Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 20 June 2022 – Friday 24 June 2022
Wednesday 29 June 2022
Friday 1 July 2022 – Wednesday 6 July 2022

Virtual Hearing

Name of registrant:	Gordon Eric Finlay
NMC PIN:	84D0132S
Part(s) of the register:	RN3, Registered Nurse – Mental Health July 1987
Relevant Location:	North Yorkshire
Type of case:	Misconduct
Panel members:	Florence Mitchell (Chair, registrant member) Jane Jones (Registrant member) Anne Phillimore (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Emma Bland
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Mr Finlay:	Not present and unrepresented at the hearing
Facts proved by admission:	Charges 1, 4 a – c, 5b, 5d, 8a – b, 9 a – d, 12 a – b, 14, 15, 16 and 17a – b.
Facts proved:	Charges 2, 3 a- b, 5a, 5c, 6, 7a – b, 8c, 10, 11a – b, 13, 18b, 19b.
Facts not proved:	Charges 18a, 19a, 19c – f.

Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Suspension Order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Finlay was not in attendance. The panel noted that the Notice of Hearing letter had been sent to Mr Finlay's registered email address on 5 May 2022.

Further, the panel noted that the Notice of Hearing was also sent to Mr Finlay's representative at the Royal College of Nursing (RCN) by email on 5 May 2022.

Mr Edwards, on behalf of the Nursing and Midwifery Council (NMC), informed the panel that Mr Finlay had responded to the Case Management Form (CMF) dated 11 March 2022 and had been in email contact with the NMC during preparatory stages prior to the hearing. Mr Edwards stated that email correspondence indicates that Mr Finlay is aware of the hearing, has been given notice of it, and service has been effective. Mr Edwards invited the panel to find that the NMC have 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.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and joining details for the virtual hearing and, amongst other things, information about Mr Finlay's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence. The panel acknowledged a completed Case Management Form which was received by the NMC on 11 March 2022; written email correspondence from both the RCN representative and Mr Finlay stating that they will not be attending the hearing which was received on 26 and 27 April 2022; and the Notice of Hearing which had been sent to two email addresses of Mr Finlay on 5 May 2022. The panel was therefore satisfied that both Mr Finlay and his RCN representative are aware of the dates of the hearing and that there has been good and proper service.

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

Decision and reasons on application for hearing to be held in private

During submissions on proceeding in absence, Mr Edwards made a request that this case be held partly in private on the basis that proper exploration of Mr Finlay's case involves reference to the health of Mr Finlay and the health of other third parties. The application was made pursuant to Rule 19 of 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.

The panel determined to go into private session in connection with the health of Mr Finlay and the health of other third parties as and when such issues are raised in order to protect their interests.

Decision and reasons on proceeding in the absence of Mr Finlay

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

Mr Edwards referred the panel to email correspondence dated 26 April 2022 from the RCN representative of Mr Finlay to an NMC Listing Officer, which states:

‘The Registrant has indicated on the CMF that he will not be attending the hearing and will not be represented. As such, I am still listed as his representative until the outcome of the hearing but will not be having any active participation or involvement in the hearing. Therefore I would not attend a case conference’.

Mr Edwards further referred the panel’s attention to an email dated 27 April 2022 from Mr Finlay to the NMC in response to the following three questions:

*‘**1) Do you wish to participate in the hearing?***

[PRIVATE]*, I cannot participate in these proceedings.* [PRIVATE]
Nor do I wish to prolong the proceedings.

2) If not are you happy for the hearing to proceed in your absence?

Yes

3) Do you have anything you wish to present to the hearing panel if you will not be participating?

I have submitted various documents and defences during the last 5 years.
I may also submit a final statement regarding the allegation of sexual harassment.’

Mr Edwards submitted that Mr Finlay had voluntarily absented himself from the hearing and invited the panel to proceed in his absence. He informed the panel that Mr Finlay has communicated his non-attendance of the hearing to the NMC in writing and has stated that he does not wish to prolong or delay proceedings. Mr Finlay has further stated that he is content for the hearing to proceed in his absence.

Mr Edwards submitted it is in the public interest and the interests of all those witnesses that are currently listed to attend, including three vulnerable witnesses, to proceed in the absence of Mr Finlay. He further submitted that the panel may consider it to be in the interests of Mr Finlay himself as he makes it clear that he wishes the matter to proceed and conclude.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mr Finlay. In reaching this decision, the panel has considered the submissions of Mr Edwards, the written representations from Mr Finlay and his RCN representative, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Finlay;
- Mr Finlay and his RCN representative have informed the NMC that they are aware of the hearing and confirmed that Mr Finlay is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure the attendance of Mr Finlay at some future date;
- Two witnesses have attended today to give live evidence, others are due to attend;
- Not proceeding may inconvenience the witnesses, some of whom are vulnerable witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;

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

There is some disadvantage to Mr Finlay in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email 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 Finlay's decisions 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 Finlay. The panel will draw no adverse inference from Mr Finlay's absence in its findings of fact.

Details of charge

That you, a registered nurse:

1. Between December 2016 and 12 June 2017 failed to record up to 315 patient contacts on PARIS in a timely manner or at all. **[Admitted]**

2. Did not complete and /or record a care plan for Patient A following referral from CMHT in February 2017.

3. Did not complete and/or record a care plan following Patient A's disclosure/s that they felt like ending their own life on:

a. 23 March 2017
b. 6 April 2017

4. Did not make notes, in the patient's electronic records, in a timely manner in respect of appointments with Patient A on:
   a. 23 March 2017
   b. 6 April 2017
   c. 3 May 2017

   [Admitted]

5. In relation to a number of text messages you exchanged with Patient A between June and July 2017, you:
   a. sent them after the patient ceased to be under your care and in breach of professional boundaries; **[Partially admitted]**
   b. did not make notes of the contact you had with Patient A in their electronic records; **[Admitted]**
   c. did not disclose to the crisis team or your manager that Patient A revealed to you that they wanted to end their life;
   d. did not disclose that you had been in contact with Patient A until after the text messages were found on Patient A's phone **[Admitted]**

6. Your actions at charge 5d above lacked integrity in that, in the light of Patient A's death, you knew you should have disclosed the contact you had with Patient A but failed to do so.

7. On or around 20 July 2017 in relation to Patient B:
   a. copied and pasted a previous care plan into their record
   b. did not complete a new assessment

8. In relation to Patient C, between 16 December 2016 and 21 March 2017 did not:
   a. Undertake and/or record a risk assessment **[Admitted]**
   b. Complete and/or record a care plan **[Admitted]**

c. assess and/or record historical risk factors

9. In relation to Patient C did not record the outcome of appointments on
   a. 6 January 2017
   b. 18 January 2017
   c. 27 January 2017
   d. 3 March 2017

   [Admitted]

10. Did not record that Patient C failed to make contact with you as planned on 16 March 2017.

11. In relation to Patient D:
    a. having been allocated the Patient on 14 November 2019, did not make contact with them until 4 December 2019;
    b. did not make notes, in the patient's electronic records, in respect of planned contacts on:
       i. 29 November 2019
       ii. 18 December 2019
       iii. 23 December 2019
       iv. 17 January 2020
       v. 6 February 2020
       vi. 7 February 2020
       vii. 12 February 2020
       viii. 14 February 2020

12. On or around 16 December 2019, in relation to Colleague A:
    a. Hugged her;
    b. Kissed her on her cheek.

    [Admitted]

13. On or around 19 December 2019 slapped Colleague B on the bottom.

14. On or around 19 December 2019 said to Colleague C:
    "*sounds like the birds keep your testicles locked away*" or words to that effect
    [Admitted]

15. On or after 19 December 2019 said to Colleague C:
    "that's where you keep your testicles" or words to that effect. **[Admitted]**

16. On unknown dates between October 2019 and February 2020 showed an explicit video to one or more colleagues at work. **[Admitted]**

17. On a date in January 2020, while talking to a colleague:
    a. Asked her to rate herself from 1-10;
    b. Said to her *"I would give you one"* or words to that effect.

    [Admitted]

18. Your actions were sexual in nature in respect of charge:
    a. 12
    b. 13

19. Your actions intended to bully and/or harass your colleague/s in that you knew that your actions would cause distress or discomfort to another person, in respect of charge:
    a. 12
    b. 13
    c. 14
    d. 15
    e. 16
    f. 17

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

Decision and reasons on application to admit the hearsay evidence of Witness 3

The panel heard an application made by Mr Edwards under Rule 31 to allow the written statement and exhibits of Witness 3 into evidence. Witness 3 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, Witness 3 was unable to attend due to private reasons relating to [PRIVATE], as explained in an email to an NMC lawyer dated 1 May 2022. [PRIVATE].
[PRIVATE]

[PRIVATE]

[PRIVATE].

Mr Edwards submitted that there is good and sufficient reason for the absence of Witness 3. He submitted that it would be in the public interest to admit their evidence under Rule 31 alongside any exhibits they provide. Mr Edwards stated that all efforts had been made by the NMC to secure the attendance of Witness 3, however, they are unable to attend due to the health reasons outlined in their email. Mr Edwards submitted that the witness statements and exhibits of Witness 3 were not the sole and decisive evidence in any charge and were both relevant and fair, and as such, invited the panel to admit this evidence.

The panel gave the application in regard to Witness 3 serious consideration. The panel noted that Witness 3's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement … is true to the best of my information, knowledge and belief'* and was signed by them. The panel considered that Witness 3 was not a witness of fact, but was a Trust Investigator tasked with conducting a local level investigation and collating evidence in response to the allegations.

The panel considered whether Mr Finlay would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 3 to that of a written statement.

The panel acknowledged that Mr Finlay had indicated that he disagrees with some of the content of Witness 3's witness statement in his response on his returned case management form. It further acknowledged that Mr Finlay agreed with the NMC's initial suggestion that Witness 3 should give evidence in-person or by video in a virtual hearing. However, the panel considered that as Mr Finlay had been provided with a copy of Witness 3's statement and, as the panel had already determined that Mr Finlay had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statements and exhibits of Witness 3, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit CCTV evidence

The panel heard an application made by Mr Edwards under Rule 31 to allow CCTV footage into evidence.

Mr Edwards informed the panel that a copy of the CCTV footage had been provided to Mr Finlay and his NMC representative a week in advance of the hearing and neither had raised any objections to the CCTV footage. Mr Edwards invited the panel to view the CCTV in private as the footage shows potentially identifiable service-users.

The panel accepted the advice of the legal assessor.

In considering the admission of CCTV evidence, the panel evaluated whether it was fair and relevant. The panel noted that a copy of the CCTV footage had been provided to Mr Finlay and his representative ahead of the hearing and no objections had been raised. As such, the panel determined it would be fair to admit as evidence. The panel also considered the CCTV evidence to be relevant, as it may relate to one or more of the charges.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the CCTV footage, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

The panel considered the responses of Mr Finlay to the charges, as set out in the Case Management Form. It noted that Mr Finlay had made full admissions to the following charges: 1, 4 a – c, 5b, 5d, 8 a – b, 9 a – d, 12 a – b, 14, 15, 16 and 17 a – b. The panel therefore finds these charges proved in their entirety, by way of Mr Finlay's admissions.

The panel noted that Mr Finlay made a partial admission in relation to charge 5a and disputes that the conduct was in breach of professional boundaries.

The panel noted that Mr Finlay disputes the following charges: 2, 3 a – b, 5c, 6, 7 a – b, 8c, 10, 11 a – b, 13, 18 a – b, and 19 a – f.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Edwards and written representations from Mr Finlay and his representative.

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

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:

- Witness 1: The father of Patient A
- Witness 2: The mother of Patient A
- Witness 4: An Investigating Officer within the HR Department at Tees, Esk and Wea Valleys NHS Foundation Trust ("The Trust")
- Witness 5: An Investigating Officer within the HR Department at the Trust
- Witness 6: Team Manager for the Harrogate Integrated Mental Health Team at the Trust. Witness 6 was the direct line manager for Mr Finlay
- Witness 7: Care Coordinator for the Community Mental Health Team at Somerset House and colleague of Mr Finlay
- Witness 8: A Mental Health Support Worker at Merchant House

- Witness 9: Team Leader at Merchant House
- Witness 10: Clinical Manager for Community Mental Health Services at Bradford District Care Trust and Investigating Officer
- Colleague B: A Mental Health Support Worker at Merchant House
- Colleague C: A Mental Health Support Worker at Merchant House

Background

The charges initially arose whilst Mr Finlay was employed as Band 6 Senior Mental Health Practitioner by Tees, Esk and Wear Valleys NHS Foundation Trust.

The NMC received a referral from a member of the public on 5 March 2019. The area of regulatory concern highlighted in the referral related to an alleged failure to maintain professional boundaries. It came to light that that Mr Finlay had communicated with a vulnerable mental health patient (Patient A) by telephone and a number of text messages which contained inappropriate content after the patient ceased to be under his care.

Further regulatory concerns identified from this referral relate to a failure to preserve patient safety, in that Mr Finlay failed to escalate Patient A's care when Patient A had disclosed a decline in mood and increased thoughts of suicide in a number of text messages to Mr Finlay. Patient A committed suicide during this period of communication. It is also alleged that Mr Finlay had poor record – keeping, in that he failed to record his patient contacts, reviews and care plans as required by the Trust in a timely manner or at all.

Following receipt of information from Bradford District Care NHS Foundation Trust on 2 November 2020, the NMC considered further regulatory concerns about the practice of Mr Finlay. It was alleged that he had been sexually inappropriate with members of staff both physically and verbally. The Trust commenced an investigation during which further concerns were brought to light regarding Mr Finlay's behaviour towards staff. In addition, it is alleged that Mr Finlay had poor record – keeping, in that he failed to record his patient contacts as required by the Trust in a timely manner or at all.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor who referred the panel to the following legal authorities: Re H 1996 AC 563; GMC v Dr RH 2020 EWHC 2518 (Admin); Sexual Offences Act 2003 section 3 and 78; Enemuwe v NMC 2015 EWHC 2081 AND 2016 EWHC 1881 (Admin); Sait v GMC 2018 EWHC 3160 (Admin); Basson v GMC 2018 EWHC 505 (Admin) and Dutta v GMC 2020 EWHC 1974 (Admin).

The panel considered the witness and documentary evidence provided by both the NMC and Mr Finlay and his representative.

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

Charge 1

That you, a registered nurse :

1. *between December 2016 and 12 June 2017 failed to record up to 315 patient contacts on PARIS in a timely manner or at all.*

The panel found charge 1 proved on the basis of the full admission of Mr Finlay.

This charge is found proved.

Charge 2

That you, a registered nurse :

2. *did not complete and /or record a care plan for Patient A following referral from CMHT in February 2017.*

Charge 3

3. *did not complete and/or record a care plan following Patient A's disclosure/s that they felt like ending their own life on:*
   a. 23 March 2017
   b. 6 April 2017

Both charges 2 and 3 are found proved.

In reaching this decision, the panel took into account the relevant paragraphs of the witness statements of Witness 3 and associated exhibits. The evidence of Witness 3 was admitted by way of hearsay application on the basis that it satisfied the test of relevance and fairness as stated in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565. The panel accepted that Witness 3 was not a witness of fact, rather they were carrying out an investigatory function, including the collection of evidence.

The panel noted that the relevant paragraphs of Witness 3's statements largely related to an internal investigation that was undertaken. The panel noted the following "*contributory factors*" were identified in the Serious Incident Report dated 29 September 2017:

> "*The patient reported on 23/03/17 and 06/04/2017 that she felt like ending her life. However, the reviewer found no evidence that a care plan / safety plan had been formulated following the referral to the CMHT in February 2017."*

The panel was mindful however, that it had not had sight of the source material upon which this assertion was based, namely, the full care plan section of the electronic records of Patient A. The panel carefully weighed this evidence and noted that further documentation demonstrated that Mr Finlay participated in a root cause analysis investigation meeting that took place on 21 August 2017. As such, the panel was satisfied that Mr Finlay would have had an opportunity to produce any care plans relevant to the dates of February 2017, 23 March 2017 and 6 April 2017 during this meeting if any such care plans had in fact, been created. The conclusion of the root cause analysis process at local level was that no care plans had been prepared for these dates.

The panel also considered Mr Finlay's own admissions within his written representations where he states that he had prioritised face-to-face contact with patients over completing documentation.

The panel found both charges proved.

Charge 4

That you, a registered nurse :

4. *did not make notes, in the patient's electronic records, in a timely manner in respect of appointments with Patient A on :*
   - *a. 23 March 2017*
   - *b. 6 April 2017*
   - *c. 3 May 2017*

The panel found charge 4 a - c proved on the basis of the full admission of Mr Finlay.

Charge 5a

5. *In relation to a number of text messages you exchanged with Patient A between June and July 2017, you:*
   a. *sent them after the patient ceased to be under your care and in breach of professional boundaries; [Partially admitted]*

This charge is found proved.

The panel took account of the written representations of Mr Finlay within his response bundle. It noted that he had acknowledged and understood that his 'Alternative to Suspension' arrangement meant that he was no longer permitted to remain in contact with patients, including Patient A. The panel determined that professional boundaries were breached by Mr Finlay's continued contact with Patient A under these circumstances.

The panel also considered the live evidence of Witness 2, who stated that Mr Finlay had responded by saying "*Oh shit!*" upon being told that Patient A's phone had been seized by the police to conduct a download and analysis of communications in the period leading up to the death of Patient A. The panel took the view that that these words could be considered an acknowledgement of the breach of professional boundaries that had taken place through telephone calls and text messages.

The panel was also of the view that the content of the text messages constituted a breach of professional boundaries, including the way in which Mr Finlay signed off his text messages as "*Gx*". The panel considered the written reflection of Mr Finlay in relation to this:

> *"I can see how others can perceive the signing off as "Gx" as inappropriate. It was nothing more than a friendly gesture and another patient might find it offensive or think there was some attachment".*

The panel also considered the written representations from the RCN on behalf of Mr Finlay which states:

> *"Mr Finlay accepts that signing off messages in this fashion could have blurred the lines of professional communication"*

The panel considered that the accepted breach of professional boundaries in this manner was exacerbated by the wider context of the health conditions of Patient A, which Mr Finlay as their Care Coordinator, was well aware of. The panel noted that Patient A was a patient with complex mental health conditions that had been described as "*severe and enduring*", particularly in relation to building trust and maintaining relationships with other people and clinical care-givers. As such, she was particularly vulnerable to any "*blurred...lines of professional communication*".

The panel further considered that a professional boundary was breached in the failure of Mr Finlay to communicate the content of the messages to the Crisis Team. It considered that because of the professional role of Mr Finlay, it was his professional responsibility to report the issues to the crisis team himself. The panel determined that it was not sufficient to rely on Patient A's own autonomy, but rather, it was his clear professional responsibility to report these contacts to the wider multi-disciplinary team.

Charge 5b

That you, a registered nurse :

5. *In relation to a number of text messages you exchanged with Patient A between June and July 2017, you:*

   b. *did not make notes of the contact you had with Patient A in their electronic records;*

The panel found charge 5b proved on the basis of the full admission of Mr Finlay.

Charge 5c

5. *In relation to a number of text messages you exchanged with Patient A between June and July 2017, you:*
   c. did not disclose to the crisis team or your manager that Patient A revealed to you that they wanted to end their life;

This charge is found proved.

The panel had sight of a number of text messages in which Patient A had clearly and unambiguously communicated their intention to end their life:

25/06/2017
18:38:23
[PRIVATE]

30/06/2017
12:53:46
[PRIVATE]

03/07/2017
09:38:09
[PRIVATE]

03/07/2017
12:27:02
[PRIVATE]

03/07/2017
12:35:21
[PRIVATE]

The panel was satisfied that the text messages established a clear intention by Patient A to end their own life. The panel went on to consider the question of whether Mr Finlay disclosed this intention to the crisis team or his own line manager.

As before, the panel considered that the obligation to disclose the content of the messages containing suicidal ideation to the crisis team or his line manager was a professional duty. The panel considered the live evidence of Witness 6, the line manager of Mr Finlay, who stated that the crisis team offices were situated down the corridor from Mr Finlay's own office, indicating that Mr Finlay was not working in an isolated context and it would have been relatively straight forward to have communicated this information in person. The panel were mindful of the text message which stated, "*but I just find it so difficult because I'd prefer to speak to you! But I can't … And I find myself in a situation I can't continue x*". It was of the view that Patient A had communicated a wish to only communicate with Mr Finlay, rather than other support workers on the crisis team. The panel was of the view that from this point onwards in particular, the responsibility to raise the alarm or communicate the suicidal ideation of Patient A became even more acute as Patient A had signalled her unwillingness to communicate with anyone else, bar Mr Finlay.

The panel also considered the following submission from Mr Finlay's RCN representative to the Case Examiners:

> "*Mr Finlay accepts that he should have documented the text messages that he had with Patient A and should have let the crisis team know about the content of their conversations. Mr Finlay accepts that there were steps that he could*

have taken to ensure that communication that he had with Patient A was know to the crisis team"

The panel also considered a record of a telephone call between the NMC and Mr Finlay dated 25 March 2019 within the documentation which stated:

> ***"****[Mr Finlay] admits that he did not inform her care giver crisis team that she had been contacting him. He admits that he should have, but was in a difficult place."*

The panel acknowledged the written representations and mitigation presented by Mr Finlay. However, it was of the view that Mr Finlay was an experienced Care Coordinator who would have known the correct procedure for informing multi-disciplinary teams regarding urgent, serious and emerging patient care issues.

Charge 5d

That you, a registered nurse:

5 *In relation to a number of text messages you exchanged with Patient A between June and July 2017, you:*
   d. *did not disclose that you had been in contact with Patient A until after the text messages were found on Patient A's phone*

The panel found charge 5d proved on the basis of the full admission of Mr Finlay.

Charge 6

6 *Your actions at charge 5d above lacked integrity in that, in the light of Patient A's death, you knew you should have disclosed the contact you had with Patient A but failed to do so.*

This charge is found proved.

The panel carefully considered the live evidence of Witness 5, who stated that the communications were not recorded because the overriding concern of Mr Finlay was that he would lose his job as he had been told not to contact patients, and he should not have been in contact with Patient A. The panel further considered the live evidence of Witness 6, who informed the panel that Mr Finlay had admitted to him that he did not record the disclosures from Patient A as he was afraid of losing his job. The panel was of the view that the failure to communicate Patient A's deteriorating mental health was not a genuine mistake, rather this was a deliberate action in withholding information from the crisis team in order to protect himself and his job.

The panel's view was supported by the reflection of Mr Finlay, which further outlines his motivation in failing to communicate with the crisis team:

> *"At the time of this brief exchange,* [PRIVATE]*,* [PRIVATE] *and if I had reported nothing would have happened to me…"*

Taking all this into account, the panel found that Mr Finlay's actions lacked integrity in that he knew he should have disclosed his contact with Patient A, but deliberately chose not to do so.

Charge 7a and b

7 On or around 20 July 2017 in relation to Patient B:
   a. copied and pasted a previous care plan into their record
   b. did not complete a new assessment

This charge is found proved.

The panel considered the live evidence of Witness 5, who considered that the care plan was more or less, a direct copy and paste of the previous care plan from a 2015 in-patient admission. The panel also considered the evidence of Witness 6, who stated that it was an acceptable practice to copy and paste the previous care plan but then make appropriate updates and amendments to reflect the current situation and plan of care.

The panel studied the care plans of Patient B and determined that the 2015 care plan had in fact been copied and pasted, with two amendments in the form of varied sentences at the beginning and the end. The panel determined that this was inappropriate as Patient B had since been discharged into the community and old references to hospital procedures and ward rounds remained in the 2017 care plan when this clearly did not reflect any changes in Patient B's clinical circumstances and was therefore highly inappropriate.

The panel noted the evidence of Witness 5 who conducted a local interview with Mr Finlay on 3 October 2018, where he clearly was aware that it was his responsibility to write an accurate care plan. The panel was mindful of the importance of accurate and up-to-date care plans given the number of clinicians and multi-disciplinary teams involved in the care of a patient.

The panel acknowledged the written representations of Mr Finlay, whereby he states that he believed this may have been a human error on his part or a failure to update due to being distracted. However, the panel was of the view that Mr Finlay was an experienced nurse and Care Coordinator, who would have known his important role in formulating and maintaining accurate care plans.

The panel found charges 7a and 7b proved.

Charge 8a and b

That you, a registered nurse:

8 In relation to Patient C, between 16 December 2016 and 21 March 2017 did not:

a. Undertake and/or record a risk assessment

b. Complete and/or record a care plan

The panel found charges 8a and 8b proved on the basis of the full admission of Mr Finlay.

Charge 8c

8 In relation to Patient C, between 16 December 2016 and 21 March 2017 did not:

c. assess and/or record historical risk factors

This charge is found proved.

The panel considered the statements and exhibits of Witness 3. It noted the following information from the exhibited Trust Serious Investigation Report dated 25 July 2017 in relation to "*contributory factors*":

> *"Contributory factors CDP2 - The reviewer found no evidence of a formal and robust risk assessment and no evidence of a subsequent CPA care plan. Consequently, there was no evidence that historical risk factors were considered"*

The panel was satisfied that this charge was found proved, noting the findings of the local investigator. The panel was mindful that the source information for these findings was not before the panel. However, it noted that Mr Finlay had participated in the root cause analysis meeting and would have been able to provide or indicate evidence to the contrary, if available.

Charge 9 a - d

9 In relation to Patient C did not record the outcome of appointments on

a. 6 January 2017

b. 18 January 2017

c. 27 January 2017

d. 3 March 2017

The panel found charges 9 a- d proved on the basis of the full admission of Mr Finlay.

Charge 10

10 Did not record that Patient C failed to make contact with you as planned on 16 March 2017.

This charge is found proved.

The panel considered relevant parts of the documentation, including a Chronology of Events from the local Trust investigation. The entry on Tuesday 14 March 2017 states:

> "*The care co-ordinator and the patient agreed that the patient would telephone the care co-ordinator on 16/03/2017 after the patient's HR meeting and the next appointment was arranged for 21/03/2017. The care co-ordinator informed the reviewer that the patient did not make contact on 16/03/2017 but this was not recorded in the ECR."*

The panel was satisfied that this charge was found proved.

Charge 11a

11 In relation to Patient D:

a. *having been allocated the Patient on 14 November 2019, did not make contact with them until 4 December 2019;*

This charge is found proved.

The panel considered the live evidence of Witness 10, who was the clinical manager of the community mental health service and investigator at the time. Witness 10 also provided further information with regard to the paper diary and electronic diary of Mr Finlay. Witness 10 stated that approximately three weeks was an unacceptably long period for a patient to be contacted and the required time-frame was in fact up to one week from referral.

Charge 11b

In relation to Patient D:

b. *did not make notes, in the patient's electronic records, in respect of planned contacts on :*
   - *i. 29 November 2019*
   - *ii. 18 December 2019*
   - *iii. 23 December 2019*
   - *iv. 17 January 2020*
   - *v. 6 February 2020*
   - *vi. 7 February 2020*
   - *vii. 12 February 2020*
   - *viii. 14 February 2020*

This charge is found proved.

The panel had sight of both Mr Finlay's paper diary and the electronic diary for the dates in question and were taken through these by Witness 10.

There were no records in the patients’ electronic diary for any of the dates set out in the charge. It was highlighted that on 14 February 2020, Mr Finlay had in fact been suspended and would not have been able to attend patient appointments on that date. However, the panel noted that there was no record of a planned meeting on that date and that it should have been recorded.

Witness 10 told the panel that during the investigation meeting on 17 June 2020, Mr Finlay had told her that he “*wasn’t good at transferring notes*”.

The panel considered the written representations of Mr Finlay, in particular, his admission that he was unfamiliar and not comfortable with the electronic diary and therefore recorded appointments in his paper diary.

The panel was of the view that Mr Finlay would have had sufficient time to learn and use the electronic diary system over the approximate 4-month period that was affected and he should have escalated any concerns or issues that he believed were preventing him from completing his patient records as required.

The panel was satisfied that this charge was found proved in its entirety.

Charge 12

On or around 16 December 2019, in relation to Colleague A:

a. Hugged her;
b. Kissed her on her cheek.

The panel found charges 12 a- b proved on the basis of the full admission of Mr Finlay.

Charge 13

On or around 19 December 2019 slapped Colleague B on the bottom.

This charge is found proved.

The panel noted that all three witnesses were consistent in stating that Mr Finlay's hand had made physical and deliberate contact with the bottom of Colleague B. The panel was assisted by the live evidence of Witness 8 who stood up and physically demonstrated the relevant area and gave a detailed description of the immediate office area that Colleague B was passing through. Witness 9 observed that Colleague B was slightly built and that the area in question would have been large enough for her to pass through without any physical contact. Both Witness 8 and Witness 9 were consistent in their observations of Colleague B immediately after the incident. Colleague B was described as sitting very close to Witness 9 afterwards and although normally "*very confident*", she was "*overly quiet*"; "*seemed shocked*"; was "*visibly upset*"; and she "*did not know how to react*".

During live evidence, Colleague B described the physical contact as a *"pat*" and stated that "*it felt deliberate*", they had "*felt the impact and the palm of his hand*". Colleague A further noted that this was "*not a graze*" that may have been accidental. Immediately after, Colleague A recalled feeling "*shaken-up*", "*shocked*" and "*uncomfortable*".

On questioning, both Colleague A and B were clear that they did not believe the physical contact was accidental and no apology had been offered by Mr Finlay.

The written reflection of Mr Finlay states the following:

> *"I did not intentionally touch the support worker on the bottom…. I was sat on a particularly low chair and I must have put my hands up to protect myself from her passing"*

The panel did not find Mr Finlay's explanation convincing, it was not tested in cross-examination. The panel noted that Mr Finlay had not acted in the same way when Colleague B had passed him shortly beforehand.

The panel was of the view that the touching of Colleague B was a deliberate action based on the detailed and cogent evidence of Witness 8, Witness 9 and Colleague B.

The panel found this charge proved.

Charge 14

On or around 19 December 2019 said to Colleague C :

"sounds like the birds keep your testicles locked away" or words to that effect

The panel found charge 14 proved on the basis of the full admission of Mr Finlay.

Charge 15

On or after 19 December 2019 said to Colleague C :

"that's where you keep your testicles" or words to that effect.

The panel found charge 15 proved on the basis of the full admission of Mr Finlay.

Charge 16

On unknown dates between October 2019 and February 2020 showed an explicit video to one or more colleagues at work.

The panel found charge 16 proved on the basis of the full admission of Mr Finlay.

Charge 17a and b

On a date in January 2020, while talking to a colleague:

a. *Asked her to rate herself from 1-10;*
b. *Said to her "I would give you one" or words to that effect.*

The panel found charge 17 a and b proved on the basis of the full admission of Mr Finlay.

Charge 18a

Your actions were sexual in nature in respect of charge :

a. *12*

This charge is found not proved.

The panel considered the written response of Mr Finlay in relation to this charge:

> *"It felt like a normal thing to do around someone's birthday and I didn't give it much thought, it was innocent and I would stress this hopefully reinforced by the CCTV footage that it was non-sexual and did not appear to create a reaction"*

The panel considered the live evidence of Witness 8, who had not considered the birthday hug sexually motivated or sexual in nature. The panel was also mindful that it did not have evidence before it from Colleague A. It also noted that the CCTV evidence was highly limited and did not provide further clarity to the issues raised in this charge.

The panel was mindful of the advice of the independent legal assessor and evaluated the cogency of the available evidence. The panel determined that there was an absence of cogent evidence to support this charge. The panel was of the view that a reasonable

person, in these circumstances, may not consider the actions in question to be sexual in nature.

Charge 18b

Your actions were sexual in nature in respect of charge:

a. 13

This charge is found proved.

The panel considered the immediate context of the action found proven in Charge 18b. The panel noted that in the moments before physical contact was made, Colleague B reported that an uninvited conversation with overt sexual connotations had taken place where Mr Finlay had stated that he regarded her as "*a challenge*" and a "*guy magnet*". Colleague B reported that Mr Finlay also joked about stalking her, following her home from a nightclub and knocking on her window.

Colleague B further reported the following at a local investigation on 15 January 2020:

Question 9:
Did you feel that GF sexualised the conversation?

Answer:
Yes. By starting to talk about me as a guy magnet, I didn't expect the conversation to continue. I was just talking about smoking. I just expected it to end and no further comments.

The panel considered that the evidence from two colleagues who had witnessed the incident and Colleague B herself was cogent, consistent and detailed. The panel considered that a reasonable person would regard the action of placing a hand on another person's bottom without consent as sexual in nature. With regard to the wider

circumstances of this incident, the panel took account of the immediately preceding conversation which was overtly “*sexualised*” on the part of Mr Finlay and the panel was of the view that this conduct indicated his state of mind in touching Colleague B on the bottom in the time immediately after.

The panel was satisfied that this charge was found proved.

Charge 19

Your actions intended to bully and/or harass your colleague/s in that you knew that your actions would cause distress or discomfort to another person, in respect of charge:

a. 12
b. 13
c. 14
d. 15
e. 16
f. 17

Charge 19a

This charge is found not proved.

The panel considered the written representations of Mr Finlay, reproduced above at charge 18a. The panel was satisfied that there was no evidence adduced by the NMC to suggest that there was an intention to bully and /or harass or cause distress or discomfort.

Charge 19b

This charge is found proved.

The panel considered the charge found proved at Charge 13 and the findings of a sexual nature at Charge 18b alongside the supporting evidence of those charges.
The panel was mindful of the consistent and detailed evidence of Witness 8 and Witness 9 in relation to the immediate reaction of Colleague B and the immediate "*discomfort*" she felt. The panel was also mindful that, in contrast to Mr Finlay, Colleague B was a junior colleague and a young and inexperienced person in the workplace.

Charge 19c, 19d and 19e

These charges are found not proved.

The panel noted that Colleague C had reported being "*taken aback*" and that Mr Finlay "*didn't come across as professional due to his comments*." However, he stated that the comments "*didn't make me feel uncomfortable*", rather the comments had "*caught me off guard but didn't offend me*."

The panel heard no first-hand evidence in relation to Charge 19e.

The panel also considered the written representations of Mr Finlay, who stated that his intention at the time was part of a "*general jokey demeanour*" and possibly an "*attempt to fit in*" and engage in "*banter*". As such, the NMC have not presented sufficient cogent evidence to meet the wording of the charge and the evidential burden has not been met.

Charge 19f

This charge is found not proved.

The panel considered evidence from witnesses who noted the reaction of the Colleague in question, who allegedly "*went quiet*" and "*stopped smiling*" upon hearing the admitted words of Mr Finlay.

However, the panel did not hear direct evidence from the Colleague concerned. As such, the NMC have not presented sufficient cogent evidence to meet the wording of the charge and the evidential burden has not been met.

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 Finlay'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 Finlay's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Mr Edwards also stated that the standard of propriety may be found by reference to rules and standards ordinarily found to be followed in the circumstances. Mr Edwards referred to the case of *Calhaem v GMC* 2007 EWHC 2606, where Mr Justice Jackson commented on the definition of "*misconduct*" and stated that it entails "*a serious breach which indicates the doctor's fitness to practice in that particular case is impaired*". Mr Justice Collins in *Nandi v GMC* 2004 EWHC 2317 commented on this definition of "*misconduct*" and stated that the word "*serious*" must be given its proper weight. Mr Edwards noted that in other contexts, "*misconduct*" has been related to conduct which would be regarded as "*deplorable*" by other fellow practitioners.

Mr Edwards invited the panel to take the view that the facts found proved and admitted amount to misconduct, in line with the definitions provided. He reminded the panel that charges were proven in relation to the clinical work of Mr Finlay, in respect of a high number of record-keeping failures spanning an extended period of time; inappropriate patient contact by text message; and failure to escalate significant changes in the mental health of patients. He further reminded the panel that charges were also found proved in relation to his professional conduct and the way in which he behaved towards a number of colleagues, at times being sexual in nature. Mr Edwards stated that it has also been found proved that the actions of Mr Finlay lacked integrity. He submitted that the proven charges relate to wide-ranging and fundamental aspects of nursing practice and skill, and constituted a serious departure from the standards of a CPN of Mr Finlay's experience. Mr Edwards further submitted that members of the nursing profession would be shocked at the clinical and professional behaviour failings found proved and admitted.

Mr Edwards invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the relevant Code at the time: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) and submitted that the actions of Mr Finlay breached specific standards within Parts 2, 3, 8, 10, 13, 16, 17, 19 and 20.

Submissions on impairment

Mr Edwards 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.

Mr Edwards invited the panel to consider whether Mr Finlay's fitness to practise is currently impaired. In considering the issue of current impairment, he reminded the panel of the four key questions posed by Dame Justice Cox in the leading case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). He also invited the panel to consider the case of *Cohen v GMC* (2008), which identified the following questions as highly relevant in determining whether a doctor's fitness to practise is impaired: whether the conduct that led to the charge is remediable; whether that conduct has been remedied; and whether the conduct is highly unlikely to be repeated.

Mr Edwards invited the panel to make a finding of current impairment and noted that the first three limbs in the case of Grant were satisfied. In relation to the fourth limb, he acknowledged dishonesty was not charged but noted that a lack of integrity was found proven.

Mr Edwards submitted that Mr Finlay's actions had put patients A, B, C and D at an unwarranted risk of harm and that he has shown little or no remorse for his actions with regard to these patients. It is clear that his failure to disclose the contact he had with Patient A fell far below the standard expected of him and failed to ensure that Patient A received the potential care she needed at that specific and crucial time. Mr Edwards noted that Mr Finlay has not demonstrated appropriate remediation in spite of clinical concerns around his record-keeping and escalation of concerns being identified on more than on occasion over time. He further submitted that these numerous and wide-ranging failures bring the nursing profession into disrepute.

Mr Edwards submitted that the sexualised behaviour of Mr Finlay towards colleagues, including his inappropriate touching of Colleague B and his inappropriate comments towards Colleagues C and D, also brought the nursing profession into disrepute. He noted that this conduct also undermined public confidence in the profession as a whole.

Mr Edwards submitted that Mr Finlay has chosen not to attend the hearing and there is therefore very limited evidence of any insight, acceptance, remorse or remediation. He noted that the panel therefore had very little information to assure them that Mr Finlay would not be at risk of repeating similar conduct in the future.

Mr Edwards therefore invited the panel to find that the fitness to practice of Mr Finlay is impaired both on public protection and public interest grounds. He submitted that not making a finding of impairment would seriously undermine public confidence in the NMC as a regulator. He submitted that in circumstances such as this, where clinical failings have been proven and breaches of standards occurred, the public would expect a finding of current impairment to be made. He further noted that those practising within the profession would find the actions of Mr Finlay deplorable.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), Schodlok v GMC 2013 EWHC 2980, and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mr Finlay's actions did fall significantly short of the standards expected of a registered nurse, and that his actions amounted to a breach of the 2015 Code. Specifically:

‘2 Listen to people and respond to their preferences and concerns

2.1 work in partnership with people to make sure you deliver care effectively

3 Make sure that people’s physical, social and psychological needs are assessed and responded to

3.1 pay special attention to promoting wellbeing, preventing illhealth and meeting the changing health and care needs of people during all life stages

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

8 Work co-operatively

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

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

13 Recognise and work within the limits of your competence

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required

16 Act without delay if you believe that there is a risk to patient safety or public protection
16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can
16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the admitted and found proven charges in this case amounted to misconduct. In reaching this conclusion, the panel firstly considered whether all proven charges amount to misconduct separately. It was satisfied that each individual proven charge, except Charge 7a, amounted to misconduct. The panel then went on to consider whether there was any nexus between the charges. It determined that charges 1 – 11 were predominantly clinical failings involving vulnerable patients with long and enduring mental health problems with the addition of breaching professional boundaries and lack of integrity which took place over an extended period of time from 2016 – 2020. Charges 12 – 19 related to Mr Finlay's professional behaviours towards colleagues which were inappropriate and sexual in nature took place over a shorter period of time from December 2019 – January 2020.

The panel also noted that Mr Finlay was absent from proceedings and considered the written mitigation he had offered response to the charges.

In these circumstances, the panel found that Mr Finlay's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Finlay'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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

d) ...'

The panel concluded that limbs a), b) and c) were engaged by the circumstances of this case. Limb a) is engaged for the full reasons set out above. Limb b) is engaged because any reasonable member of the public, fully informed of the facts of this case, would lose confidence in the professions if there was no finding of current impairment in these circumstances. The panel acknowledged that Charge 6, relating to a lack of integrity had been found proven and concluded that integrity is a fundamental tenet of the nursing profession, and as such, was to be considered under limb c).

The panel also considered the questions posed in the case of *Cohen* when evaluating current impairment. In considering whether the concerns can be addressed, the panel noted that areas of discrete clinical practice such as record-keeping are capable of being addressed. However, the panel also noted that attitudinal concerns such as a lack of integrity, may be more difficult to remediate. The panel considered that even with the apparent fear Mr Finlay had of losing his job, he still put his own interests before the acute clinical needs of the patient, thereby demonstrating a significant lack of integrity which may be more difficult to address effectively. The panel considered a failure or refusal to escalate clinical matters to his manager or communicate patient concerns to the wider multi-disciplinary team to be more difficult to remediate.

In considering whether the conduct has been remediated, the panel acknowledged that Mr Finlay cooperated in the local investigation and made admissions to some of the charges. He has also engaged with the NMC process and provided detailed written information by way of reflection and further information, although he did not attend the hearing. The panel acknowledged Mr Finlay had developed a health issue over the course of these events relating to depression and anxiety. The panel also acknowledged that both Mr Finlay and the rest of the mental health team in the area were under considerable work pressure. This was confirmed by his Line Manager who had offered some options for managing record-keeping that were undertaken by other members of staff, which Mr Finlay did not take up.

The panel was of the view that Mr Finlay has shown no insight into the impact of his failures in record-keeping, for example in relation to his failure to record 315 patient contacts over a protracted period of time and the potential impact of this on wider patient care or upon his colleagues. The panel noted Mr Finlay's written submissions which cited his reasons for his record-keeping failures, namely, that he was prioritising patient care. However, it found that this explanation failed to acknowledge the fundamental importance of record-keeping for patient care and for colleagues working in teams. The panel further noted that following his failure to record the 315 patient contacts and the remedial action taken by the Trust to address that, he nonetheless repeated that behaviour in a new Trust, as found proved at Charge 11b. He provided no understanding or insight into these failings. The panel concluded that Mr Finlay has not shown remorse or taken steps towards remediation. Although Mr Finlay did provide some thoughtful reflections in terms of the impact of his behaviour on colleagues, this nevertheless was limited and the panel was not able to test whether those reflections have impacted on Mr Finlay's behaviour at work. The panel noted that he has not worked in a nursing role for an extended period of time.

The panel went on to consider whether the conduct is likely to be repeated. The panel was concerned to note that failures in record-keeping had been repeated over time in separate

instances, as reflected in the charges. It was of the view that this conduct is highly likely to be repeated.

For the reasons set out above, the panel found the practice of Mr Finlay impaired 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, 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 finds Mr Finlay's fitness to practise impaired on the grounds of public interest.

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

The Notice of Hearing, dated 5 May 2022, was sent by the NMC to Mr Finlay and had advised him that it would seek the imposition of a striking off order if a panel found his fitness to practise currently impaired.

Mr Edwards submitted that the appropriate form of sanction was a matter for the panel to decide. Mr Edwards submitted that there were a number of aggravating and mitigating factors which the panel may consider relevant.

Addressing aggravating factors, Mr Edwards submitted that Mr Finlay's record-keeping errors were repeated behaviours despite him being made aware of concerns relating to his record-keeping at local level. He further submitted that there was a significant risk of harm to patients and colleagues caused by his wide-ranging failures, in particular, the poor record-keeping of Mr Finlay. Mr Edwards also stated that there was a patient death in respect of the death of Patient A. Mr Edwards submitted that concerns in relation to record-keeping persisted over a prolonged period of time for a wide number of patients. Mr Edwards submitted that there was a lack of insight shown by Mr Finlay in relation to the very serious concerns raised about a number of aspects of his nursing practice. Lastly, Mr Edwards stated that the panel may consider that there are attitudinal issues in terms of the responses provided by Mr Edwards when concerns were raised about his clinical practice.

Addressing mitigating factors, Mr Edwards outlined contextual mitigation relating to Mr Finlay's role in a very busy team under immense pressure to provide care to a high number of patients with severe and enduring mental health conditions. Mr Edwards noted that Mr Finlay had reported his high case load to his manager a number of times. However, Mr Edwards reminded the panel of the live evidence of the manager of Mr Finlay, who stated that support was offered to Mr Finlay to help in managing his workload. His manager found that despite Mr Finlay raising this as a concern, he did not take up any help that was offered.

Mr Edwards submitted that Mr Finlay had also raised personal mitigation within his written representations [PRIVATE]. Mr Edwards also stated that there have been no previous

disciplinary findings against Mr Finlay. Mr Edwards stated that despite the regulatory issues that were outlined throughout the case, Mr Finlay has been described by those who knew him as a good Community Psychiatric Nurse (CPN) in various written testimonials within the documentation. Mr Edwards noted that Mr Finlay was effectively headhunted in his role as Care Co-Coordinator due to his long experience as a CPN. It was felt at that time, that Mr Finlay would add value to the team.

In light of the submitted aggravating and mitigating features, Mr Edwards invited the panel to consider the most appropriate form of sanction. He stated that the NMC sanction bid is a striking off order, which is the most serious form of sanction that can be imposed.

Mr Edwards submitted that Mr Finlay has demonstrated little insight or remediation into his failings. He stated that Mr Finlay pointed to his heavy workload for his record-keeping errors, and noted that these errors continued throughout the period in question, including after he had moved employers. Mr Edwards submitted that one of the most serious charges admitted by Mr Finlay was a failure to document 315 contacts with patients. Mr Finlay also failed to alert any relevant colleagues, teams or managers with regard to Patient A when he was made directly aware of their worsening mental health.

Mr Edwards submitted that there is evidence of deep-seated attitudinal problems. He stated that charges found proved and admitted in relation to colleagues A, B, C and D involved highly inappropriate behaviour. In particular, his actions towards Colleague B, where he had slapped her on the bottom, was very serious in the context of a busy working environment where colleagues are striving to the same goal of providing care to vulnerable patients.

Mr Edwards submitted that the panel may consider that concerns relating to Mr Finlay's attitude and maintenance of proper professional boundaries with patients and colleagues are difficult to remediate. As such, it would be very difficult to formulate conditions of practice that address these specific risks and mitigate the potential harm that may be caused to patients and colleagues that may work with Mr Finlay in the future.

In light of the seriousness of the charges found proved, the high number of patients put at risk by the repeated conduct of Mr Finlay and his lack of insight, Mr Edwards submitted that removal from the register, either on a temporary or permanent basis, was the only appropriate form of sanction. He invited the panel to consider that permanent removal from the register by way of striking off order was the only appropriate sanction.

Once the panel had retired, Mr Edwards provided additional information as requested by the panel, that Mr Finlay had been the subject of a conditions of practice order from 2 November 2020 which was subsequently changed to a suspension order on 8 April 2022, which is still in place.

Decision and reasons on sanction

Having found Mr Finlay'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 Finlay made repeated record-keeping errors on a multitude of occasions;
- There was a risk of harm to vulnerable patients caused by his poor record-keeping;
- A wide number of patients were impacted by the poor record-keeping of Mr Finlay, 315 patient contacts were not recorded initially and Patients A, B, C and D were subsequently affected;
- The lack of insight of Mr Finlay;

- The absence of remorse of Mr Finlay who does not appear to reflect on the scale of his record-keeping failures over time and the impact of this on patients and their families, carers and other treating professionals;
- Mr Finlay only made admissions in relation to his continued text message contact with Patient A once copies of the text messages including times and dates had been presented at the Coroner's Inquest;
- Mr Finlay displayed a lack of integrity in that; he was aware that he should not be communicating with Patient A by text message or at all; in failing to alert colleagues of this communication he concealed his own wrong doing;
- One of the charges found proved is of a sexual nature and was linked to bullying and harassment of a colleague.

The panel also took into account the following mitigating features:

- At the time the regulatory concerns arose, Mr Finlay was working in a busy team under pressure to care for a high number of vulnerable patients with severe and enduring mental health conditions;
- Mr Finlay had reported that his case load was too high. However, the panel also acknowledged that he had failed to take up offers of support and failed to implement suggested ways of managing his workload;
- [PRIVATE];
- There are a number of written testimonials attesting to the professional skills of Mr Finlay and his good character

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Finlay'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 Finlay’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 Finlay’s registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of some of the charges in this case and Mr Finlay’s indication that he no longer wishes to return to practice. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Finlay’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;*

As all four of the factors above did not apply to Mr Finlay’s case, the panel was of the view that a suspension order would not be appropriate. 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 Finlay's actions is incompatible with Mr Finlay 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 considering 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 Finlay'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 Finlay'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 Finlay's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

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

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 Finlay's own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Edwards. He invited the panel to impose an interim suspension order for a period of 18 months on grounds of public protection and otherwise in the wider public interest. He reminded the panel that Mr Finlay has 28 days from receipt of this determination to appeal the decision of the panel. He submitted that an interim suspension order was therefore necessary to cover any potential appeal which may be received from Mr Finlay. In light of the findings of fact and the sanction imposed today, Mr Edwards submitted an interim suspension order was the only appropriate form of interim order. If an appeal is submitted, Mr Edwards stated that a period of 18 months would provide time for this matter to be addressed by the Courts.

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. In imposing an interim suspension order, the panel was mindful of the risk of repetition and noted that the interests of Mr Finlay were outweighed by the interests of the general public, which included public protection concerns and maintaining public confidence in the profession. It was satisfied that 18 months was an appropriate and proportionate length of time for the interim suspension order in the event that an appeal was submitted.

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

This decision will be confirmed to Mr Finlay in writing.

That concludes this determination.