Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday 7 – Friday 9 September 2022

Virtual Meeting

Name of registrant:	**Paul Hunter**
NMC PIN:	05H1111E
Part(s) of the register:	Registered Nurse – RNA Adult Nursing – September 2005
Relevant Location:	Lancashire
Type of case:	Misconduct
Panel members:	Dale Simon (Chair, Lay member) Janet Richards (Registrant member) Mary Golden (Lay member)
Legal Assessor:	Angus Macpherson
Hearings Coordinator:	Khadija Patwary
Facts proved:	Charges 1)a), 1)b), 1)c), 1)d), 1)e), 1)f), 2)a), 2)c), 2)d) and 2)e)
Facts not proved:	Charges 1)f) and 2)b)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that Mr Hunter was not in attendance and that the Notice of Meeting had been sent to Mr Hunter's registered email address on 1 August 2022.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date and venue of the meeting.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr Hunter has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse, between 6 and 7 April 2020:

1) In relation to Resident A:
    a) Spoke in a harsh and uncaring manner saying 'what do you want me to do?' and 'I'm not psychic you know' or words to that effect; **(proved)**
    b) Failed to carry out an adequate examination when Resident A informed you she was suffering stomach pain; **(proved)**
    c) Used unnecessary and excessive force to remove the call bell from Resident A's hand; **(proved)**
    d) By your actions in charge 1c) above caused physical injury to Resident A; **(proved)**
    e) Failed to record details of the incident in charges 1a) – d) above in Resident A's care log; **(proved)**
    f) Failed to report details of the incident in charges 1a) – d) above to colleagues at the handover. **(not proved)**

2) Following Resident B suffering an unwitnessed fall:
    a) Failed to protect the safety and wellbeing of Resident B by failing to assist them back to their room, including but not limited to not providing Resident B with a wheelchair; **(proved)**
    b) Handled Resident B roughly and with unnecessary and excessive force by throwing their legs onto the bed; **(not proved)**
    c) Failed to follow the Home's unwitnessed falls policy in that you:
        i) Did not attempt to establish the reason for the fall; **(proved)**
        ii) Did not notify Careline/GP **(proved)**
        iii) Did not initiate 72 hours of observations **(proved)**
    d) Failed to record the incident in Resident B's care log **(proved)**
    e) Failed to report the incident to colleagues at the handover. **(proved)**

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

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case with the representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Nurse Deputy Manager at the Home at the time of the allegations;
- Witness 2: Interim Home Manager at the Home at the time of the allegations;
- Resident A: Resident of the Home at the time of the allegations;
- Witness 3: Resident A's daughter;
- Witness 4: Part time Care Assistant at Home at the time of the allegations.

Background

The charges arose whilst Mr Hunter was employed as a registered nurse by Beaufort Care Home (the Home). The allegations against Mr Hunter arose from two separate incidents during one single night shift between 6 and 7 April 2020. Mr Hunter was the nurse in charge during the shift. It is alleged that on 6 April 2020, Resident A pressed the call button and called for a nurse due to pain in her stomach. Mr Hunter responded to the bell and Resident A explained that the pain may be as a result of a full catheter. It is alleged that Mr Hunter spoke to Resident A in a rude and derogatory way and did not check her stomach or catheter to check if it was full. It is further alleged that Mr Hunter allegedly forcefully took the call button out of Resident A's hand, resulting in bruising of Resident A's hand.

During the same shift, a further incident was reported in relation to Resident B. Resident B had an unwitnessed fall and as he was unable to immediately call for assistance, he proceeded to shuffle down the corridor on the floor in order to seek help. It is alleged that Mr Hunter saw Resident B sitting on the floor in the corridor. At that time Resident B had blood coming from a wound on his head. Mr Hunter did not assist Resident B back to the room nor did he assist Resident B with a wheelchair. It is alleged that Mr Hunter told Resident B to go back to his room and then followed him without assisting. There are different accounts as to how Resident B got back onto his bed but it is alleged that Mr Hunter took hold of Resident B's legs and threw them on the bed. Mr Hunter failed to record details of this incident in Resident B's care log as required to do so.

The following day both residents reported these incidents to the day shift nurse who was unaware that anything had occurred because the Registrant had not recorded anything in the Resident's notes or mentioned anything during handover.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC.

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

Charge 1)a)

1) In relation to Resident A:
    a) Spoke in a harsh and uncaring manner saying 'what do you want me to do?' and 'I'm not psychic you know' or words to that effect;

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Resident A, Witness 1 and Witness 3. Witness 1's record of Resident A's complaint dated 7 April 2020 detailing the incident and the Disciplinary Hearing notes dated 13 April 2020 which provide Mr Hunter's responses to the allegations.

The panel considered Witness 1's record of Resident A's complaint which stated that:

> *"I [Resident A] used the call bell twice and the third time he came and he said 'is that you again' I was also tapping on table because the door was shut trying to attract attention when he opened the door he said 'is that you again what do you want' I said I've got awful pain in my stomach and when looked my catheter was full and I thought it was that causing me pain and he said 'what do you want us to do' by this time he was roaring at me saying 'I'm not psychic you know' I wanted someone to look at stomach and pain. Then he said is it pain killers you want and I said 'I don't know what I want' he said do I want pain killers he had two pain killers and gave them which I took but I still needed someone to check my catheter. He also said 'act your age' I said 'I am 80 you know' and he replied 'don't act like a child.' I went to pick up the buzzer and he leant across and grabbed the buzzer ~~in~~ from my hand which hurt very much hurt my fingers and hand I felt like my wrists were being pulled. I showed him what he had done the marks you've just done that I felt like I was fighting over the buzzer. 'He's a bully' he has treated me like this when I first met him. He put the buzzer down and walked out. I was upset both hands hurt."*

Resident A had made a direct complaint to Witness 1 in the morning following the incident, had reported the matter to her daughter [Witness 3], and subsequently made a statement for the NMC. The panel was of the view that her account of the incident was clear and consistent. The panel noted that Mr Hunter partially accepted some of this charge as he had stated in the Disciplinary Hearing notes: "*I may have said I'm not psychic… can't recall saying (act your age/child) I don't know it was half 3 or 4 in the morning I don't recall."* The panel was of the view that the comments accepted by Mr Hunter were uncaring in the context of this case, as he was dealing with a patient who had reported they were in pain. Mr Hunter's comments therefore supported the allegations made by Resident A. The panel determined it is more likely than not that Mr Hunter spoke in a harsh and uncaring manner.

In light of the above, the panel therefore finds charge 1)a) proved.

Charge 1)b)

1) In relation to Resident A:
    b) Failed to carry out an adequate examination when Resident A informed you she was suffering stomach pain;

This charge is found proved.

In reaching this decision, the panel took into account the evidence considered in respect of charge 1)a).

Resident A's account suggests that she was not examined by Mr Hunter. The panel also noted Witness 1's statement in which she stated *"The Nurse had a duty to undertake an appropriate assessment when Resident A complained of pain to ensure they were ok…*" Further, the panel was of the view that a registered nurse with Mr Hunter's length of experience would be aware that he was expected to assess a resident's pain and take the appropriate measures to relieve it. The panel therefore concluded that Mr Hunter had a duty to carry out an adequate examination of Resident A.

In the Disciplinary Hearing notes Mr Hunter stated "*quickly palpated her stomach. Didn't check catheter may have had a quick glance*." The panel determined that the assessment described by Mr Hunter would have been less than adequate for a resident who was complaining of significant abdominal pain. The panel determined on the balance of probabilities that Mr Hunter failed to carry out an adequate examination.

In light of the above, the panel therefore finds charge 1)b) proved.

Charge 1)c)

1) In relation to Resident A:
    c) Used unnecessary and excessive force to remove the call bell from Resident A's hand;

This charge is found proved.

In reaching this decision, the panel took into account the evidence considered in respect of charge 1)a). The panel also noted the photographs of the injuries to Resident A's hands.

In the Disciplinary Hearing notes Mr Hunter stated *"*(snatch buzzer from her) *No, I did not. She grabbed it from my hands. Hard to explained. As I was resetting it. She grabbed my hands tightly*." The panel noted that although Mr Hunter accepted that there had been a physical altercation between himself and Resident A, there was no record of such an incident in his daily notes. It is the duty of a registered nurse to accurately record care given to residents and any incidents which have occurred during the shift. The panel therefore was of the opinion that Mr Hunter's failure to record an incident undermined his account. The panel determined on the balance of probabilities that Mr Hunter used unnecessary and excessive force to remove the call bell from Resident A's hand.

In light of the above, the panel therefore finds charge 1)c) proved.

Charge 1)d)

1) In relation to Resident A:
    d) By your actions in charge 1c) above caused physical injury to Resident A;

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witness 1, Resident A and Witness 3 as well as the photographs of Resident A's hands.

In the Disciplinary Hearing notes Mr Hunter stated "*there was no sign of bruising at the time. Certainly, wasn't bruised when I was in the room.*" The panel reflected that bruising may not have appeared as soon as the incident had occurred. In any event, although Mr Hunter said he did not see any bruising, he did not state that he had examined Resident A's hand. The panel noted that Mr Hunter did not report and escalate this incident to a senior colleague whereas Resident A reported the incident to Witness 1 the following morning. The panel accepted Resident A's account and determined that on the balance of probabilities that Mr Hunter's actions in charge 1)c) above caused physical injury to Resident A.

In light of the above, the panel therefore finds charge 1)d) proved.

Charge 1)e)

1) In relation to Resident A:
   e) Failed to record details of the incident in charges 1a) – d) above in Resident A's care log;

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witness 1 and Witness 2.

The panel noted that Witness 1 stated that "*As per the policy, records should include any untoward incident or accident, which the Nurse failed to do. It is very serious that this was not recorded because the next nurse on shift would not be aware that Resident A was unwell and therefore her health could deteriorate quickly*." It also considered that Witness 2 stated "*no entries were made by the Nurse on Resident A's care record…"* The panel determined that Mr Hunter failed to record details of the incident in charges 1a) – d) above in Resident A's care log.

In light of the above, the panel therefore finds charge 1)e) proved.

Charge 1)f)

1) In relation to Resident A:
   f) Failed to report details of the incident in charges 1a) – d) above to colleagues at the handover.

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 2. Witness 2 stated that '*we were not aware of the incident prior to Resident A informing [Witness 1] because the Nurse had failed to record it Resident A's care log. No entries were made by the Nurse on Resident A's care record to highlight the incident…I cannot confirm if the Nurse did or did not hand the incident over to the morning staff because I do not have the handover record, but no other staff raised this."* The panel was unable to identify any other supporting evidence. Consequently, it was not satisfied on the balance of probabilities that Mr Hunter failed to report details of the incident in charges 1)a) – d) above to colleagues at the handover.

In light of the above, the panel therefore finds charge 1)f) not proved.

Charge 2)

2) Following Resident B suffering an unwitnessed fall:

This preamble is found proved.

In reaching this decision, the panel took into account Witness 1's record of Resident B's complaint, the local statement of Ms 1 and the witness statements of Witness 4. It also took into account the Disciplinary Hearing notes.

The panel considered that although there is a dispute concerning this incident, it is common ground between Resident B and Mr Hunter that Resident B suffered a fall which was not witnessed.

Charge 2)a)

a) Failed to protect the safety and wellbeing of Resident B by failing to assist them back to their room, including but not limited to not providing Resident B with a wheelchair;

This charge is found proved.

The panel considered Witness 1's record of Resident B's complaint which stated that:

> *"Resident B said he fell sideways and his head hit the floor at 4.00am. I tried to ring the buzzer but it was not available/ missing. Resident B thought the two carers who called ½ hour befor had took the buzzer. Resident B sat himself up on the floor. Wasn't dizzy but unbalanced. Resident B looked for the buzzer and it wasn't there. After Resident B ~~fell~~ shuffled to the corridor didn't find the buzzer. I climbed my way along the corridor After 20 minutes or so the nurse find you I showed the nurse how I got about I shuffled back to my room and they didn't do anything didn't get me a wheelchair In my opinion the thought it was a joke. I have fallen down before in the hall way before and it is a joke to them. The male nurse put dressing on my eye. ~~I climbed~~ I climbed onto the bed using my strength. The nurse helped ~~me~~ me once I was in bed by throwing my legs in."*

The panel was of the opinion that a registered nurse with over 15 years experience could be expected to take the correct action to protect a resident's safety and wellbeing after an unwitnessed fall.

The panel noted that Mr Hunter, on his own account, did not take into consideration when permitting Resident B to shuffle back to his room his head injury or his general condition; nor did he reference any other reason as to why he might have decided to allow Resident B to return to his room unaided. In any event the panel preferred the account given by Resident B on the balance of probabilities it finds that it is more likely than not that Mr Hunter failed to protect the safety and wellbeing of Resident B by failing to assist them back to their room, including but not limited to not providing Resident B with a wheelchair.

In light of the above, the panel therefore finds charge 2)a) proved.

Charge 2)b)

2) Following Resident B suffering an unwitnessed fall:
    b) Handled Resident B roughly and with unnecessary and excessive force by throwing their legs onto the bed;

This charge is found NOT proved.

In reaching this decision, the panel took into account the local statement of Resident B and the Disciplinary Hearing notes.

The panel noted that differing accounts were given by Resident B to Witness 1 and by Mr Hunter. In the Disciplinary Hearing notes, Mr Hunter stated that *"I assisted him to sit on his bed. Cleansed his wound and applied dressing. Asked if he wanted to go back to Bed, he said yes. So, I liked his legs in…*" The panel noted that Mr Hunter's account was broadly supported by the local statements of the two carers. It considered that in the absence of any other evidence, it could not be satisfied that Mr Hunter handled Resident B roughly and with unnecessary and excessive force by throwing his legs onto the bed.

In light of the above, the panel therefore finds charge 2)b) not proved.

Charge 2)c)i)

2) Following Resident B suffering an unwitnessed fall:
   c) Failed to follow the Home's unwitnessed falls policy in that you:
      i) Did not attempt to establish the reason for the fall;

This charge is found proved.

In reaching this decision, the panel took into account the Falls Prevention Policy, the Disciplinary Hearing notes, Ms 1's and Witness 4's local statements.

The panel also reflected that it would be reasonable to expect a nurse with more than 15 years' experience to known the appropriate action to take after a patient had fallen. The panel noted that Mr Hunter was provided with a copy of the Falls Prevention policy which he did not adhere to. It also noted that Ms 1 and Witness 4 asked Mr Hunter about what had happened. The panel determined that Mr Hunter failed to follow the Home's unwitnessed falls policy in that he did not attempt to establish the reason for the fall.

In light of the above, the panel therefore finds charge 2)c)i) proved.

Charge 2)c)ii)

2) Following Resident B suffering an unwitnessed fall:
   c) Failed to follow the Home's unwitnessed falls policy in that you:
      ii) Did not notify Careline/GP

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 and Witness 2 as well as the Accident/ Incident Report.

The panel noted that Witness 2 stated "*I checked Resident B's electronic care log because if Resident B had fallen even if it were unwitnessed the Nurse would have been expected to document this in their notes. There was no entry by the Nurse to suggest Resident B had experienced a fall…*" The panel determined that Mr Hunter failed to follow the Home's unwitnessed falls policy in that he did not notify Careline/GP.

In light of the above, the panel therefore finds charge 2)c)ii) proved.

Charge 2)c)iii)

2) Following Resident B suffering an unwitnessed fall:
   c) Failed to follow the Home's unwitnessed falls policy in that you:
      iii) Did not initiate 72 hours of observations

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 and Witness 2 as well as the Accident/ Incident Report.

The panel noted that Witness 2 stated "*the Nurse should have documented the fall on the care log and initiated 72 hours of observations for Resident B, however the Nurse did not escalate the fall or report it on morning handover for anyone to ensure this for Resident B's safety*." The panel determined that Mr Hunter failed to follow the Home's unwitnessed falls policy in that he did not initiate 72 hours of observations.

In light of the above, the panel therefore finds charge 2)c)iii) proved.

Charge 2)d)

2) Following Resident B suffering an unwitnessed fall:
    d) Failed to record the incident in Resident B's care log

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2.

The panel noted that Witness 2 stated "*I checked Resident B's electronic care log because if Resident B had fallen even if it were unwitnessed the Nurse would have been expected to document this in their notes. There was no entry by the Nurse to suggest Resident B had experienced a fall…"* The panel determined that Mr Hunter failed to record the incident in Resident B's care log.

In light of the above, the panel therefore finds charge 2)d) proved.

Charge 2)e)

2) Following Resident B suffering an unwitnessed fall:
    e) Failed to report the incident to colleagues at the handover.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2.

The panel noted that Witness 2 stated "*the Nurse did not escalate the fall or report it on morning handover for anyone to ensure this for Resident B's safety."* The panel determined that Mr Hunter failed to report the incident to colleagues at the handover.

In light of the above, the panel therefore finds charge 2)e) proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Hunter'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, if the facts found proved do amount to misconduct, the panel must decide whether, in all the circumstances, Mr Hunter's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard 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.'

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

The NMC submitted that the following paragraphs of the Code were breached by Mr Hunter:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.1** treat people with kindness, respect and compassion*
> ***1.2** make sure you deliver the fundamentals of care effectively*
> ***1.3** avoid making assumptions and recognise diversity and individual choice*
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
> ***1.5** respect and uphold people's human rights*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> ***2.1** work in partnership with people to make sure you deliver care effectively*
> ***2.6** recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *To achieve this, you must:*
> ***3.4** act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*
>
> ***4 Act in the best interests of people at all times***
> *To achieve this, you must:*
> ***4.1** balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*
>
> ***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'*

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The panel had regard to the NMC's Statement of Case, wherein it is stated:

> *'These provisions of the Code, amongst others, constitute fundamental tenets of the profession and it is submitted that Mr. Hunter has clearly breached these, amongst others. A nurse who is unable to treat patients with care and kindness. It is submitted that cumulatively the misconduct is serious and Mr. Hunter's conduct is a serious departure from the standards of behaviour expected of a registered nurse.*
>
> *In the absence of any evidence supplied by Mr. Hunter to demonstrate insight, acknowledgement of wrong doing and remorse it is submitted that, at present, he is still liable to engage in conduct that would breach fundamental tenets of the profession in the future.*
>
> *Mr. Hunter's actions have clearly put patients at risk of harm. The allegations concern more than one incident that took place over the course of a single shift. The incidents involved causing physical harm to a vulnerable patient in Mr. Hunter's care. These are serious incidents that had the potential of causing serious and significant harm to patients in Mr. Hunter's care. 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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. Mr. Hunter caused physical injury to a patient and his behavior with both patients is concerning and without any evidence of remorse or insight, the potential to place patients at unwarranted risk of harm remains.*
>
> *Mr. Hunter's actions have brought the nursing profession into disrepute by virtue of him failing to follow basic nursing principles and displaying aggressive and unkind*

behaviour. Mr. Hunter acted in a way which would cause harm to patients and displayed a lack of compassion for vulnerable patients who are reliant on nurses. He failed to treat his patients with dignity and respect and members of the public would rightly be concerned to know that a registrant was conducting himself in a manner that clearly fell far below the standards expected of a nurse.

Mr. Hunter's actions have breached fundamental tenets of the profession by the extremely concerning incidents that occurred during a single shift. Alongside causing physical injury to a patient, Mr. Hunter is alleged to have been rude and unkind towards both patients and in the absence of any evidence supplied by Mr. Hunter to demonstrate insight, acknowledgement of wrong doing and remorse, it is submitted that, at present, he is liable to engage in conduct that would breach fundamental tenets of the profession in the future.

Additionally, Mr Hunter's failure to engage with his regulator and comply with the investigation, undermines a fundamental tenet of nursing practice as it calls into question his integrity and trustworthiness as a registered professional. It is arguable that members of the public would be concerned to know that a registered nurse was unwilling to cooperate with an investigation. The panel may conclude that para 23 of the Code is also engaged which requires all registered professionals to "Cooperate with all investigations and audits". The Code confirms that this includes investigations against the Registrant. By virtue of not responding to any of the NMC's numerous requests for Mr. Hunter to make contact the panel may conclude that this section of the Code is engaged.

In the absence of any evidence supplied by Mr. Hunter to demonstrate insight, acknowledgement of wrong doing and remorse, it is submitted that, at present, he is liable to engage in conduct that would breach fundamental tenets of the profession in the future.

In considering whether Mr. Hunter is currently impaired, there are also relevant factors identified in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) that the panel should consider when deciding on the question of impairment. The panel should consider whether the conduct which led to the charge is easily remediable, whether it has been remedied and whether it is highly unlikely to be repeated.

In the NMC's guidance on remediation, it is noted that examples of conduct which may not be possible to remedy, and where steps such as training course or supervision at work are unlikely to address the concerns include attitudinal concerns.

There is no evidence before the panel to show that Mr. Hunter has any insight or expressed remorse in relation to his wrongdoing or made any attempts to remediate his behaviour. It is submitted that Mr. Hunter's behaviour and lack of engagement indicates attitudinal issues which are of course more difficult to remediate, therefore the risk of the behaviour being repeated remains.

It is therefore submitted that Mr. Hunter's fitness to practise is impaired on the ground of public protection.

It is further submitted on behalf of the NMC that a reasonable and fully informed member of the public would expect a finding of impairment to follow such behaviour and would be shocked and offended if impairment were not found. Any other outcome would undermine confidence in the profession and in its regulation and therefore a finding of current impairment is also necessary on grounds of public interest.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin) and CHRE v NMC and Grant [2011] EWHC 927 (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 Hunter's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Hunter's actions amounted to a breach of the Code as alleged by the NMC.

The panel bore in mind, when reaching its decision, that Mr Hunter should be judged by the standards of the reasonable registered nurse and not by any higher or more demanding standard.
Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mr Hunter's practice fell far below the standard that one would expect of the average registered nurse acting in Mr Hunter's role.

In all the circumstances, the panel determined that Mr Hunter's performance amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Hunter'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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

d) *...'*

The panel finds that Residents A and B were harmed and put at a risk of potential harm as a result of Mr Hunter's misconduct. Mr Hunter's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel further noted that the matters found proved were in respect of two residents. They were not isolated incidents although they happened on the same night shift. The panel went on to consider whether there is a risk of repetition and in doing so it assessed Mr Hunter's current insight, remorse and remediation.

Regarding insight on misconduct, the panel had nothing before it to demonstrate any evidence of Mr Hunter's insight. The panel noted that there was no evidence from Mr Hunter concerning how his misconduct impacted negatively on the residents themselves, other members of staff or the reputation of the nursing profession.

In relation to remorse, the panel noted that there was no evidence of remorse, nor any comment or reflection from Mr Hunter at all on the case. The panel also noted that Mr Hunter expressed no remorse at the Disciplinary Hearing. He has not engaged with the NMC's investigation and consequently the panel has not had the benefit of hearing either directly or indirectly from him.

The panel was satisfied that the misconduct in this case is capable of remediation. However, the panel considered that Mr Hunter's conduct appeared to be a consequence of attitudinal issues in addition to deficits in his clinical practice. In consequence his conduct is not easily remediable. Resident A described Mr Hunter as a "*bully*" and both Resident A and B state that he has behaved harshly towards them in the past. The panel also noted that Mr Hunter appeared to be dismissive of the allegations put to him doing the disciplinary process and failed to recognise the shortcomings in his admitted responses to Resident A and B. He described Resident B's injury as "*looked worse than it was*" without examining him even though he was aware he had fallen out of bed. He also accepted that he may have said to Resident A "*I am not psychic*" after she had told him that she was in pain.

As a consequence of Mr Hunter's lack of engagement with the NMC the panel had no information before it to suggest that Mr Hunter had taken any steps to strengthen his practice. Therefore, there remained a risk of repetition.

The panel therefore decided that a finding of impairment is warranted on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel concluded that public confidence in the profession would be undermined if a finding of current impairment were not made in this case and therefore also finds Mr Hunter's fitness to practise impaired on the grounds of public interest.

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 Hunter off the register. The effect of this order is that the NMC register will show that Mr Hunter 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.

Representations on sanction

The panel had regard to the NMC's Statement of Case, wherein it is stated:

'The panel may consider that the aggravating factors in this case:

- *Risk of harm*
- *Actual harm*

The NMC have not identified any mitigating factors.

In accordance with the NMC guidance, sanctions should be considered in ascending order of seriousness. Taking the least serious sanctions first, it is submitted that taking no action and a caution order would not be appropriate in this case. The sanctions guidance states that taking no action will be rare at the sanction stage and this would not be suitable where the nurse presents a continuing risk to patients. In this case, the seriousness of the misconduct means that taking no action would not be appropriate. A caution order would also not be appropriate as this would not mark the seriousness

and would be insufficient to maintain high standards within the profession or the trust the public place in the profession.

A conditions of practice order would not be appropriate in this case as the concerns raised in this case appear to relate to a harmful attitude displayed by Mr Hunter. It is alleged that Mr Hunter he has shown a harsh and uncaring attitude, used unnecessary and excessive force and caused injury to an elderly patient in his care. It is submitted that there are unlikely to be any proportionate, workable and measurable conditions which could be imposed to deal with these concerns whilst providing adequate protection to the public and patients/residents.

Furthermore, the evidence indicates that Mr Hunter may have a problem with his attitude, rather worryingly, towards patients under his care. Given these concerns, it is submitted that there are no conditions that could be properly formulated, that would be sufficient to adequately protect the public.

Having considered the guidance, it is submitted that suspension order would also not be suitable given the facts of this case. When considering a suspension order, there are two factors listed in the guidance which explain when a suspension may be suitable, which in the circumstance of this case, suggest that such an order is unsuitable. The relevant factors are:

- *a single incident of misconduct but where a lesser sanction is not sufficient;*
- *no evidence of harmful, deep-seated personality or attitudinal problems.*

As mentioned previously, the evidence in this case does suggest altitudinal concerns as it shows a harmful attitude towards vulnerable residents. The charge relating to causing physical injury is particularly serious and given that there has been no engagement from Mr Hunter and therefore no evidence of insight, the concerns remain.

For the reasons above it is submitted that that only sanction appropriate and proportionate is a striking off order. It is submitted that the concerns in this case raise fundamental questions about the professionalism of Mr Hunter and that his actions are incompatible with continued registration.'

Decision and reasons on sanction

Having found Mr Hunter'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:

- Risk of harm and actual harm
- Lack of insight into failings
- Lack of remorse

The panel also took into account the following mitigating features:

- Unblemished career
- The panel noted Mr Hunter's references to difficult personal circumstances in the Disciplinary Hearing notes, however, in the absence of further detail, the panel were unable to attach much weight to it.

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 Mr Hunter'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 Hunter's misconduct was not at the lower end of the spectrum. 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 Hunter's registration would be a sufficient and appropriate sanction. The panel is mindful that any conditions imposed must be relevant, proportionate, measurable and workable. Mr Hunter's attitudinal issues, lack of insight, reflection and remediation led the panel to conclude that the risk of repetition is high and that there are no practical or workable conditions that could be formulated to address the identified concerns. The panel noted that there is no information before it as to whether Mr Hunter is willing to comply with any conditions, given his lack of engagement throughout the proceedings. The panel therefore concluded that the placing of conditions on Mr Hunter's registration would not adequately address the seriousness of this case and would not protect the public and public interest concerns.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a 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; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel was of the view that this was not a single instance of misconduct and that there was evidence of actual harm caused to Residents A and B. Mr Hunter failed to demonstrate any insight into his failings and as a consequence there remains a significant risk that he may repeat the behaviour. It noted that Mr Hunter's attitude towards the residents was uncaring, and he did not demonstrate he had the required qualities of a registered nurse.

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

The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel was of the view that there was no evidence of insight, remorse or reflection, nor of any efforts to demonstrate that Mr Hunter has strengthened his nursing practice. Mr Hunter's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with his remaining on the register. The panel was of the view that the findings demonstrate that Mr Hunter'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 matters it identified, in particular the effect of Mr Hunter'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 elapse 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 Hunter's 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 had regard to the NMC's Statement of Case, wherein it is stated:

> *'In the event that the panel imposes a substantive sanction, other than taking no further action or imposing a caution order, the NMC seek an interim order for a period of 18 months to cover any appeal period. Should the panel agree with the NMC's sanction bid an interim suspension order would be necessary to protect the public and otherwise in the public interest for the reasons given above.'*

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.

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

This will be confirmed to Mr Hunter in writing.

That concludes this determination.