not fully take into account that their care plan provided for short-term admissions;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's care plan and the disciplinary interview notes dated 23 July 2015.

The panel noted that following a Trust discharge meeting held on 10 July 2014 Patient A's care plan was updated to include the following:

> *'If the risk of overdose becomes significant to be re-admitted on a short term basis.'*

The panel also had sight of the interview notes from 23 July 2015 disciplinary investigation interview in which Mr McKee stated that he was aware of the updated care

plan from the Trust meeting on 10 July 2014 and that he had agreed to admit her on the morning.

The panel had regard to Patient A's patient record and determined that whilst Mr McKee was aware of the provision of short term stays in the updated care plan, he deviated from the plan without providing any written rationale. The panel therefore found this charge proved.

Charge 1.a.iv.

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:

        iv. You did not fully take into account that their two care coordinators and psychotherapist were recommending short-term admission and their reasons;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. The panel had particular regard to Patient A's Patient records, the Clinical Review of Standards: A Report to Support the fact-finding investigation into professional standards and the evidence of Ms 2, Ms 3, Mr 5 and Mr 6.

The panel had regard to the evidence of Ms 2 who said that she had a telephone conversation with Mr McKee on 25 July 2014:

> *'At this time, I did not have any concerns that Patient A would not get admission. I was confident she would be admitted for a number of reasons, namely that the care plan indicates that a 72 hour admission was useful in such situations; and secondly [Ms 3], [Mr 7] and I were all asking for admission and with three*

professionals asking for admission I would have expected the registrant to take this seriously into account. I cannot recall a time where all three of us have requested admission and it be refused…

…I informed [Mr McKee] of the escalating nature of the risk; namely about all the behaviour she had exhibited up to that point i.e. the increased overdoses, putting a plastic bag over her head and she was clearly suicidal. I also told Registrant about the overdose on the 23 July 2014 when I had call an ambulance for Patient A.'

The panel also had regard to the evidence of Ms 3, who attended Miranda House and recommended the short term admission of Patient A and sought for Mr McKee to reconsider when he refused admission.

The panel also took into account the evidence of Mr 6 and the Clinical Review of Standards: A Report to Support the fact-finding investigation into professional standards report. Having considered all of the evidence before it, the panel determined that Mr McKee was aware of the recommendations of the three professionals involved in Patient A's care, and in refusing to admit Patient A, the panel was of the view that it was more likely than not that Mr McKee did not take into account the reasons provided by the three professionals and their recommendations to admit Patient A. The panel had sight of Patient A's Patient Records and noted that Mr McKee did not record his rationale for his decision not to take the opinion of three professionals into account. Accordingly, the panel found this charge proved.

Charge 1.a.v.

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:

v. You did not take into account that they had described wanting to a put a bag over their head;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to the transcript of the coroner's inquest and the evidence of Ms 2 and Mr 6.

The panel had regard to the witness statement of Ms 2 in which she stated that she had informed Mr McKee about Patient A putting a plastic bag over her head.

The panel also had regard to the evidence of Mr 6 who noted that Mr McKee had been made aware of Patient A putting a plastic bag over her head but that he failed to carry out any proper assessment in relation to this.

The panel noted Mr McKee's response in the transcript of the coroner's inquest in which it is recorded that he stated the following:

> *'I know there is one failure of mine on that day and that was not to explore the issue of the plastic bag'*

The panel was of the view that Mr McKee was made aware of Patient A putting a plastic bag over her head and, by his own admission, he did not take this into account. The panel therefore found this charge proved.

Charge 1.a.vi.

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:

vi. You did not take into account that they had been found with a bag over their head earlier in the day;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to the transcript of the coroner's inquest, Patient A's patient record and the evidence of Ms 2, Ms 3, Mr 5 and Mr 6.

The panel noted that during a conversation with Mr McKee on 25 July 2014, Ms 2 made him aware of Patient A putting a plastic bag over her head. The panel also had regard to the evidence of Ms 3 who said that she advised Mr McKee that Patient A was found by the ambulance with a plastic bag on her head earlier that day.

The panel noted Mr McKee's response in the transcript of the coroner's inquest in which it is recorded that he stated the following:

> *'I know there is one failure of mine on that day and that was not to explore the issue of the plastic bag'*

The panel had sight of Patient A's care notes in which Mr McKee had not recorded any information about how Patient A had been found with a plastic bag on her head earlier in the day. The panel therefore found this charge proved.

Charge 1.a.vii.

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:

        vii. You did not assess the possible impact of their consumption of nitrazepam on their presentation;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. The panel had particular regard to Patient A's patient record, the evidence of Mr 1, Ms 2, Mr 5 and Mr 6.

In Patient A's patient record Mr McKee made the following entry:

> *'[Patient A] presented as calm and collected she appeared a little "drowsy" which [Patient A] said was due to her use of Nitrolopan that she was buying from the internet.'*

The panel had regard to the evidence of Mr 1 who said that it sounded like Patient A was under the influence of drugs when he spoke to her on 25 July 2014. The panel also had regard to the expert evidence of Mr 6 who was of the opinion that Patient A's demeanour may have been impacted by her consumption of drugs and that this could cause her to appear as being calm and controlled.

The panel noted that whilst Mr McKee acknowledged that Patient A had taken drugs, he did not properly consider that the drugs could have impacted on her demeanour. The panel therefore found this charge proved.

Charge 1.a.viii.

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:

        viii. The alternative care plan to admission you identified did not adequately protect them;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient record and the expert evidence of Mr 5 and Mr 6.

The panel had sight of Patient A's patient record and noted that Mr McKee made the following note:

'[Patient A] was informed home treatment may contact the team'

The panel had regard to the evidence of Mr 6 who stated that the least restrictive option in providing care should be adopted but that Mr McKee should have made a robust and safe plan of care after he decided to not admit Patient A. Mr 6's expert opinion was that in the circumstances, the alternative plan of care was not robust and it did not sufficiently address the risks.

The panel noted that there was no evidence to suggest that anyone other than Mr McKee was involved in implementing an alternative care plan to admission. The panel was of the view that sending Patient A home with the instruction that awaiting contact from Patient A was not robust and did not adequately protect her. The panel therefore found this charge proved.

Charge 1.a.ix.

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:

        ix. You placed undue reliance on previous assessments;

This charge is found proved.

In reaching its decision the panel had regard to the all of the evidence before it. It had particular regard to Mr McKee's statement to the Coroner, the Coroner's inquest transcript, the evidence of Ms 8 and the expert evidence of Mr 5 and Mr 6.

The panel had regard to Mr McKee's statement to the Coroner in which he stated the following:

> *'My colleagues from the Crisis Team had face to face contact with [Patient A] on the prior Wednesday night (23rd July 2014) and completed a full mental health assessment. Another assessment was undertaken on the Thursday night (24th July 2014). During the assessment on the Thursday [Patient A] presented at Hull Royal Infirmary (HRI) claiming to have taken an overdose...*
>
> *… Given the absence of any increased identified risk we offered [Patient A] weekend support from the Crisis Team, as an alternative to a hospital admission. [Patient A] had accepted weekend support from the Crisis Team in the past.'*

The panel had regard to the expert evidence of Mr 5 and Mr 6 who said that Mr McKee should have undertaken his own assessment and that each presentation should be treated as unique.

The panel considered that it was clear that Mr McKee had placed undue reliance on the previous assessment as he stated that he did not think that there was an increased risk. The panel was of the view that in the circumstances Mr McKee should have undertaken a fresh review. The panel therefore found this charge proved.

Charge 1.a.x.

1. On 25 July 2014 in relation to Patient A;

    a. Did not carry out an adequate clinical / gatekeeping assessment in that:

        x. You did not seek a second opinion from a psychiatrist;

This charge is found proved.

In reaching this decision the panel had regard to the expert evidence of Mr 5 and Mr 6.

The panel noted that Mr 6 in his evidence stated that he was of the opinion that given the dispute and conflict on whether to admit Patient A, as the clinical lead, Mr McKee should have sought a second opinion from a psychiatrist. Mr 5 also formed the view that Mr McKee should have sought a second opinion from a psychiatrist.

The panel noted that the situation was escalated to Colleague 2, the Team leader, but he was also a Band 7 mental health nurse. Whilst there appeared to be no formal escalation process in place at the time that the charges arose, the panel was of the view that Mr McKee should have been aware of the need to seek a second opinion from a psychiatrist on whether to admit Patient A in the circumstances. The panel heard evidence that three other professionals with a detailed knowledge of Patient A were requesting a short admission in line with an agreed care plan supported by Patient A's psychiatrist and psychologist. The panel heard no evidence that Mr McKee sought a second opinion from a psychiatrist. The panel therefore found this charge proved.

Charge 1.a. Concluding remarks

The panel had regard to the question of adequacy and noted that in both his oral evidence and his witness statement, Mr 5 stated that *'[Mr McKee] did not undertake a proper nor adequate assessment of Patient A when she presented to the crisis team on 25 July 2014.'*

The panel also noted the witness statement of Mr 6 in which he stated the following:

> *'Registrant A carried out and inadequate assessment at the time and failed to write it up sufficiently in the clinical notes.'*

The panel was of the view that all of the subsections contained within charge 1.a. which have been found proved cumulatively establish that Mr McKee did not carry out an adequate clinical / gatekeeping assessment. The panel considered that whilst seeking a second opinion from a psychiatrist may not have been a formal pathway at the time that the incident occurred, given the circumstances and the dispute between medical professionals and the police, the panel was of the view that this should have formed part of the clinical / gatekeeping assessment.

Charge 1.b.

1. On 25 July 2014 in relation to Patient A;

    b. Told them the reason for not admitting them was a lack of bed space;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Mr 1, Ms 2, Ms 3 and Ms 8.

The panel had regard to the written statement of Ms 3 in which she stated the following:

> *'Patient A was asked questions on how she felt and she explained how she was feeling and that she wanted to be admitted. [Mr McKee] explained that there were no beds available.'*

The panel also had regard to the witness statements of Mr 1 and Ms 2 who both stated that Mr McKee informed them that he would not be able to admit Patient A due to a lack of beds. The panel noted that it was not within the remit of Mr McKee's role to determine whether a bed was available, this was determined by another member of staff. In her written statement Ms 8 stated that if beds were not available at Miranda House then an alternative bed should have been sought in a different area.

The panel noted that the evidence of Ms 3 was supported by her contemporaneous record and that her oral and documentary evidence was consistent and reliable. It also noted that her evidence was supported by the evidence of Mr 1 and Ms 2 who had also been told by Mr McKee that there were no beds available. The panel was therefore of the view that it was more likely than not that Mr McKee told Patient A that the reason for not admitting her was due to a lack of beds. Accordingly, the panel found this charge proved.

Charge 1.c.

1. On 25 July 2014 in relation to Patient A;

    c. Did not further risk assess them when they banged their head against a wall after the initial clinical / gatekeeping assessment;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient record, the evidence of Ms 3, Mr 4 and the expert evidence of Mr 6.

The panel had regard to the witness statement of Ms 3 in which she stated the following:

> *'[Mr McKee] still asserted that there were no beds available. At which point; Patient A became distressed and began hitting her head against the wall. [Mr McKee] and the other assessor then left the room. I was left alone with Patient A, which I do not believe to be particularly good practise, particularly when a patient is being violent and self-harming.'*

The police were called and when they attended Miranda House they were told to escort Patient A home after she had been hitting her head against the wall. The panel had regard to the witness statement of Mr 4 in which he stated the following:

> *'[Ms 3] told Patient A that she would see her on Monday morning, at which point she responded and said that she would not see her on Monday as she would be dead by then" and that when she gets home she is going to kill herself. At that point [Ms 3] became slightly emotional, she was trying everything she could do to keep the patient safe, we all tried to speak to the patient and keep her safe, reassure her that it will be all right, none of us were happy with the situation.*
>
> *At which point, I left them in the room and went back out to the reception area to see the registrant and his colleague. I informed them of the recent comments Patient A had said and asked them again if they might reconsider and reassess Patient A again, based on this additional information, alongside all that they know about the patient attempting suicide several times. They still refused and said that she needs to be taken home.'*

The panel had regard to the expert evidence of Mr 6 who stated that Patient A should have been reassessed after she started banging her head against the wall in accordance with the NICE Guidelines.

The panel had sight of Patient A's patient record and noted that there was no evidence that Mr McKee undertook a reassessment after she started hitting her head against the wall. The panel also determined that not only did he not reassess her, Mr McKee left the room when Patient A started banging her head against the wall. The panel therefore found this charge proved.

Charge 1.d.

1. On 25 July 2014 in relation to Patient A;

    d. Did not further risk assess them when they self-ligatured after the initial clinical / gatekeeping assessment;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient record, the evidence of Ms 3, Mr 4 and the expert evidence of Mr 6.

The panel had regard to the witness statement of Ms 3 in which she stated the following:

> *'[Mr McKee] still asserted that there were no beds available. At which point; Patient A became distressed and began hitting her head against the wall. [Mr McKee] and the other assessor then left the room. I was left alone with Patient A, which I do not believe to be particularly good practise, particularly when a patient is being violent and self-harming. I tried my best to manage the situation and deescalate the situation to no avail… Patient A then proceeded to take her shoe lace and tie it around her neck and pulled quire tightly, choking herself'*

The police were called and when they attended Miranda House they were told to escort Patient A home after she had self-ligatured. The panel had regard to the witness statement of Mr 4 in which he stated the following:

> *'[Ms 3] told Patient A that she would see her on Monday morning, at which point she responded and said that she would not see her on Monday as she would be dead by then" and that when she gets home she is going to kill herself. At that point [Ms 3] became slightly emotional, she was trying everything she could do to keep the patient safe, we all tried to speak to the patient and keep her safe, reassure her that it will be all right, none of us were happy with the situation.*

At which point, I left them in the room and went back out to the reception area to see the registrant and his colleague. I informed them of the recent comments Patient A had said and asked them again if they might reconsider and reassess Patient A again, based on this additional information, alongside all that they know about the patient attempting suicide several times. They still refused and said that she needs to be taken home.'

The panel had regard to the expert evidence of Mr 6 who stated that Patient A should have been reassessed after she self-ligatured in accordance with the NICE Guidelines.

The panel had sight of Patient A's patient record and noted that there was no evidence that Mr McKee undertook a reassessment after she self-ligatured. The panel therefore found this charge proved.

Charge 1.e.

1. On 25 July 2014 in relation to Patient A;

    e. Said "leave her, she'll faint before she dies" or words to that effect when they had self-ligatured;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 3 and the transcript of the Coroner's inquest.

The panel had regard to the witness statement of Ms 3 in which the following is stated:

'Patient A then proceeded to take her shoe lace and tie it around her neck and pulled quite tightly, choking herself. At this point; I went outside and shouted for help. I cannot remember exactly who came back. However; I recall that [Mr McKee] said to me to leave her as she was; that she will faint before she dies.'

The panel had sight of the transcript for the Coroner's inquest and noted the following:

> ***'[Counsel for Patient A's family] and for you to suggest at that point that you should leave her to faint and take it off her was wholly inappropriate wasn't it?***
>
> *[Mr McKee] as I said in the HR process it was to surprise giving [Patient A] something to think about and I think it's also as […] said you know you are in control you take control of the situation.'*

The panel noted that Mr McKee admitted to saying *"leave her, she'll faint before she dies"* or words to that effect when Patient A had self-ligatured. He tried to provide a justification for saying this. The panel considered his explanation and noted the expert evidence of Mr 6 who said that saying such a thing to a patient in distress is inappropriate and not an acceptable way to de-escalate a situation.

Having regard to all of the above the panel found this charge proved.

Charge 1.f.

1. On 25 July 2014 in relation to Patient A;

    f. Did not further risk assess them after they had been restrained in relation to the self-ligature after the initial clinical / gatekeeping assessment;

This charge is found proved.

The panel noted that there is an overlap between this charge and charge 1.d. It therefore found this charge proved for the same reasons as set out in charge 1.d.

The panel had sight of Patient A's patient record and noted that there was no evidence that Mr McKee undertook a reassessment after she been restrained when she self-

ligatured. The panel therefore found this charge proved for the same reasons as set out in charge 1.d.

Charge 1.g.i.1.

1. On 25 July 2014 in relation to Patient A;

    g. When the police attended Miranda House:
        i. Said words to the effect of:
            1. She is just a member of the public now;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Mr 4 and Mr McKee's response at the investigation meeting.

The panel had regard to the witness statement of Mr 4 in which the following is stated:

> *'I went back to reception and spoke to the nurses again. I asked them exactly what they wanted from the police. The two nurses informed me that she was "just a member of the public now".'*

The panel also had regard to Mr 4's contemporaneous notes.

The panel had sight of Mr McKee's responses during the investigation meeting in which he stated the following:

> *'The police were reluctant to get involved and a bit tense. They were concerned and not happy but they were ok. We said that she is a member of the public, not a patient and we rely on you to escort her off the premises.'*

The panel noted that Mr McKee admitted to saying to the police that Patient A was just a member of the public now. Furthermore, the panel was of the view that the evidence of Mr 4 was credible and reliable. Accordingly, the panel found this charge proved.

Charge 1.g.i.2.

1. On 25 July 2014 in relation to Patient A;

    g. When the police attended Miranda House:
        i. Said words to the effect of:
            2. She has been assessed and we want her out of the building;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Mr 4 and Mr McKee's response at the disciplinary investigation meeting on 23 July 2014.

The panel had regard to the witness statement of Mr 4 in which the following is stated:

> *'I went back to reception and spoke to the nurses again. I asked them exactly what they wanted from the police. The two nurses informed me that she was "just a member of the public now". That they had completed their assessment and wanted her out of the building.'*

The panel also had regard to Mr 4's contemporaneous notes.

The panel had sight of Mr McKee's responses during the disciplinary investigation meeting on 23 July 2014 in which he stated the following:

> *'The police were reluctant to get involved and a bit tense. They were concerned and not happy but they were ok. We said that she is a member of the public, not*

a patient and we rely on you to escort her off the premises. They were still not happy so they called the sergeant'

The panel was of the view that the evidence of Mr 4 was credible and reliable. Accordingly, the panel found this charge proved.

Charge 1.g.ii.

1. On 25 July 2014 in relation to Patient A;

    g. When the police attended Miranda House:

        ii. Discussed Patient A in the car park;

This charge is found proved.

In reaching its decision the panel had regard to all of the information before it. The panel had particular regard to the evidence of Mr 4 which included his witness statement for the Coroner's inquest and his witness statement provided to the NMC. The panel also had regard to the second interview transcript with Mr 6 dated 16 February 2015.

The panel had regard to Mr 4's witness statement for the Coroner's inquest in which the following was stated:

'Whilst waiting in the carpark the manager of MIRANDA HOUSE approached me and asked why I was there…

… While I was explaining my reasoning to [the sergeant] and the manager, we we're [sic] joined by [Mr McKee], [Colleague 1] and [Mr 9].'

The panel noted Mr McKee's responses in the transcript of the second interview dated 16 February 2015 in which the following is stated:

'…we all had a conversation in the car park, 2 pcs, me, [Colleague 1] and a sergeant.'

Having regard to all of the above the panel determined that Mr McKee did discuss Patient A in the car park with the police.

Accordingly, the panel found this charge proved.

Charge 1.g.iii.

1. On 25 July 2014 in relation to Patient A;

    g. When the police attended Miranda House:

        iii. Raised your voice to the police;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Mr 4 and Ms 8.

In his witness statement Mr 4 explained that he was having a conversation with Mr McKee and Colleague 1 and he refused to take Patient A home, he then stated the following:

'At this time everyone raised their voices. I refused and they demanded that I get the Sergeant.'

The panel also had regard to the oral evidence of Mr 4 who conceded that during this conversation he also raised his voice.

The panel had sight of Mr McKee's interview transcript dated 23 July 2015 in which he denied that the conversation with the police was heated.

The panel preferred the evidence of Mr 4 who they found to be a credible and reliable witness. The panel noted that Mr 4's was willing to accept responsibility for his own actions which in the panel's view went to his credibility. The panel was therefore of the view that it was more likely that not that Mr McKee raised his voice to the police. Accordingly, the panel found this charge proved.

Charge 1.h.

1. On 25 July 2014 in relation to Patient A;

    h. Decided they should not be admitted;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to the Patient A's patient records, the evidence of Ms 3, Mr 4 and Mr 6.

The panel had sight of Patient A's patient record in which Mr McKee stated that Patient A was to be treated in the community.

The panel had regard to the witness statement of Ms 3 in which the following is stated:

> *'Patient A was asked questions on how she felt and she explained how she was feeling and that she wanted to be admitted. [Mr McKee] explained that there were no beds available.'*

Ms 3 sought to change Mr McKee's mind but he stood by his original decision and the police were called to escort Patient A from the premises.

The panel had regard to the evidence of Mr 4 who, in his witness statement, stated the following:

'Eventually my Sergeant went up to inspector level for advice as he could not make the decision. He spoke to the inspector and I was informed shortly after that we had no other choice but to take her home.'

The panel also had regard to Mr McKee's responses during interviews and the Coroner's inquest and noted that he has always stood by his decision to not admit Patient A on 25 July 2014.Having regard to all of the above the panel determined that Mr McKee decided that Patient A should not be admitted. The panel therefore found this charge proved.

Charge 1.i.i.

1. On 25 July 2014 in relation to Patient A;

    i. Did not make an adequate record in that:
        i. You did not record your discussions with other clinicians about their admission before their attendance at Miranda House;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Mr 1, Ms 2 and Ms 3, and the expert evidence of Mr 5 and Mr 6.

The panel had regard to the evidence of Mr 1 and Ms 2 who contacted Mr McKee by telephone on 25 July 2014 prior to Patient A arriving at Miranda House.

The panel had sight of Patient A's patient record in which Mr McKee has recorded contact with Ms 2 and the crisis team, but did not contain any details of the conversation.

The panel heard evidence from Mr 5 and Mr 6 about what would be deemed as an adequate record as set out in the NICE Guidelines.

The panel was of the view that whilst Mr McKee made some notes about a telephone conversation he had with Ms 2, he did not record what the discussion was about. The panel therefore determined that Mr McKee did not make an adequate record of the conversations with other clinicians before Patient A attended Miranda House. Accordingly, the panel found this charge proved.

Charge 1.i.ii.

1. On 25 July 2014 in relation to Patient A;

    i. Did not make an adequate record in that:

        ii. You did not make a contemporaneous note during their appointment;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient records, the expert evidence of Mr 5 and Mr 6 and the NICE Guidelines.

The panel had sight of Mr McKee's entries into Patient A's patient records on 25 July 2014. The panel heard expert evidence from Mr 5 and Mr 6 who both stated that whilst the notes were made contemporaneously by Mr McKee, they were inadequate and did not include all of the information required by the NICE Guidelines. The panel accepted the expert evidence and having taken the NICE Guidelines into account it determined that Mr McKee did not make an adequate contemporaneous record during Patient A's appointment. Accordingly, the panel found this charge proved.

Charge 1.i.iii.

1. On 25 July 2014 in relation to Patient A;

    i. Did not make an adequate record in that:

        iii. You did not include a structured risk / clinical assessment;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient record and the expert evidence of Mr 5 and Mr 6.

The panel had sight of Patient A's patient record and it noted that Mr McKee had not included a structured risk / clinical assessment. The panel also heard expert evidence from Mr 5 and Mr 6 who confirmed that Mr McKee did not include a structured risk/clinical assessment in Patient A's patient records on 25 July 2014.

Having regard to all of the above the panel found this charge proved.

Charge 1.i.iv.

1. On 25 July 2014 in relation to Patient A;

    i. Did not make an adequate record in that:

        iv. You did not record their presenting features;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient record and the expert evidence of Mr 5 and Mr 6.

The panel noted Patient A's clinical record in which Mr McKee had written that she appeared a little drowsy. The panel noted that this was the only record of Patient A's presenting features and it heard expert evidence from Mr 5 and Mr 6 who stated that Mr McKee failed to record that this drowsiness could have been as a result of her taking drugs. The panel therefore determined that Mr McKee did not make an adequate record in Patient A's patient records in relation to her presenting features. Accordingly, the panel found this charge proved.

Charge 1.i.v.

1. On 25 July 2014 in relation to Patient A;

    i. Did not make an adequate record in that:

        v. You did not adequately record their needs;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient record and the expert evidence of Mr 5 and Mr 6.

The panel had sight of Patient A's patient records and noted that there was limited reference to her needs. The panel had regard to the expert evidence of Mr 5 and Mr 6 who both stated that Mr McKee did not include the required information about in Patient A's specific needs at the time of presentation in her patient records. Taking all of the above into account, the panel found this charge proved.

Charge 1.i.vi.

1. On 25 July 2014 in relation to Patient A;

    i. Did not make an adequate record in that:

vi. You did not record a rationale for providing them with community-based care;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient record and the expert evidence of Mr 5 and Mr 6.

The panel had sight of Patient A's patient record and noted that the action to be take was to *'await contact'*. The panel noted that Mr McKee had not provided any rationale as to why he had decided to not admit and to instead provide community-based care. The panel had regard to the expert evidence that Mr McKee should have recorded the proposed course of action and how it should be enacted but he did not. Accordingly, the panel found this charge proved.

Charge 1.i.vii.

1. On 25 July 2014 in relation to Patient A;

    i. Did not make an adequate record in that:

        vii. You did not adapt the care plan to provide community-based care;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient record, care plan and the expert evidence of Mr 5 and Mr 6.

The panel had sight of Patient A's care plan and noted that following the meeting on 10 July 2014 the care plan was updated to include a short in-patient stay when her risk of overdose increased. Having heard expert evidence from Mr 6, the panel was of the view that given Mr McKee had deviated from the care plan and decided to provide care in the

community instead of a short in-patient stay, he should have updated and adapted the care plan but he did not. The panel therefore found this charge proved.

Charge 1.i.viii.

1. On 25 July 2014 in relation to Patient A;

    i. Did not make an adequate record in that:

        viii. Your action plan "to await contact" was insufficiently detailed;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient record and the expert evidence of Mr 5 and Mr 6.

The panel had sight of Patient A's patient record in which Mr McKee has written *'action – await contact'* on 25 July 2014. Prior to this note Mr McKee does not record reasons as to why the action plan was to await contact from Patient A.

The panel had regard to Mr McKee's responses during his disciplinary hearing in September 2015, in particular:

> *'…in my own head I am quite clear I did a good assessment and realised that I didn't document it.'*

The panel noted that Mr McKee appears to accept that he did not make an adequate record of his assessment of, and rationale for not admitting Patent A.

The panel had sight of Patient A's patient records and noted that Mr McKee had written that Patient A was informed that she could contact the out of hours mental health team that that they were to *'await contact'*. The panel determined that Mr McKee's action plan

was insufficiently detailed and inadequate. The panel therefore found this charge proved.

Charge 1.i.ix.

1. On 25 July 2014 in relation to Patient A;

    i. Did not make an adequate record in that:

        ix. You did not record a rationale for not admitting them;

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it. It had particular regard to Patient A's patient record, Mr McKee's responses during disciplinary proceedings and the expert evidence of Mr 5 and Mr 6.

The panel had regard to Mr McKee's responses during his disciplinary hearing in September 2015, in particular:

> *'…in my own head I am quite clear I did a good assessment and realised that I didn't document it.'*

The panel noted that Mr McKee appears to accept that he did not make an adequate record of his assessment of, and rationale for not admitting Patent A. Furthermore, the panel, having had sight of Patient A's patient records it noted that Mr McKee did not record a rationale for not admitting her. Accordingly, the panel found this charge proved.

Charge 2

2. Your decision to refuse admission contributed to Patient A's death

This charge is found proved.

In reaching its decision the panel had regard to all of the evidence before it.

The panel had sight of the Coroner's written judgement and conclusion on 23 October 2015 regarding the death of Patient A. The panel noted that it considered a wide range of potential contributory factors. In the narrative conclusion it was found that had Patient A been admitted after the initial assessment or after *'the two further missed opportunities, she would have survived and not died when she did*.' The panel also noted the information it was given upon the resumption of this hearing, that the Coroner's conclusion has now been quashed, and a new inquest ordered.

In any event, in considering this charge the panel has had particular regard to the expert evidence of Mr 5 and Mr 6.

The panel had regard to the expert evidence of Mr 5 who undertook an investigation into the incident on 25 July 2014 and produced a report *'Clinical Review of Standards: A report to Support the fact-finding investigation into professional standards.'* Mr 5, in his evidence, told the panel that an admission into hospital would have mitigated the risk of fatal self-harm or suicide, but he could not be certain that it would have prevented the outcome.

Mr 6 carried out an independent review to investigate the circumstances leading up to the death of Patient A. The review panel comprised of Mr 6 (independent nurse advisor), Mr 10 (Medical Director, Greater Manchester West Mental Health Foundation Trust) and Ms 11 (Acute Services Manager, Pennine Care NHS Foundation Trust). Mr 6, Mr 10 and Ms 11 documented their findings in a report entitled *'Report of the Independent Review into the circumstances surrounding the care and treatment of Patient A, who died on 25 July 2014'.* The panel noted the outcome of the independent review:

'14. ANALYSIS AND CONCLUSIONS:

14.1 The inescapable and overwhelming conclusion is that should Patient A have been admitted to hospital on 25th July she would most likely not have died that evening. The clinical team that knew her best were well aware of the accumulating risks and attempted to enact the agreed contingency plan for these circumstances. The assessment undertaken by the CRHTT appeared cursory, uni-disciplinary [sic] *and with little regard or respect for the opinion of the two care coordinators.*

14.2 There was evidence that over the last 72 hours before her death that the risks were significantly mounting and these had been identified by those professionals that knew her best.

14.3 The CRHTT in the circumstances proved to be a hindrance rather than a help

14.4 It appears that they didn't fully appreciate the significant changes in Patient A's presentation and risks which included:

1. *Continued to take overdose of medication*
2. *The Nitrazepam could have exacerbated her instability and irritability*
3. *She had had an unsettled night with minimal sleep further disorientating her, slurring her speech and increasing effects of the medication*
4. *Inability to attend the gym as a coping mechanism due to an injury*
5. *Threat to place plastic bag over her head*
6. *Expressing a wish to die.*

14.5 The assessment by two experienced staff, one a band 6 and one a band 7 was limited with no clear outcome. They concluded that she had capacity though it was far from clear as to what this referred to, but appeared to serve the agenda that Patient A was free to make her own decisions about her care and safety, and possibly reinforce the notion that she did not need urgent mental health care and attention.

14.6 There was no psychological formulation and the assessment at the gate keeping was inadequate.'

The panel preferred the evidence of Mr 6 to Dr 13 (who gave evidence to the Coroner but did not give oral evidence in this hearing). Dr 13's evidence was solely based on patient records available to him at that time, as such, there were gaps in his knowledge as he did not have access to all of the records that Mr 6 had access to. The panel noted the witness statement of Mr 6 in which he refuted claims set out in Dr 13's report:

'[Dr 13] also states that it is difficult to make a conclusion about the contribution of [Mr McKee's] decision making. I disagree. Admitting Patent A to the hospital would have mitigated the increased risk. I cannot for certain claim that this would have prevented the outcome, as Patient A's mood and actions could have changed in an instant. However, [Mr McKee's] rejection and attitude at the time did not help create a sense of feeling valued and supported and was a significant contributor to the outcome.'

The panel also had regard to Mr 6's oral evidence in which he stated that a hospital admission would have significantly reduced the risk of Patient A being able to self-harm. When a patient is admitted they would have had any potentially dangerous or harmful items confiscated, and been monitored by hospital staff and treated for any issues arising.

The panel was of the view that the investigation and *'Report of the Independent Review into the circumstances surrounding the care and treatment of Patient A, who died on 25 July 2014'* was carried out by three highly qualified and independent professionals. The panel also had the opportunity to cross examine Mr 6 when he gave live evidence to the panel. The panel determined that he was a credible, objective and reliable witness. The panel preferred the evidence of Mr 6 to the evidence of Dr 13. The panel is satisfied that the investigation that was undertaken by Mr 6, Mr 10 and Ms 11 was thorough and more detailed than that carried out by Dr 13 and, as a consequence, attached more weight to the *'Report of the Independent Review into the circumstances surrounding the care and treatment of Patient A, who died on 25 July 2014'.*

In conclusion, the panel determined that despite concerns raised by medical professionals about Patient A's increased risk of fatal self-harm or suicide on 25 July 2014, Mr McKee deviated from Patient A's care plan and refused admission for a short-term in patient stay. The panel considered that while there were other factors that could have contributed to her death, if Patient A had been admitted into hospital, she would not have had access to the drugs she had ordered on the internet, a plastic bag or any other potentially harmful substances or material. Furthermore, she would have had received care and appropriate support from professionals. Having examined all of the evidence presented to it, and having particular regard to the expert evidence, the panel was of the view that on the balance of probabilities, it was more likely than not that if Patient A was admitted on 25 July 2014 she would not have died on that day. The panel found that Mr McKee's decision to refuse the admission of Patient A contributed to her death and therefore found this charge 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 McKee'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 McKee'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.'*

Ms Smith 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: Standards of conduct, performance and ethics for nurses and midwives 2008' (the Code) in making its decision.

Ms Smith identified the specific, relevant standards where Mr McKee's actions amounted to misconduct. She submitted that in order to find misconduct Mr McKee's

actions and omissions have to be found serious. Ms Smith submitted that there are two aspects that should be considered in determining the seriousness. Firstly, the extent of the falling short of what would be considered proper in the circumstances and the other consideration being the risk of harm if the conduct was repeated.

Ms Smith drew the panel's attention to the broad heading formed in the stem of each of the charges and she submitted that there are a number of failures in Mr McKee's practice.

Ms Smith submitted that Mr McKee's failure to carry out an adequate gatekeeping assessment was serious, his adherence to the required factors was superficial at best, and in some cases non-existent. Ms Smith submitted that as a very senior mental health nurse, Mr McKee would have been aware of the standards that he should have been adhering to, and he should have been setting an example to more junior colleagues. Ms Smith submitted that Mr McKee's actions in respect of not following the standards expected in Patient A's gatekeeping assessment was very serious and amounted to misconduct.

Ms Smith addressed the panel on charges 1.b and 1.e. and submitted that these charges relate to comments made by Mr McKee to Patient A. Ms Smith submitted that the comments made by Mr McKee in charge 1.e demonstrate a lack of dignity and compassion afforded to Patient A. Furthermore, Mr McKee's comments in respect of charge 1.b were simply not true. She submitted that Mr McKee's comments were callous and caused further upset and distress to Patient A.

Ms Smith referred the panel to charges 1.c, 1.d and 1.f, she submitted that these charges relate to instances which should have led to a further risk assessment. Ms Smith submitted that the opportunities for a further risk assessment were missed, but that taken together they demonstrate that Mr McKee appears to have pre-determined the question of whether Patient A was going to be admitted. She submitted that Mr McKee chose to ignore the "red flags", and continued to ignore them when a further risk assessments were required. Ms Smith submitted that Mr McKee's approach when he was challenged was arrogant, defensive and argumentative. Ms Smith submitted that

this kind of behaviour demonstrated that Patient A was not the focus of Mr McKee's considerations on that day.

Ms Smith submitted that in charge 1.g and the possible breach of confidentiality in the car park illustrate that Mr McKee was concentrating on arguing with the police, who were simply seeking a place of safety for Patient A, rather than the interests of Patient A herself.

In respect of the record keeping charges, Ms Smith submitted that Mr McKee was a senior nurse who knew the required standards of documentation. She submitted that what Mr McKee wrote in Patient A's notes were wholly lacking in a situation where he was rejecting actions set out in Patient A's care plan and the clinical opinion of professionals involved in her care. Ms Smith submitted that in these circumstances Mr McKee's failure to make full and proper notes was very serious.

Ms Smith addressed the panel on charge 2, she submitted that Mr McKee's conduct had the most serious consequence in that it contributed to the death of Patient A.

Ms Smith submitted that all of the charges individually and cumulatively amount to misconduct.

Submissions on impairment

Ms Smith 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) and *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311.

Ms Smith submitted that Mr McKee's engagement with Patient A ultimately led to very serious harm. Mr McKee's response to being challenged was defensive and Ms Smith

submitted that there is almost no acceptance by Mr McKee about his deficiencies in handling of, engagement with and his decision making in respect of Patient A. Ms Smith submitted that Mr McKee has chosen to not engage with these NMC proceedings and there is no information that suggests he has accepted the need to strengthen his practice. Ms Smith submitted that Mr McKee's actions did place Patient A at serious risk of harm and that he continues to pose a risk of harm to patients.

Ms Smith submitted that Mr McKee's actions brought the profession into disrepute, his failure to show kindness and compassion is fundamental. She submitted that there remains a risk of repetition in the future.

Ms Smith submitted that public confidence in the profession would be undermined if a finding of impairment was not found in relation to Mr McKee's misconduct.

The panel accepted the advice of the legal assessor.

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 McKee's actions did fall significantly short of the standards expected of a registered nurse, and that his actions and omissions amounted to a breach of the Code. Specifically:

> ***1*** *You must treat people as individuals and respect their dignity.*
>
> ***3*** *You must treat people kindly and considerately.*
>
> ***5*** *You must respect people's right to confidentiality.*
>
> ***8*** *You must listen to the people in your care and respond to their concerns and preferences.*

10 *You must recognise and respect the contribution that people make to their own care and wellbeing.*

21 *You must keep your colleagues informed when you are sharing the care of others.*

24 *You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues.*

26 *You must consult and take advice from colleagues when appropriate.*

28 *You must make a referral to another practitioner when it is in the best interests of someone in your care.*

42 *You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.*

45 *You must ensure any entries you make in someone's paper records are clearly and legibly signed, dated and timed.*

54 You must act immediately to put matters right if someone in your care has suffered harm for any reason.

56 *You must cooperate with internal and external investigations.*

61 *You must uphold the reputation of your profession at all times.*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel accepted the submissions of Ms Smith and was of the view that the charges both individually and collectively are very serious. The panel found that Mr McKee demonstrated a flagrant disregard for required standards during the gateway assessment and the clinical opinions of the medical professionals directly

involved in Patient A's care. It also found that Mr McKee ignored the wishes of Patient A, who was clearly distressed. The panel determined that Mr McKee's actions when Patient A self-harmed in his presence were wholly inappropriate as he did not act in her best interests or act immediately to prevent injury and to provide care. Furthermore, the panel found that despite opportunities arising where a further risk assessment would be required during Patient A's time at Miranda House, Mr McKee did not carry out any further assessments and continued to refuse admission.

The panel was of the view that Mr McKee appeared to have pre-determined that Patient A would not be admitted and that even in the face of "red flags" he did not reassess Patient A and dismissed her requests for help. The panel considered that Mr McKee's behaviour when he was challenged by people who were simply trying to act in Patient A's best interests fell far below the standards expected and raised some serious attitudinal concerns. The panel was of the view that all of the above was exacerbated by Mr McKee holding a position of authority, and as a Band 7 mental health nurse, he should have acted as a role model to his colleagues.

The panel found that Mr McKee's actions fell significantly short of the conduct and standards expected of a nurse and, both individually and collectively, were serious enough to amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr McKee'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. 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) *….'*

The panel finds that limbs a, b and c were engaged in this case.

The panel found that Mr McKee placed Patient A at a risk of harm and that his decision to not admit her contributed to her death. The panel was also of the view that that Mr McKee is liable to act in a similar way in the future.

The panel determined that Mr McKee's actions and behaviour brought the profession into disrepute and breached fundamental tenets of the medical profession. Mr McKee did not adhere to the standards expected of a band 7 nurse, the panel found that he failed to act in the best interests of Patient A and he treated her in a way that lacked basic kindness and compassion, and failed to consider her presenting problems and risks. Furthermore, the panel found that Mr McKee demonstrated significant attitudinal concerns in his behaviour towards other medical professionals and the police, it considered that this behaviour brought the profession into disrepute and breached fundamental tenets of the profession. The panel considered that Mr McKee is liable to act in such a way in the future.

Having had regard to all of the evidence before it, which included Mr McKee's responses to the events which led to the charges against him, the panel determined that he has demonstrated a wholly inadequate level of insight into his failings. Furthermore, the panel found that he does not appear to recognise the gravity of the consequences of his actions and omissions or demonstrate any remorse.

Whilst the panel considered that the charges are potentially remediable as they relate to clinical failings, it was of the view that in the light of Mr McKee's disengagement from these proceedings, his lack of insight, remorse and his lack of desire to strengthen his practice, the shortfalls identified have not been remediated. The panel therefore determined that the risk of repetition and the consequent risk of harm is high. The panel therefore 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.

In addition, in view of the seriousness and nature of this case, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also found Mr McKee's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr McKee'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 McKee's name off the register. The effect of this order is that the NMC Register will show that Mr McKee's 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

Ms Smith drew the panel's attention to the relevant NMC Guidance on sanctions and drew the panel's attention to the NMC guidance on 'Serious concerns which could result in harm to patients if not put right' (Reference: FTP-3b).

Ms Smith informed the panel that in the NMC's sanction bid is that of a striking off order. She submitted that the charges found proved against Mr McKee raise substantial attitudinal concerns, and demonstrate a wholesale disregard and lack of compassion and care on his part for Patient A. She submitted that in the NMC's view, Mr McKee's conduct is fundamentally incompatible with him remaining on the Register and invited the panel to impose a striking off order.

Decision and reasons on sanction

Having found Mr McKee'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:

- Mr McKee placed Patient A at a grave risk of harm.
- Mr McKee's behaviour towards Patient A, colleagues and the police demonstrated serious attitudinal concerns.
- Mr McKee treated Patient A, who was an extremely vulnerable patient, with a lack of basic fundamental care and compassion.
- Despite having had numerous opportunities to demonstrate insight and remorse, Mr McKee has demonstrated no insight or remorse.
- Mr McKee was a Band 7 nurse and in his role as a clinical lead he should have been setting an example to his colleagues.

The panel acknowledged that Mr McKee worked within a high pressure role and environment, however, the panel determined that this was not a mitigating feature and it found no mitigating features in this case.

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 and attitudinal issues identified, an order that does not restrict Mr McKee'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 McKee'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 McKee's registration would be a sufficient and appropriate response. Having found that there are

serious attitudinal concerns about Mr McKee, taken together with the seriousness of the misconduct and his lack of engagement and insight, the panel is of the view that there are no practical or workable conditions that could be formulated. The panel was of the view that whilst the misconduct is clinical in nature and therefore could be addressed through re-training, Mr McKee's deep seated attitudinal concerns cannot be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr McKee'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 harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *...*

The panel also had regard to the NMC guidance on 'Serious concerns which could result in harm to patients if not put right', in particular:

> *'We wouldn't usually need to take regulatory action for isolated incidents of these failings unless the incident suggests that there may be an attitudinal issue such as displaying discriminatory views and behaviours. This may indicate a deep-seated problem even if there is only one reported incident. A pattern of incidents is usually more likely to show risk to patients or service users, requiring us to act.'*

The panel found that whilst the charges relate to one day and one patient, Mr McKee's misconduct persisted despite having a number of opportunities to correct his behaviour

and act in a professional and compassionate way. The panel has found that Mr McKee has no insight into his misconduct and that it is likely that his behaviour would be repeated and, as a consequence, he poses a risk to patients or service users.

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 McKee's actions is fundamentally incompatible with him 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 McKee'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 McKee'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 McKee'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 sanction 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 McKee 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 McKee's own interest until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Smith. She submitted an interim order is necessary on the grounds of public protection and it is otherwise in the public interest. Ms Smith referred to the panel's decision on impairment and its finding that Mr McKee poses a real risk of significant harm to patients. Ms Smith submitted that where a striking off order has been imposed, the public interest threshold is met. Ms Smith invited the panel to impose an interim suspension order for a period of 18 months, she submitted that if no appeal is made then the interim order will lapse and the striking off order take effect.

The panel 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, 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 due to cover the appeal period.

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

That concludes this determination.