Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 10 January 2022 – Friday, 14 January 2022
&
Thursday, 27 January 2022 – Wednesday, 2 February 2022
&
Friday, 8 April 2022
&
Monday, 6 June 2022 – Friday, 10 June 2022

Virtual Hearing

Name of registrant:	Anthony Kaycee Chukwurah
NMC PIN:	11D0763E
Part(s) of the register:	Registered Nurse – Sub-part 1 Mental Health Nursing – 23 July 2011
Relevant location:	Brighton and Hove
Type of case:	Misconduct
Panel members:	Suzy Ashworth (Chair, Lay member) Rachel Childs (Lay member) Carla Hartnell (Registrant member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Philip Austin, (Days 1 – 14) Xenia Menzl (Days 15 – 16)
Nursing and Midwifery Council:	Represented by Stephen Earnshaw (Days 1 – 11) and Leeann Mohamed (Days 12 - 16), Case Presenters
Mr Chukwurah:	Present on Days 3, 4, 5, 7, 8, 15. Not present on all other days. Represented throughout by Tom Hoskins, counsel, on behalf of the Royal College of Nursing

Facts proved:	**All proved**
Facts not proved:	**None**
Fitness to practise:	**Currently impaired**
Sanction:	**Striking-Off Order**
Interim order:	**Interim suspension order (18 months)**

Preliminary arguments

At the outset of the hearing, Mr Hoskins, instructed by the Royal College of Nursing (RCN), on your behalf, invited the panel to adjourn this hearing until midday on 11 January 2022. He informed the panel that there have been two expert witnesses instructed in this case, one on behalf of the Nursing and Midwifery Council (NMC), and one on behalf of the defence.

Mr Hoskins submitted that, in short, you do not accept sending the text messages, as alleged. However, he submitted that it is not yet clear what case you are expected to answer as the experts have reached different conclusions in their reports. Mr Hoskins told the panel that knowing the NMC's case against you is hugely important and, as one of the expert witnesses is not available until tomorrow, there is not much progress that can be made in dealing with this today.

Mr Hoskins opposed against proceeding with any application today as your defence might change depending on the expert evidence received. He further submitted that there is the possibility that you may agree with some of the new evidence provided.

Furthermore, Mr Hoskins submitted that he does not have any initial objections to an application for Patient A to be treated as a vulnerable witness. He said that it could be possible to write down the questions that he has for Patient A, seeing as your defence may be one of attribution and not fabrication.

Mr Hoskins submitted that there are still redactions to be discussed and is hopeful that these can be addressed without the intervention of the panel.

Mr Hoskins submitted that this adjournment is not likely to prejudice the entire hearing. He invited the panel to adjourn now until it has received total clarity on what is being alleged.

Mr Earnshaw, instructed by the NMC, invited the panel to proceed today in determining what redactions are necessary and whether Patient A can be considered as a vulnerable witness for the sake of these proceedings. He referred the panel to Rule 23 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) in support of his argument that Patient A is a vulnerable witness, and invited the panel to make directions now.

However, he did accept that time will need to be taken after that for the expert evidence to be discussed, and for Mr Hoskins to take instructions from you. He submitted that there will be no prejudice in proceeding in the way mentioned above.

The panel accepted the advice of the legal assessor.

The panel was of the view that it was appropriate to adjourn at this stage of the hearing. It must be a fundamental right for a registrant to know the totality of the case before a hearing begins. The panel had regard to Rule 32 of the Rules in making this decision.

The panel determined that as the expert evidence has not yet been finalised in this case, you are not currently in a position to fully respond to the allegations against you. The panel considered this to be of the utmost importance in terms of fairness, as a registrant needs to be aware of the case being brought against them by the NMC. To not have this evidence available could give rise to an injustice.

The panel determined that it would not be sensible to proceed with any other matters before having the expert evidence finalised as the scope of the case could change completely, impacting on the extent of any redactions made. The panel noted that there appears to be an agreement that Patient A is to be treated as a vulnerable witness by both parties in any event.

The panel was satisfied that adjourning at this point would allow the two experts instructed in this case to liaise with one another, and potentially reach an agreed position. It noted

that there is not currently an agreed position as to the evidence that has been located on your mobile telephone.

Furthermore, the panel noted that the NMC's first witness is due to be called on 13 January 2022, and that there is sufficient time to resolve this issue before then.

Therefore, in taking account of all the above, the panel decided to grant the adjournment until such a time that the expert witnesses have had a preliminary discussion.

Upon resumption, the panel would expect to have an updated opening note, a written summary of what has been agreed between the expert witnesses (if possible), a position in respect of the vulnerable witness and the specific questions to be asked or the ambit of them, the witness running order and any agreed redactions.

Decision to proceed and expert witness direction

Upon resuming on 12 January 2022, the parties informed the panel that the expert witnesses have not been able to discuss this matter during the adjourned period. It was indicated that the expert witnesses would be unable to discuss the evidence together until 17 January 2022.

The panel was of the view that although matters have not progressed significantly, and it reiterated your right to know of the case against you, the panel was persuaded that as you wished to continue with this matter, it would proceed to hear the NMC case despite the continuing uncertainties. The panel considered that the evidence from the expert witnesses had most bearing on the evidence that it would hear from Patient A, both in terms of the substance of that evidence and in terms of potential special measures that might need to be put in place to accommodate Patient A. In the event that Patient A is not attending the hearing before 28 January 2022, the panel was of the view that there would be little impact of this evidence before that time on your case and therefore were persuaded that the case could proceed.

Furthermore, having been informed that the expert witnesses in this case would not be in a position to discuss matters with each other until 17 January 2022, the panel determined that, before its return, it should have received a written statement setting out the areas of agreement and disagreement between the expert witnesses. This should be served on the panel by close of business on 26 January 2022.

Application on proposed redactions

Mr Hoskins invited the panel to redact part of Mr 1's evidence that is contained within the exhibit bundle. He submitted that Mr 1 conducted the initial investigation into this matter after it had been reported to him. Patient A declined to participate in this investigation.

Mr Hoskins referred the panel to the case of *Enemuwe v NMC* [2015] 2081 (Admin*)* in support of his application. He submitted that normally, the findings of fact made at an early investigation by a person/panel are not admissible in proceedings before this type of committee.

Mr Hoskins invited the panel to exclude any conclusions that Mr 1 reached on the evidence, as the panel itself is being asked to adjudicate on this matter separately. He submitted that whilst the panel may have had sight of what you are asking to be redacted, this can be disregarded in any event.

Mr Earnshaw referred the panel to Rule 31 of the Rules. He submitted that it would be relevant and fair to keep the evidence of Mr 1, in its current form, before the panel.

Mr Earnshaw submitted that Mr 1 conducted the preliminary investigation in relation to this matter and it is not disputed by either party that this panel are the arbiters of the facts of the case. He submitted that much of Mr 1's evidence involves him merely recounting what he was told, and it is unclear how this is unfair or prejudicial to you.

Mr Earnshaw submitted that the key parts of the exhibit bundle have already been redacted. He submitted that what the panel has received ought to be admitted into evidence as it is part of the factual narrative.

The panel accepted the advice of the legal assessor.

The panel had sight of the proposed redactions. It was aware that matters that fall under the opinion of a witness may sometimes be relevant to its consideration on the facts, but any previous findings in relation to the evidence would not be. Nonetheless, the panel considered the evidence that it is being asked to exclude is part of the factual narrative, as Mr 1 recounts what he was told during his initial investigation. The panel considered that nothing within section of evidence could reasonably be considered to be a "conclusion" from the investigation, and instead was simply a descriptive account of the evidence that Mr 1 had considered. The panel was of the view that the evidence was relevant, and that it could give it appropriate weight in due course. Therefore, the panel determined that it would be appropriate to include this evidence and it decided to reject Mr Hoskins' application on that basis.

Details of charge

That you, a registered nurse:

1. On or around 8 February 2019 gave your personal mobile phone number to Patient A without clinical justification.

2. Between 8 February and 16 February 2019 sent text messages to Patient A without clinical justification.

3. On or about 15 February 2019 sent a text message to Patient A asking how many boyfriends she had had, or words to that effect.

4. On or about 16 February 2019 sent a text to Patient A asking when she had last had sex, or words to that effect.

5. On or about 16 February 2019 sent a text to Patient A asking whether she would like to be your girlfriend, or words to that effect.

6. And your conduct as specified in charges 1 and/or 2 and/or 3 and/or 4 and/or 5 was sexually motivated in that you intended to pursue a future sexual relationship with Patient A.

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

NMC Opening

The NMC received a referral in relation to you from the Sussex Partnership Foundation Trust (the Trust) on 2 October 2019. At the time of the alleged events, you were working as a registered nurse for the Trust in the capacity of a Mental Health Liaison Nurse. You had begun your employment on 11 September 2017 and this employment ended on 5 September 2019.

The regulatory concern from which the charges emanate involves you allegedly breaching professional boundaries with a patient in your care, namely, Patient A. It is alleged that you sent text messages to Patient A in which you asked about her sexual history and suggested that she should enter into a personal relationship with you.

The allegations came to light when Ms 2, a Social Worker employed by Brighton and Hove City Council (the Council), seconded to the Mental Health Team at the Trust and allegedly undertook an assessment of Patient A. Ms 2, in the presence of Ms 3, is said to have assessed Patient A in clinic on 4 March 2019, with Patient A having been referred through

the Assessment and Treatment Service due to her presentation at Accident and Emergency (A&E) following a number of overdoses during a short period of time.

During the alleged assessment, Patient A is said to have disclosed that she had been texting a member of staff from the A&E Department. Ms 2 was allegedly shown the text messages and she read them. Ms 2 allegedly noted down the telephone number of the person who Patient A had been texting in her note book. Ms 2 allegedly believed that the messages Patient A had been receiving were clearly inappropriate.

On 7 March 2019, Ms 2 allegedly telephoned Patient A and she was told the spelling of the man's name and his description. Patient A also allegedly gave the exact date of when she first went to A&E, that being 9 February 2019, which correlated with her care notes. Patient A allegedly informed Ms 2 that you and she texted most days between 9 February 2019 and 16 February 2019, when things started to become "*weird*". Ms 2 allegedly asked Patient A for the text messages to be sent to her and on 20 March 2019, Ms 2 received screenshots of the text messages by Patient A. It is alleged that the telephone number shown in the screenshots ends in '*1714*', and it is accepted by you that this was your mobile telephone number.

In her NMC witness statement, Patient A alleges that you were a mental health nurse who assessed her and, during the course of this assessment, you gave her your mobile telephone number. You allegedly said to her that you do not normally give out your mobile telephone number, but she was special. Patient A also alleges that the text messages between you were sexual. When Ms 2 became aware of the contents of the messages, she told Patient A that the matter would have to be escalated as a concern.

Mr 1, Band 8 Lead Nurse at the Trust, conducted the initial independent investigation once the matter was referred. Patient A did not engage in the process.

You denied any contact with Patient A outside the context of A&E and said that your mobile telephone number was available on the internet and that your mobile phone had been hacked.

Both you and the NMC have instructed expert witnesses in this matter. It is alleged that Mr 4, the NMC's expert witness, examined both Ms 2's mobile telephone and your mobile telephone. He sets out his initial findings in his report.

It is alleged that upon examining your mobile telephone, Mr 4 was able to identify a journal titled 'calllog.db'. Whilst technical in nature, Mr 4 alleges that a journal can include content which is no longer in the main database on the mobile telephone. Amongst other records of activity, the 'calllog.db' database allegedly includes the text messages includes some of the text messages between you and Patient A, albeit each is truncated to 50 characters. The journal is also allegedly dated 14 March 2019, and appears to be orphaned from the current 'calllog.db' database. In summary, Mr 4's findings reveal phone contact between you and Patient A.

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

Mr Earnshaw made a request that the entire hearing be held in private on the basis that proper exploration of this case involves reference to the health and wellbeing of Patient A. He submitted that Patient A's health is inextricably linked to the allegations, and any public interest in her health being aired in public session is outweighed by the need to protect her privacy. This application was made pursuant to Rule 19 of the Rules.

Mr Hoskins did not oppose the application. He submitted that this decision is a matter for the panel.

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.

Rule 19 states:

19.—(1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.

(2) Subject to paragraph (2A), a hearing before the Fitness to Practise Committee which relates solely to an allegation concerning the registrant's physical or mental health must be conducted in private.

(2A) All or part of the hearing referred to in paragraph (2) may be held in public where the Fitness to Practise Committee—

(a) having given the parties, and any third party whom the Committee considers it appropriate to hear, an opportunity to make representations; and

(b) having obtained the advice of the legal assessor, is satisfied that the public interest or the interests of any third party outweigh the need to protect the privacy or confidentiality of the registrant.

(3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied—

(a) having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and

(b) having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.

(4) In this rule, "in private" means conducted in the presence of every party and any person representing a party, but otherwise excluding the public.

Having heard that there will be reference to the health and wellbeing of Patient A throughout these proceedings, the panel determined to hold such parts of the hearing in private. The panel was aware that Patient A's health is inextricably linked to the allegations, however, it considered it to be in the interests of justice to have matters that do not directly relate to her health to be heard in public session.

The panel noted that two expert witnesses had been warned to give live evidence at this hearing, as well as other witnesses, and it was of the view that it would be in the public interest and in the interests of justice for this evidence to be available to the public should a request be made to see it.

The panel was satisfied that it would be possible to distinguish between public and private matters in the particular circumstances of this case, and it determined to rule on whether or not to go into private session in connection with these matters as and when such issues are raised.

Application for special measures to be introduced for Patient A

Mr Earnshaw informed the panel that, in principle, there are no objections between the parties for special measures to be introduced when Patient A gives evidence. However, he submitted that an area still open for debate is the manner in which Patient A is to be cross-examined.

Mr Earnshaw reminded the panel of Rule 23 of the Rules, and also referred it to the NMC note which sets out the position in respect of the vulnerable witness. Furthermore, he invited the panel to have regard to the document titled 'The Advocate's Gateway – Ground rules hearings and the fair treatment of vulnerable people in court' dated 2 September 2019 in support of his application, and took the panel through appropriate and workable measures that have previously been identified as steps to consider.

Mr Earnshaw submitted that there appears to be no objection to Patient A's Community Psychiatric Nurse (CPN) being present alongside Patient A when she gives her evidence. He also submitted that Mr Chukwurah has agreed through Mr Hoskins that he will not be appearing physically on the screen, and Patient A will also be permitted to have convenient breaks when required.

Mr Earnshaw submitted that steps should be taken to allow Patient A to give her best possible evidence, so the panel should consider whether it is appropriate to restrict Mr Hoskins to asking the proposed questions he has devised. Mr Earnshaw told the panel that he was broadly content with the questions that Mr Hoskins had prepared for Patient A, although he did propose a number of amendments to specific questions.

Mr Hoskins agreed that there was no objection to Patient A's CPN being present in the room with her whilst she gives her evidence, as long as it is clear who she is for the record. He submitted that there are also no concerns about Patient A giving her evidence by video link, or by her having pertinent documents before her to refresh her memory. Mr Hoskins agreed that the sole area of disagreement is whether it is necessary to restrict his cross-examination to a list of questions approved by this panel.

Mr Hoskins submitted that Patient A's evidence is of central importance to this case, and he is not deliberately trying to make the situation more difficult. However, he submitted that restricting him to the proposed questions is disproportionate given the dynamic nature of hearings, as new evidence could arise which may end up being unexplored if he is limited to asking pre-determined questions. He said that it cannot be pre-empted what evidence may be forthcoming, and this is a dangerous position for Mr Chukwurah to be put in if the panel agrees to the application. Mr Hoskins stated that all matters would need to be fully aired before this regulatory panel in order for it to reach its conclusion.

Mr Hoskins referred the panel to Patient A's witness statement where it was indicated that she would be willing to attend a hearing in respect of this matter.

Mr Hoskins submitted that he has not seen any evidence to confirm that Patient A has been diagnosed with a mental disorder, and it is unclear to what extent that the NMC's instructing lawyer is qualified to say. He acknowledged that he had been provided with information to suggest that Patient A had attempted to take her own life previously.

Mr Hoskins submitted that it would be unfair to restrict his cross-examination based on the health evidence provided relating to Patient A. He submitted that clear evidence would need to be adduced stating what Patient A's health condition is, how that manifests itself, and what benefit pre-determined questions would have for her. In the absence of this, Mr Hoskins submitted that Mr Chukwurah's defence could be severely impacted by restricting cross-examination in this way. He submitted that whilst 'The Advocate's Gateway – Ground rules hearings and the fair treatment of vulnerable people in court' may be a useful tool, it should not be taken as granted that these measures are appropriate in each and every case.

Mr Hoskins submitted that, at this point, it is unclear what Patient A needs from this process in order to achieve her best evidence. He submitted that there is nothing to suggest the necessity of having pre-determined questions for her, as there is nothing to indicate that Patient A has asked for this to be done.

The panel accepted the advice of the legal assessor.

The panel was provided with details of recent correspondence between the NMC and Patient A, which indicated that the only adjustment Patient A wished to be put in place was Mr Chukwurah not to appear on camera.

The panel noted that the bulk of the proposed special measures have been agreed between the parties. The remaining area of contention was the necessity of having pre-determined questions prepared by Mr Hoskins, on behalf of Mr Chukwurah, given to Patient A.

In taking account of the evidence before it, the panel noted that it had not been provided with any significant health information relating to Patient A. It only had the NMC note of the instructing lawyer, setting out her views in dealing with this matter.

The panel considered that it would be disproportionate to restrict Mr Hoskins' cross-examination of Patient A at this stage of proceedings. It noted that Mr Hoskins wants to challenge Patient A's evidence and, in the interests of justice, it determined that he should not be inhibited from doing so. The panel had nothing before it from Patient A to suggest that it was necessary to have pre-determined questions put to her, or indeed that she felt this to be desirable. It determined that the request for Mr Hoskins to adduce prepared questions is a high-bar threshold, and it had not been met in the particular circumstances of this case. Therefore, Mr Hoskins should be given the appropriate latitude to ask further questions of Patient A arising out of the evidence she gives.

Furthermore, the panel noted that Mr Earnshaw does not object to the areas of questioning proposed by Mr Hoskins and, in the absence of any significant evidence to the contrary, it had to take account of the judgment of both counsel in this case.

However, the panel acknowledged from the information it had received that Patient A may have some underlying vulnerabilities, so it sought to assure her that the following steps had been agreed so that she would be able to attend and give her best evidence:

- Mr Chukwurah will not be able to appear on camera whilst Patient A gives evidence.
- Her CPN can be present in the same room throughout Patient A's evidence, and can raise any concerns she may have to the panel during her evidence.
- She will be offered regular breaks (approximately every 20 minutes) the length of which can be determined based on her CPN's guidance.
- She can give her evidence in private session, so that no members of the public who are not directly involved with the hearing can attend.

However, in taking account of all the above, the panel decided to reject the NMC's application for having pre-determined questions put to Patient A by Mr Hoskins. It was of the view that it would be disproportionate to grant this application at the current time in the interests of justice and fairness to both parties, but the panel can keep matters under review.

The panel's expectation is that the questions asked of Patient A by Mr Hoskins will broadly reflect what has been advanced in the document headed 'Proposed Questions for Patient A' (dated 27 January 2022), unless further evidence arises.

Decision and reasons on facts

In reaching its decisions on the disputed charges, the panel had regard to all the oral and documentary evidence it had received in this case, together with the written submissions made by Mr Earnshaw, on behalf of the NMC, and Mr Hoskins, on your behalf.

Before making a finding on the outstanding facts, the panel heard and accepted the advice of the legal assessor. 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 oral evidence from the following witnesses called on behalf of the NMC:

- Mr 1: Lead Nurse for the Mental Health Liaison Team at Royal Sussex County Hospital (RSCH), on behalf of the Trust

- Ms 2: Social Worker employed by the Council, seconded to the Mental Health Team at the Trust
- Ms 3: Senior Social Worker and Approved Mental Health Professional employed by the Council, seconded to the Trust
- Mr 4: Expert witness specialising in the forensic examination of computers, mobile devices (phones and tablets) and related data.
- Ms 5: Service Manager for Urgent Care at RSCH.
- Ms 6: Mental Health Liaison Team Leader at RSCH.
- Patient A Patient who was using the services of the Trust

The panel also heard oral evidence from you. It bore in mind that you had not been made subject to any previous regulatory findings.

In approaching its consideration on the facts of this case, the panel had particular regard to the agreed report from the witness experts of both parties, both of whom concluded that messages between Patient A's mobile telephone and your mobile telephone were found on your device.

Mr 4 stated that these had been stored in a journal titled ‘calllog.db’ and he was able to confirm that the retrieved data showed text messages that had not been tampered with. Mr 4 was very clear that there would have been no other way for these text messages to have got on to your mobile telephone, other than them having been sent from that device.

The panel noted that whilst the times of the text messages were not identical in the screenshots and ‘calllog.db’, they were consistent with the content shown. Mr 4 explained that the times are different in the ‘calllog.db’ as this shows the exact time the text message would have been sent and/or received on your mobile telephone. Nonetheless, the panel did not consider the timings to be so far apart so as to make this evidence inconsistent or unreliable. It was satisfied from Mr 4’s evidence that the screenshots of the text messages had not been tampered with.

Finally, it was Mr 4’s expert opinion that the original deletion of the messages was likely to have been actioned by the person in possession of your mobile telephone, and was not likely to be the result of a system or telephone update.

The panel placed considerable weight on the agreed expert report and the other evidence given by Mr 4.

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

Charge 1

1. On or around 8 February 2019 gave your personal mobile phone number to Patient A without clinical justification.

This charge is found proved.

In reaching this decision, the panel took account of the evidence from Patient A, Mr 1, Ms 2, Ms 3, and Mr 4, as well as your own evidence.

In particular, the panel had regard to Patient A's evidence, in which she stated:

> '*KC was a mental health nurse. KC conducted the assessment alone. We had just one assessment and as the end he gave me his phone number. KC had his phone on him and he wrote it down on a piece of paper from his box…*'

The panel noted from the 'symphony records' that Patient A entered the A&E department on 8 February 2019 at 21:02 hours, and did not leave until 04:43 hours on 9 February 2019. Mr 1 said it was likely that Patient A would have attended in a state of toxicity, and would have needed to have become less so before she was able to talk to someone and make use of the services available.

You do not dispute that you saw Patient A within the clinical setting on 8/9 February 2019, nor do you dispute that a mental health review was conducted with various referrals made. You completed two clinical notes in respect of the care delivered to Patient A, one of which was the original review completed at 03:20 hours on 9 February 2019, and the second completed on 14 February 2019 at 03:50 hours. Therefore, the panel was satisfied that you had clinically attended to Patient A on this occasion.

The panel noted that Patient A was consistent in her oral and documentary evidence as she had said that you had given her your mobile telephone number because you had told her she was '*special*'.

Furthermore, at their first meeting together, Patient A had told Ms 2 that you had given her your mobile telephone number. Ms 2 told the panel in her oral evidence that upon seeing the text messages on Patient A's mobile telephone at this meeting, she made a physical note of the mobile telephone number that these text messages had been sent from. This meeting was also held in the presence of Ms 3, who recalls Ms 2 going through the text messages that Patient A was showing her on her mobile telephone. As far as Patient A was concerned, she believed she was sending text messages to you.

During your oral evidence, you accepted that the mobile telephone number that Patient A was texting was your mobile telephone number. However, you told the panel that you have no knowledge of receiving any text messages from Patient A, nor do you recall responding to her at any point.

You told the panel that Patient A may have been able to obtain your personal number through searching you on the internet. The panel was informed that, in order to do so, Patient A would have needed to have made a mental note of the name on your name badge, and then searched your full name to locate the name of the company you formerly owned on the internet. She would then have had to search various sources of information about that company in order to locate your mobile telephone number. The panel did not consider it likely that, following her attempt at suicide by overdose, Patient A would have gone to such lengths to find a way to contact you privately.

In advance of the hearing, you had stated in your response to the regulatory concerns '*I don't know how she would have got my phone number as this never a practice I would do…*' [sic] which suggested to the panel that you were aware of how inappropriate giving your mobile telephone number to Patient A could be and that there was no clinical justification for doing so. The panel also heard from Ms 2, who confirmed that there could be no clinical justification for a registered nurse in the A&E department to give a personal telephone number to a patient: '*If a social worker hears that a member of staff has given a personal number to a patient, they would immediately be concerned. It is completely inappropriate.*'

Having heard all of the evidence before it, the panel was of the view that, on the balance of probabilities, it was more likely than not that you had given Patient A your mobile telephone number without clinical justification. The panel considered Patient A's evidence to be more credible; that being, that you had written down your mobile telephone number on a piece of paper for her, and told her that she could contact you if she needed any further support because she was '*special*'. Despite receiving evidence to suggest that

Patient A had been in a poor mental health state on 8 and 9 February 2019, the panel did not consider this to have affected her ability to recall the events as she saw them.

The panel preferred the evidence of Patient A, and it did not find your account to be credible. The explanation you offered would have meant that Patient A, after having had a mental health crisis (including an overdose), made a note of your full name on your name badge, went home reasonably quickly after being seen by you, searched your name on the internet, discovered you previously ran a company, then googled your company and got your mobile telephone number from there. Patient A was clear in her oral evidence that she never really looks at the name badge of the person assessing her as that person always introduces themselves.

The panel also considered Patient A's evidence to be more credible, and it found that account to be true on the balance of probabilities.

Therefore, the panel found charge 1 proved.

Charge 2

2. Between 8 February and 16 February 2019 sent text messages to Patient A without clinical justification.

This charge is found proved.

In reaching this decision, the panel took account of the evidence from Patient A, Mr 1, Ms 2, Ms 3, and Mr 4, as well as your own evidence.

In particular, the panel had regard to Patient A's evidence, in which she stated:

> '*I don't remember how the messages started but I messaged him because I was upset, the messages were by text. During the first messages, he mentioned his name…*'

The panel had sight of the screenshots which showed text messages sent and received by Patient A between 14 February 2019 and 16 February 2019. Your personal mobile telephone number was at the top of these screenshots. The panel also had sight of Mr 4's schedule and the agreed expert witness report, which showed text messages sent from your mobile telephone between 8 February 2019 and 16 February 2019.

In respect of this charge, the panel reminded itself of the findings of Mr 4, that fragments of text messages had been preserved on and recovered from your mobile telephone that confirmed text messages had been received from and sent to Patient A from that device. Mr 4 had said there would have been no other way for these text messages to have got on to your mobile telephone, other than being sent from that device.

The panel noted that the person responding to Patient A by text message through your mobile telephone does not query how the mobile telephone number for that device was obtained. There appeared to be a reference to a prior meeting, which was consistent with you having assessed Patient A in the A&E department. It is worthy of note that Patient A believed that she was communicating with you via text message.

The panel further noted from the 'calllog.db' that there was other evidence of correspondence from your mobile telephone around the same time as the conversation with Patient A. During your oral evidence, you had accepted that it was you who had contacted your wife, estate agents, and other colleagues about work shifts at the times shown in the 'calllog.db'. This other correspondence consisted of both text messages and telephone calls, and these were interspersed between messages to and from Patient A, some of which, only had a two minute gap. There was nothing in the 'calllog.db' which you

said you did not recognise, save for the correspondence with Patient A from your device. Therefore, in order to believe your account, the panel deduced that someone would have had to have taken your mobile telephone on multiple occasions during a relatively short timeframe to communicate with Patient A, without you knowing, either side of you contacting various people from that very same device. It did not consider this to be a likely explanation for the proximity of other correspondence found on your mobile telephone if this had not been you.

You also attempted to deflect blame on to another member of staff who you had suggested looked similar to you, but the panel did not consider this to be a credible explanation. The panel received evidence from the NMC witnesses who stated that there were very few similarities between you and this other member of staff, so it is unlikely that Patient A would have confused the two of you.

The panel adopted a common sense approach in considering this matter, and it determined that it was much more likely that you had sent these text messages to Patient A, rather than that anyone else had done so. It considered there to be no plausible explanation for how the text messages with Patient A had got on to your mobile telephone if you were not the one who had sent them.

The panel considered it to be wholly inappropriate for a registered nurse to send text messages to a vulnerable patient without clinical justification, particularly in the circumstances where you had only just performed a clinical assessment of Patient A, and that she had attempted suicide that day. You also recognised that this behaviour would be inappropriate for a registered nurse during your oral evidence.

Given the panel's previous conclusions, that there was no clinical justification for giving Patient A your personal telephone number, the panel found that there was similarly no clinical justification for sending text messages to Patient A.

The panel consequently found that you had sent Patient A text messages without clinical justification between 8 February and 16 February 2019. You had sent Patient A text messages from your own personal mobile telephone.

Therefore, the panel found charge 2 proved.

Charge 3

3. On or about 15 February 2019 sent a text message to Patient A asking how many boyfriends she had had, or words to that effect.

This charge is found proved.

In reaching this decision, the panel took account of the evidence from Patient A, Mr 1, Ms 2, Ms 3, and Mr 4, as well as your own evidence.

The panel noted that the primary evidence in support of this charge comes from the screenshots provided by Patient A, which depict accurately a conversation between you and Patient A over text messages. In one of the screenshots, the panel noted that there is a text message from your mobile telephone number, and this reads '*How many boyfriends have you ever had??*' [sic]. Patient A responded to this message on 15 February 2019 at 00:47 hours saying '*Just one*'.

Whilst the 'calllog.db' itself was not able to retrieve a message reading '*How many boyfriends have you ever had??*' [sic], the panel did not consider this piece of documentary evidence to be unreliable. Mr 4 had explained in his oral evidence that not all messages were capable of being retrieved due to the way the Android mobile telephone works. Mr 4 had stated that the database keeps some messages but not others, so it is not a complete record as the '*journal only needs to record whichever transactions are about to change*'. In any event, the panel noted that part of the retrieved 'calllog.db' is consistent with the screenshots, as Patient A is recorded as having responded saying

‘*Just one*’ in a fragment of preserved conversation. This suggests Patient A was asked the question ‘*How many boyfriends have you ever had??*’ [sic], even if the ‘calllog.db’ has not retrieved the prior text message.

Furthermore, in response to Patient A saying ‘*Just one*’, the reply text message in both the screenshot and the ‘calllog.db’ reads ‘*Wow so what did you do together*’ which the panel considered to be corroborative. The nature of the response itself was also indicative of Patient A being asked a question to the effect of ‘*How many boyfriends have you ever had??*’ [sic].

The panel had also found Patient A to have been credible and reliable in this particular area of her oral evidence. It was of the view that she did not attempt to embellish her evidence in any way. Instead, she was the NMC witness who downplayed the allegations against you the most. However, Patient A was adamant that you had asked her a question asking how many boyfriends she had had. Ms 2 also recalled seeing this text message when she viewed the messages on Patient A’s phone at their first meeting together.

In taking account of its earlier conclusions, that you were the person who had sent Patient A text messages without clinical justification between 8 February and 16 February 2019, the panel was satisfied that, on or about 15 February 2019, you sent a text message to Patient A asking how many boyfriends she had had, or words to that effect.

Therefore, the panel found charge 3 proved.

Charge 4

4. On or about 16 February 2019 sent a text to Patient A asking when she had last had sex, or words to that effect.

This charge is found proved.

In reaching this decision, the panel took account of the evidence from Patient A, Mr 1, Ms 2, Ms 3, and Mr 4, as well as your own evidence.

In particular, the panel had regard to Patient A's evidence, in which she stated:

> '*KC asked me questions about my sexual history. I felt the text messages got a bit inappropriate and I think I showed them to one friend who said the same. I can't remember which friend I showed them to. I was living with five other people at the time, it was one of my housemates. The questions he asked me about my sexual history were whether I had a boyfriend, when was the last time I had sex…*'

In considering this charge, the panel, again, had sight of the screenshots provided by Patient A. In one of the screenshots, the panel noted that there is a text message from your mobile telephone number, and this reads '*When was the last time you had sex*' [sic].

However, in respect of this particular charge, the panel noted that the evidence from the screenshot was not corroborated by the data retrieved by Mr 4 in the 'calllog.db'. Nonetheless, the panel did not consider the lack of corroboration from the 'calllog.db' to be determinative of this charge. It acknowledged Mr 4's evidence that it would not be possible to retrieve all of the data from your Android mobile telephone, and instead, it was able to place significant weight on Patient A's oral testimony, alongside the screenshots provided.

The panel found Patient A to have been credible and reliable in this particular area of her oral evidence. She specifically remembered being asked when she last had sex by you due to the intimate nature of the question. Patient A said in her oral evidence that '*this is where it got weird*' and this was supported by her response '*That's a bit personal*' as shown in the screenshots.

The panel was satisfied that the screenshots represented a conversation that took place between you and Patient A. There were no breaks in the messages in the screenshots, and the conversation flowed from what you had asked Patient A previously. Whilst the panel was not entirely clear what time this text message had been sent from your device, in order to believe your account, the panel would have had to accept that someone had taken your mobile telephone without you noticing after 02:18 hours. Although this was not an impossibility, in considering the likelihood of this happening on the balance of probabilities, the panel determined that this was unlikely to have occurred.

The panel considered there to be a clear escalation in the messages shown in the screenshots that are corroborated by the 'calllog.db', and it was able to come to a common sense conclusion that you had asked Patient A when she had last had sex, or words to that effect.

There was no rational or logical explanation provided by you as to how this question was asked of Patient A, through the use of your mobile telephone, without you knowing. The panel did not find the account you provided to be credible and it rejected your evidence.

In taking account of its earlier conclusions, that you were the person who had sent Patient A text messages without clinical justification between 8 February and 16 February 2019, the panel was satisfied that, on or about 16 February 2019, you sent a text to Patient A asking when she had last had sex, or words to that effect.

Therefore, the panel found charge 4 proved.

Charge 5

5. On or about 16 February 2019 sent a text to Patient A asking whether she would like to be your girlfriend, or words to that effect.

This charge is found proved.

In reaching this decision, the panel took account of the evidence from Patient A, Mr 1, Ms 2, Ms 3, and Mr 4, as well as your own evidence.

The panel had sight of the screenshots provided by Patient A, one of which, shows a text message from your mobile telephone number reading '*So do you want to be my girlfriend*' [sic].

However, similarly to charge 4, the panel noted that the evidence from the screenshot was not corroborated by the data retrieved by Mr 4 in the 'calllog.db'. Again, the panel did not consider the lack of corroboration from the 'calllog.db' to be determinative of this charge. It was able to place significant weight on Patient A's oral testimony, alongside the screenshots provided.

For the same reasons as above, the panel was satisfied that the screenshots represented a conversation that took place between you and Patient A. The panel noted that the question '*So do you want to be my girlfriend*" [sic] was asked as part of the same conversation as '*When was the last time you had sex*' [sic], and these messages were sent in the early morning of 16 February 2019, at some time after 02:18 hours. There were no breaks in the messages in the screenshots, and the conversation flowed from what had asked Patient A previously.

There was no rational or logical explanation provided by you as to how this question was asked of Patient A, through the use of your mobile telephone, without you knowing. The panel did not find the account you provided to be credible and it rejected your evidence.

In taking account of its earlier conclusions, that you were the person who had sent Patient A text messages without clinical justification between 8 February and 16 February 2019, the panel was satisfied that, on or about 16 February 2019, you sent a text to Patient A asking whether she would like to be your girlfriend, or words to that effect.

Therefore, the panel found charge 5 proved.

Charge 6

6. And your conduct as specified in charges 1 and/or 2 and/or 3 and/or 4 and/or 5 was sexually motivated in that you intended to pursue a future sexual relationship with Patient A.

This charge is found proved in its entirety

In reaching this decision, the panel took account of the evidence from Patient A, Mr 1, Ms 2, Ms 3, and Mr 4, as well as your own evidence.

In assessing whether your conduct was '*sexually motivated*' in charges 1 and/or 2 and/or 3 and/or 4 and/or 5, the panel decided to take a common sense approach to what amounts to '*sexual motivation*' in its normal and natural meaning.

The panel specifically had sight of the screenshots and the 'calllog.db' in considering this charge.

From her oral evidence, the panel was of the view that Patient A had initially believed your intentions to be based on a clinical concern, in that she thought you were offering her additional support. She explained to the panel that the text message conversation had started in a normal fashion, but then it got '*weird*'.

In taking a cumulative approach to the text messages recorded in the screenshots, the panel was satisfied from the general escalation of the conversation that your intention was to pursue a sexual relationship with Patient A. It was of the view that your initial questions promoted and prompted answers of intimacy, as you had asked the following:

'*How many boyfriends have you ever had???*

Wow so what did you do together

Chilling doing what???

Nothing else???

So what was involved in that??' [sic]

When Patient A did not respond to the last text message in the above list, you followed up with a further text message, '*Have you had a think about what we talked about*' [sic], seeking to solicit a response. The panel considered you to be actively pursuing a response from Patient A and it was satisfied that the motivation for the conversation was sexual.

This was supported by the further questions you asked of Patient A, as you then moved on to questions that were clearly and explicitly intimate, such as:

'*When was the last time you had sex*

So do you want to be my girlfriend' [sic].

The majority of these text messages were also supported by the 'calllog.db' retrieved by Mr 4, and the panel was satisfied that these two pieces of evidence had not been tampered with.

From the above, the panel found your conduct as specified in charges 1 and/or 2 and/or 3 and/or 4 and/or 5 to be clearly sexually motivated and it rejected your account. The panel found you to have attempted to build emotional trust with Patient A to see if you could '*groom*' her for a future sexual relationship.

As a registered nurse, the panel was of the view that you would have been aware that your actions in sending sexually motivated text messages to Patient A were wholly inappropriate and wrong. Patient A was very vulnerable at the time you sent the text messages to her, particularly as she had recently attempted suicide prior to her attending the A&E department.

Furthermore, Patient A told the panel that upon showing the text messages to her flatmate, she was advised by her to call the police. This, in the panel's judgment, showed how concerned a member of the general public was at seeing the content of the text message conversation.

In taking account of all the above, the panel found that your conduct as specified in charges 1 and/or 2 and/or 3 and/or 4 and/or 5 was sexually motivated, in that you intended to pursue a future sexual relationship with Patient A.

Resuming Hearing on Monday, 6 June 2022

At the start of the resumption of this hearing on Monday 6 June 2022, Mr Hoskins informed the panel that Mr Chukwurah had chosen not to be in attendance today. He told the panel that he had been instructed by Mr Chukwurah that he has more pressing professional commitments which he needs to carry out, as this could be of more significant importance to him moving forward in terms of his personal finances.

Mr Hoskins submitted that it is not without good reason that Mr Chukwurah cannot attend today. He invited the panel to proceed with hearing submissions at the misconduct and impairment stage of proceedings. Mr Hoskins submitted that there is not much more evidence that will be adduced at this hearing, but Mr Chukwurah would like to address the panel again on the matter of sanction, and outlined his availability.

Mr Hoskins confirmed that he has permission to represent Mr Chukwurah in his absence, and that he has been instructed not to make any submissions to contest misconduct and

current impairment. Mr Hoskins submitted that he will, in due course, following evidence to be given by Mr Chukwurah, make submissions at the sanction stage, should the hearing reach that point.

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 Chukwurah'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. Firstly, 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 Chukwurah's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In her submissions, Ms Mohamed referred the panel to the case of *Roylance v GMC* (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 Mohamed invited the panel to take the view that Mr Chukwurah's conduct amounted to breaches of *The Code: Professional standards of practice and behaviour for nurses and*

midwives (2015) (the Code). She then directed the panel to specific paragraphs and identified where, in the NMC's view, his actions amounted to misconduct.

Ms Mohamed submitted that Mr Chukwurah embarked on a course of conduct in contacting Patient A, and this was particularly serious as it was in pursuit of a sexual relationship. She submitted that this in itself is serious enough to constitute misconduct.

Ms Mohamed submitted that Mr Chukwurah had access to Patient A through the nature of his employment. She submitted that Mr Chukwurah has undoubtedly breached professional boundaries by behaving in the manner that he did.

Mr Hoskins again confirmed that he was not going to advance any submissions in respect of misconduct.

Submissions on impairment

Ms Mohamed 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 uphold proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. She referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Mohamed reminded the panel of Mr 1's evidence, that Mr Chukwurah's conduct and behaviour had the potential to cause significant harm to Patient A. She also referred the panel to Ms 2's evidence, who had informed the panel that Patient A was a particularly vulnerable person who had previously attempted three overdoses in quick succession.

Ms Mohamed submitted that whilst Patient A did not openly say during her evidence that Mr Chukwurah's behaviour had caused her to suffer harm, it is likely that this would have had this effect. Furthermore, she submitted that Mr Chukwurah had breached a

fundamental tenet of the nursing profession by breaching professional boundaries, and that his actions had also brought the nursing profession into disrepute.

Ms Mohamed submitted that vulnerable patients should be able to use services available to them without fear. She submitted that Patient A was engaging with the Trust to seek treatment and, in the course of this, she was pursued by Mr Chukwurah in breach of his position as a registered nurse.

Ms Mohamed invited the panel to find that Mr Chukwurah's fitness to practise as a registered nurse is currently impaired.

Mr Hoskins confirmed that he was not going to advance any submissions in respect of current impairment. He submitted that this is a matter for the panel's professional judgement. However, Mr Hoskins invited the panel to take account of the references provided on Mr Chukwurah's behalf, along with the victim impact statement provided by Patient A's CPN.

Decision and reasons on misconduct

The panel heard and accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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 Chukwurah's actions did fall significantly short of the standards expected of a registered nurse, and it considered them to amount to several breaches of the Code. Specifically:

> ***"20 Uphold the reputation of your profession at all times***
>
> *To achieve this, you must:*

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

20.3 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

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It went on to consider each charge individually in determining whether Mr Chukwurah's actions were sufficiently serious so as to amount to misconduct.

The panel noted that the regulatory concerns identified relate to Mr Chukwurah's conduct and behaviour, which are directly linked to his nursing practice. Mr Chukwurah had given Patient A his personal telephone number and sent text messages to her, both without clinical justification. The nature of the text messages from Mr Chukwurah were sexually motivated and, in the panel's view, he intended to pursue a future sexual relationship with her.

The panel considered Mr Chukwurah to have demonstrated a pattern of behaviour over a number of days. It was of the opinion that this behaviour fell far below the standards expected of a registered nurse, exacerbated by the context of the environment Mr Chukwurah was working in. Patient A had attended the A&E Department in an extremely vulnerable state, requiring crisis intervention after an overdose. Mr Chukwurah then chose to gravely abuse his position of trust by taking advantage of the situation and encouraging

Patient A to contact him on his personal mobile telephone when she had left the Department.

Mr Chukwurah's behaviour was not a single instance. When Patient A had failed to reply to particular text messages, Mr Chukwurah would prompt her to respond. The communication was ultimately ended by Patient A.

The panel had no doubt that Mr Chukwurah's actions, in breach of all protocols, in each of the charges found proved, amounted to serious misconduct. It considered the importance of maintaining professional boundaries to be particularly significant when dealing with vulnerable and young patients in crisis. The panel determined that other members of the nursing profession would consider Mr Chukwurah's actions to be deplorable.

In summary, the panel found that Mr Chukwurah's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct in all of the charges found proved.

Decision and reasons on impairment

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

Registered 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 registered nurses with their lives and the lives of their loved ones. To justify that trust, registered nurses must act with integrity, and 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 considered limbs a, b and c above to be engaged, both as to the past and to the future.

The panel had found a patient in Mr Chukwurah's nursing care to have been exposed to an unwarranted risk of harm. It had also found Mr Chukwurah to have breached fundamental tenets of the nursing profession, and it found him to have brought the reputation of the nursing profession into disrepute by virtue of his actions.

The panel had regard to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns are capable of remediation, whether they have been remediated, and whether there is a risk of repetition of the incidents occurring at some point in the future.

The panel noted that the concerns identified are not easily remediable, in principle. Mr Chukwurah's misconduct is directly linked to his nursing practice, however, it does not relate to clinical nursing deficiencies; it relates to Mr Chukwurah's behaviour both inside and outside of the nursing environment. The panel considered Mr Chukwurah's behaviour to be more difficult to remediate as it could be suggested that there is an underlying attitudinal issue present in this case.

In assessing Mr Chukwurah's level of insight, the panel noted that he denied the allegations at this hearing, as is his right. However, since the panel has handed down its decision on the facts of this case approximately two months ago, no further evidence has been adduced by Mr Chukwurah demonstrating a change of position, or a development in his insight. Mr Chukwurah has not sought to furnish the panel with a reflective piece. Instead, the only material it had been provided with was an impairment bundle containing positive references for his current role, but no consideration from Mr Chukwurah on how his behaviour adversely affected Patient A, colleagues, employers, the nursing profession, or the wider public.

In the absence of any evidence, the panel determined that Mr Chukwurah has shown no insight into his misconduct. It could not be satisfied that Mr Chukwurah fully understood or appreciated the gravity of his misconduct. The panel had no assurances from Mr Chukwurah that he would not behave in a similar way in future. He has not demonstrated

any remorse or remediation for his behaviour, nor has he shown a willingness to strengthen his practice in respect of his misconduct.

The panel determined that Mr Chukwurah had made no attempts to demonstrate insight at this hearing. Mr Chukwurah was aware of the dates the panel would be resuming this hearing, but has chosen to prioritise his working commitments and financial situation instead of attending before this panel today.

The panel determined that there is no evidence before it to suggest that Mr Chukwurah has attempted to reflect on or remediate his misconduct.

The panel noted that Mr Hoskins was not instructed to offer any submissions on behalf of Mr Chukwurah for the misconduct and impairment stage of these proceedings. It therefore considered there to be minimal information to alleviate the panel's concerns, and insufficient evidence to persuade it that Mr Chukwurah no longer presented an ongoing risk.

In light of all the above, the panel had insufficient evidence before it to allay its concerns that Mr Chukwurah currently poses a risk to patient safety. It considered there remained a risk of repetition of the incidents found proved and a risk of unwarranted harm to patients in his care, should adequate safeguards not be imposed on his nursing practice. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered there to be a high public interest in the consideration of this case. It was of the view that a fully informed member of the public would be seriously concerned by Mr Chukwurah's behaviour, taking account of the panel's findings throughout these proceedings. Mr Chukwurah was in a position of trust as a result of him being employed as a Mental Health Liaison Nurse, and he was expected to safeguard Patient A at a time she was at her most vulnerable. Instead of maintaining professional boundaries, Mr Chukwurah sought to pursue Patient A for the purposes of a future sexual relationship.

The panel noted that Patient A's support workers were particularly concerned by Mr Chukwurah's behaviour, and escalated this against Patient A's wishes as they considered it to be a clear safeguarding concern. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mr Chukwurah's fitness to practise as a registered nurse 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 Chukwurah off the register. The effect of this order is that the NMC register will show that Mr Chukwurah 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.

Mr Chukwurah's evidence on sanction

The panel heard oral evidence from you. During your evidence you continued to deny the facts found proved. However, you acknowledged to your own counsel that, hypothetically, the facts found proved would reduce trust in the profession, are against the code of conduct and are unacceptable. You acknowledged that Patient A was vulnerable when she attended in A&E and that anyone making such contact with her outside the accepted protocols would be taking advantage of her. You stated that, hypothetically, had you done these things patients could lose trust in the service, and that '*sexting*' is highly inappropriate.

You explained that you have a passion for nursing and that your whole family is dedicated to this profession. However, you stated that only your close family members know about the charges against you. You explained that the process has had an adverse effect on you and you lost your '*laugh and spark*' and that your social life has been put under strain.

You told the panel how the process has also had a negative effect on your health, physically and mentally, and how you are currently experiencing financial difficulties.

Submissions on sanction

Ms Mohamed outlined the aggravating features of the case. She submitted that the case involved a vulnerable patient, who came to seek medical help from a registered professional. You have committed a breach of trust and abused your position by giving Patient A your personal mobile telephone number and communicating with her. This was not a one off incident, but a series of communications undertaken by you and not a momentary lapse of judgement. Ms Mohamed referred to your oral evidence at this stage and submitted that you continued to show a lack of insight into the misconduct found proved by the panel. Lastly, there was a potential for significant patient harm.

Ms Mohamed submitted that taking no action would not be appropriate in this case given the panel's findings and the public protection issues identified, as well as the public interest in this case, nor would taking no action be proportionate.

Ms Mohamed submitted that for the same reasons and the identified risk of repetition, a caution order is also not appropriate nor would it be proportionate.

Ms Mohamed then submitted that, for the same reasons as above, a conditions of practice order would not be proportionate nor would it be appropriate. She also submitted that there are no conditions that could address the misconduct identified in this case.

Ms Mohamed then addressed a suspension order. She submitted that this was not a single incident of misconduct and that there are attitudinal issues identified in this case. Further, you lack insight into the misconduct, how your behaviour affected Patient A and the serious potential harm it could have caused. Ms Mohamed therefore submitted that temporary removal from the register, in form of a suspension order, would also not be proportionate nor would it be appropriate in this case.

Ms Mohamed lastly addressed the panel regarding a striking-off order. She submitted that the charges found proved fall in the most serious category of misconduct. You breached professional boundaries and the misconduct found proved is difficult to remediate. She submitted that your behaviour was incompatible with remaining on the register. Ms Mohamed therefore invited the panel to strike you off the register.

Mr Hoskins invited the panel to bear in mind the specific misconduct and to put it into proper context. He submitted that the misconduct found proved was not so serious to warrant imposing the most serious sanction, but that a suspension order would be the most appropriate. He agreed that the misconduct found proved by the panel was serious, and submitted that a suspension order would safeguard patients, and would mark the misconduct in an appropriate and proportionate way.

Mr Hoskins submitted that the misconduct found proved was wrong in its nature, however, the facts take this case away from a striking-off order. He submitted that there had not been an enduring effect on Patient A. He said that, in the context of the positive

references provided on your behalf, his previously unblemished career and his insight, a striking-off order would be disproportionate.

Mr Hoskins argued that whilst the behaviour found proved was inappropriate and wrong the communication was not predatory. You were not trying to shift the blame onto Patient A, but Patient A was the person who sent the first text and then re-established contact 'on Valentine's Day'. Patient A was also the person to suggest meeting up. When Patient A ceased contact and remonstrated with the sender of the messages that the content was inappropriate, no more messages were sent. There were no efforts from the sender to conceal the messages, even after they had been identified as inappropriate, nor did you try to stop Patient A from reporting the communication. Mr Hoskins accepted that the exchange of messages was wrong given the power dynamic, however, he argued that it was not predatory.

Mr Hoskins submitted that the repeated messages were not representative of a risk of repetition but rather constituted a single lapse of judgement. He reminded the panel that the allegations are said to have occurred almost three years ago and that you have since been suspended facing serious proceedings which he has found stressful. He submitted that over the period during which the messages were sent you saw Patient A in A&E again, gave appropriate clinical care, and the consultation was purely professional.

Mr Hoskins then moved to the impact on Patient A. He submitted that the panel should accept her evidence that, in her view, you had not done anything 'too serious' and that there was no long lasting impact on her accessing any services, nor has it prevented her from reaching out in crisis or contacting services. Mr Hoskins acknowledged that Patient A was vulnerable but argued that there was no discernible effect on Patient A. He stated that her mental health issues do not mean that she does not have the capacity to judge the impact your actions had on her.

Mr Hoskins submitted that you are an exceptional practitioner and there had been no concerns regarding his practice prior to the incident. You are a hard working professional

and not the sort of person who contacts patients, '*sexts*' them and is only found out on one occasion. Mr Hoskins referred the panel to the positive references you provided and pointed out that he had also previously worked as a police officer. He submitted that you chose to work with members of the public and be of service to them. He said that no concerns were before the panel regarding you in that role either. Mr Hoskins submitted that the risk of repetition is very low.

Further, Mr Hoskins submitted that in the evidence you had given a true account of his insight, not only speaking of the effect on himself but also the effect the misconduct found proved had on Patient A. You were able to expand your thinking and include the wider effect on the public's trust in the profession. You are someone who can appreciate the effect such conduct would have on patients, colleagues, the public and the profession as a whole, had you done these things, which you maintained you had not.

Lastly, Mr Hoskins reminded the panel of the effect these proceedings had had on you and the impact it would have on him should he be struck off the register. He stated that you faced serious consequences and that the effect it had already had on his private and professional life would mean that the risk of repetition is very low.

Decision and reasons on sanction

Having found your 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:

- Abuse of position of trust:

The panel considered '*Clear sexual boundaries between healthcare professionals and patients: guidance for fitness to practise panels*' published by the Council for Healthcare Regulatory Excellence (now the Professional Standards Authority) referred to in the NMC's sanction's guidance document SAN 2 "Considering sanctions for serious cases", which states:

> '[R]*esearch shows that abusers often target vulnerable groups of patients, including those seeking help for mental health or emotional problems.'*

The panel noted that the NMC guidance itself states:

> '*Sexual misconduct will be particularly serious if the nurse, midwife or nursing associate has abused a special position of trust they hold as a registered caring professional*'

The panel noted Mr Hoskins' argument that Patient A was the one initiating contact via messages. However, it was of the view that the only reason that Patient A was able to make such contact was because you gave Patient A your personal mobile phone number and told her to contact him if needed because she was 'special'. The panel has already determined that your actions amounted to grooming, taking into consideration both, Patient A's vulnerability and your relative position of power. The panel also considered that you were acting in a senior nursing role and had also previously been a member of the police force and therefore would have had a clear understanding of the professional boundaries you were required to observe when working with patients. The panel concluded that this was a serious breach of trust by a senior mental health nurse working in an accident and emergency setting seeing young vulnerable people in their time of crisis.

- Lack of insight into your failings:

The panel could not accept that you demonstrated any meaningful insight into the experience of Patient A and the concerns raised about potential consequences from your actions. It considered that you appeared unable to empathise in any way with Patient A and did not acknowledge what Patient A had experienced, both as a

patient and during the course of this contested hearing. In your oral evidence you continued to downplay the impact your misconduct may have had on Patient A and the serious consequences your behaviour could have had on a very vulnerable patient. The panel was concerned that despite the number of opportunities you had been given to demonstrate insight you failed to do so adequately and in an appropriate manner and continued to seek to blame others and place responsibility on Patient A. While the panel accepted that you were entitled to maintain that you had not behaved in the way alleged, it considered your insight into even the theoretical impact of such behaviour to be very limited.

- Pattern of misconduct over a period of time:

  The panel determined that your invitation to Patient A to make contact with you outside the context of A&E and the subsequent inappropriate personal text messages represented a deliberate course of conduct. This pattern started with an offer of support, moved to the sharing of personal information and then progressed to detailed sexual enquiries. The panel determined this to be escalating behaviour and as previously stated, to be the grooming of a patient in a very vulnerable state of mind. The panel considered your actions to be predatory.

- Conduct which put patients at a risk of suffering harm:

  The panel considered that you focussed on Patient A's view that your actions were not serious and that consequently you seemed to have no understanding of the potential harm his misconduct could have caused. The panel found this of particular concern as you were the nurse responsible for Patient A's care, for undertaking her assessment, and were acutely aware of Patient A's vulnerability. The panel considered that it would have been clear that there was a risk of harm to a patient who, having presented in an A&E department following an attempt on her own life, was then drawn into a sexually motivated text exchange with someone who was supposed to have been caring for her. It was fortunate that the evidence suggests that there may have been no obvious reported damage to Patient A at this time but

this should not, in the panel's view, in any way detract from the very serious risk of harm that your behaviour posed.

- Attitudinal issues:

  The panel considered that your lack of insight, its finding that you were aware of Patient A's vulnerable state of mind, the pattern of misconduct over a period of time, your abuse of your position of trust and your willingness to put Patient A at a risk of suffering harm and concluded this demonstrates significant attitudinal issues.

The panel considered mitigating features in this case in line with the NMC guidance SAN 1. The panel noted the positive references provided by you. The panel noted that there were no previous concerns regarding your practice before it, however it did not consider this to be a mitigating factor. In conclusion, the panel found no mitigating features in this case.

There are no mitigating features to weigh against the aggravating features.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues identified. 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 your 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 your 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 your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Additionally, 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 your 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 referred to the guidance document SAN 2: Considering Sanctions for Serious Cases: 'Cases Involving Sexual Misconduct':

> '*They will very often find that in cases of this kind, the only proportionate sanction will be to remove the nurse, midwife or nursing associate from the register. If the panel decides to impose a less severe sanction, they will need to make sure they explain the reasons for their decision very clearly and very carefully. This will allow people who have not heard all of the evidence in the case, which includes the victims, to properly understand the decision.*'

The panel was of the view that this was an extremely serious case of misconduct which involved the grooming of a vulnerable patient by a senior registered mental health nurse in a position of trust. The panel considered that the misconduct could not be described as a "single instance of misconduct". You gave a vulnerable patient your personal mobile telephone number, after telling her she was 'special', and told her she could contact you outside the normal protocols. You then engaged in a text exchange over the course of many days in which he sought to elicit increasingly personal sexual information from Patient A. This culminated in you asking Patient A if she wanted to be his girlfriend, with clear sexual motivation. The panel considered this to be a pattern of sexually motivated behaviour that persisted for over a week.

The panel, in its assessment of the aggravating features of this case, has previously determined that you demonstrated significant attitudinal issues and it was not satisfied that you had shown any meaningful insight into the misconduct found proved. Consequently, given this lack of insight, the panel remains concerned that there is a real risk of repetition.

The conduct was a significant departure from the standards expected of a registered nurse. The panel noted that such a serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

For all these reasons, the panel was unable to justify only removing you from the register temporarily and therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction in this case.

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?*

Your 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 your actions were so serious that to allow you 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 only appropriate and proportionate sanction is that of a striking-off order. Your actions have brought the profession into disrepute and are incompatible with the standards that the public would expect of a registered nurse.

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

Representations on interim order

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

Mr Hoskins made no submissions.

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 ongoing public protection concerns. It determined for the same reasons as set out in its decision for the striking-off order to impose an interim order.
The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, and would be inconsistent due to the reasons already identified in the panel's determination for imposing the substantive striking-off order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

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

That concludes this determination.