Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday 14 December 2022 – Thursday 22 December 2022
(14 – 16 December 2022 heard as a physical hearing)
(All other dates heard as a virtual hearing)
Thursday 23 – Friday 24 February 2023
Monday 10 – 17 July 2023

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

Name of registrant:	**Verity Castle**
NMC PIN:	15H1093E
Part(s) of the register:	Registered Nurse – Sub Part 1 Learning Disabilities Nursing – September 2015
Relevant Location:	Nottinghamshire
Type of case:	Misconduct
Panel members:	Anthony Griffin (Chair, Lay member) Shorai Dzirambe (Registrant member) Asmita Naik (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Dylan Easton (14 – 22 December 2022) Elena Nicolaou (23 – 24 February 2023 onwards)
Nursing and Midwifery Council:	Represented by Laura Paisley, Case Presenter (14 – 22 December 2022) Adam Slack (23 – 24 February 2023 onwards)
Miss Castle:	Present and represented by Briony Molyneux instructed by the Royal College of Nursing (RCN)
No case to answer:	Charge 1
Facts proved:	Charges 2, 3, 5, 6, 7, 10 and 12

Facts not proved:	Charges 4, 8, 9 and 11
Fitness to practise:	Impaired
Sanction:	**Conditions of Practice Order (12 months)**
Interim order:	**Interim Conditions of Practice Order (18 months)**

Details of charge (as amended)

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

1. Failed to independently assess whether the seclusion of Patient A was justified. **[No case to answer]**

2. Failed to **[PROVED]**
   a) consider and/or
   b) use

   sufficient alternative less restrictive options to calm Patient A before making a decision to seclude them.

3. Made a decision to seclude Patient A when that decision was not clinically justified. **[PROVED]**

4. Caused or permitted Patient A to be restrained when this was not clinically justified. **[NOT PROVED]**

5. Caused or permitted Patient A to be restrained on the bed and/or on the floor when restraining a patient in those places should have been avoided. **[PROVED]**

6. Caused or permitted Patient A to be placed in the prone position on the floor during the said restraint. **[PROVED]**

7. Caused or permitted Patient A to be dragged or pushed along the floor during the said restraint. **[PROVED]**

8. Failed to maintain Patient A's dignity by failing to take adequate steps to ensure that her body was covered for as long as possible during the said restraint. **[NOT PROVED]**

9. Failed to admonish and/or stop more junior colleagues who had taken part in the seclusion of Patient A from laughing and/or making celebratory gestures outside the seclusion room following Patient A's seclusion. **[NOT PROVED]**

10. Failed to provide sufficiently detailed or accurate written reasons to justify the decision to seclude Patient A in their seclusion documentation in that:-
    a) You recorded "assaults on staff" on Form H as a reason for seclusion when no such assault had taken place at the time of the decision to seclude Patient A; **[PROVED]**
    b) In the event that you considered alternative, less restrictive options before resorting to seclusion, you failed to record those options and why they had not been used;

11. Failed to ensure that a second nurse carried out the nursing reviews of Patient A's seclusion at **[NOT PROVED]**
    a) 03.20 am on 8 November 2018;
    b) 05.20 am on 8 November 2018.

12. Failed to carry out the six hourly nursing review at 7.20 a.m. **[PROVED]**

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

Background

The charges arose whilst you were employed as a registered nurse by Calverton Hill Hospital (the Hospital). At the time of the allegations, you worked on Clumber Ward (the Ward), which cared for female patients with learning disabilities.

Patient A was [PRIVATE] and was admitted to the Ward on 27 October 2015. She had been nursed in long-term segregation since July 2018, and this was considered

necessary to ensure the safety of both staff and patients and to manage a serious risk of violence.

On 8 November 2018, the concerns relate to your activities around Patient A. As the nurse responsible for the Ward, it is said that you failed to take appropriate actions and decisions and/or exercised sufficient control over staff working under your supervision with regards to the seclusion, restraint, record keeping, and behaviour towards Patient A.

Decision and reasons on application for hearing to be held in private (1)

At the outset of the hearing, Ms Paisley on behalf of the Nursing and Midwifery Council (NMC) made a request that part of this case be held in private on the basis that proper exploration of your case involves CCTV footage of a vulnerable patient. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Molyneux, on your behalf, indicated that she supported the application.

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

The panel decided to go into private session for the CCTV footage in order to protect the dignity of Patient A. The panel has not viewed the CCTV footage yet, and once having seen the footage, it determined that it may revisit this decision should it deem it appropriate.

Decision and reasons on application for hearing to be held in private (2)

Ms Molyneux made a request that this case be held partly in private on the basis that proper exploration of your case involves reference to your health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Paisley indicated that she supported the application.

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

The panel decided to go into private session as and when issues of your health are raised in order to protect your right to privacy.

Submissions on application to admit hearsay evidence

Ms Paisley submitted the following written submissions:

'<u>Sole and decisive evidence</u>

1. *It is submitted that none of the applications for the evidence outline at paragraph 1 of this document relate to evidence that is 'sole and decisive' in respect of any of the charges. There is full CCTV of the incident in question which will be presented to the Panel. Further, in respect of charges 10 – 12, the Panel will be provided with documentary evidence.*

2. *The Panel will further hear evidence from Witness 2 who was involved (albeit not for the entirety) in the incident.*

   <u>Ms 1</u>

3. *Ms 1 is a HCA who was involved in the restraint of Patient A.*

4. *Ms 1 was interviewed at local level by [Witness 1]. The minutes of this interview are exhibited by [Witness 1] and appear in the exhibits bundle at pages 81 – 83 ([Witness 1]/13).*

5. *Her evidence is not sole and decisive in respect of any of the charges. There is nothing to suggest that the answers she provided in interview were fabricated in any way.*

6. *The NMC has made numerous and significant attempts to engage Ms 1 in these proceedings. The Panel is referred to the NMC's Hearsay Bundle at pages 1 – 37. Despite numerous attempts, Ms 1 declined to engage with the NMC on the basis that she is "[PRIVATE]" (page 31)*

7. *Of course, submissions and comment can made in relation to weight.*

8. *The NMC submits that the Panel should allow exhibit [Witness 1]/13 to be admitted as hearsay.*

Ms 2

9. *Ms 2 is a Mentoring Manager and at the time of the incident was working as a Senior Support Worker. She was involved in the restraint of Patient A.*

10. *Ms 2 was interviewed at local level by [Witness 1]. The minutes of this interview are exhibited by [Witness 1] and appear in the exhibits bundle at pages 84 – 89 ([Witness 1]/15). Ms 2 provided a witness statement to the NMC which appears in the witness statement bundle at pages 29 – 30, and is dated 30 November 2022.*

11. *The NMC has made numerous and significant attempts to secure the continued engagement of Ms 2 in these proceedings. The panel is referred to the NMC's hearsay bundle at pages 96 – 106.*

12. *Despite the attempts of the NMC, Ms 2 has declined to engage further with these proceedings stating in an email on 13 November 2022 at page 96:*

"Good afternoon …,

I hope this email finds you well.

I have been thinking long and hard about the upcoming hearing and I have made the decision to not stand as a witness. I have many reasons for my decision.

[PRIVATE]

Kind regards,

Ms 2"

13. *Of course, submissions and comment can made in relation to weight.*

14. *The NMC submits that the Panel should allow exhibit [Witness 1]/15 and the statement of Ms 2 to be admitted as hearsay.*

Ms 3

15. *Ms 3 is a HCA who was involved in the restraint of Patient A.*

16. *Ms 3 was interviewed at local level by [Witness 1]. The minutes of this interview are exhibited by [Witness 1] and appear in the exhibits bundle at pages 94 – 97 ([Witness 1]/17).*

17. *Her evidence is not sole and decisive in respect of any of the charges. There is nothing to suggest that the answers she provided in interview were fabricated in any way.*

18. *The NMC has made numerous and significant attempts to engage Ms 3 in these proceedings. The Panel is referred to the NMC's Hearsay Bundle at pages 38 - 55. Despite numerous attempts, the NMC has been unsuccessful in its attempts to contact Ms 3.*

19. *Of course, submissions and comment can made in relation to weight.*

20. *The NMC submits that the Panel should allow exhibit [Witness 1]/17 to be admitted as hearsay.*

Mr 1

21. *Mr 1 is a HCW who was involved in the restraint of Patient A.*

22. *Mr 1 was interviewed at local level by [Witness 1]. The minutes of this interview are exhibited by [Witness 1] and appear in the exhibits bundle at pages 98 – 102 ([Witness 1]/18).*

23. *His evidence is not sole and decisive in respect of any of the charges. There is nothing to suggest that the answers he provided in interview were fabricated in any way.*

24. *The NMC has made numerous and significant attempts to engage Mr 1 in these proceedings. The Panel is referred to the NMC's Hearsay Bundle at pages 58 – 95. Upon receiving written questions from the NMC, Mr 1 responded by email on 14 November 2022, at page 90 of the bundle, stating:*

"Hi …
Having read your email with all contents i should safely say i dont think i will be in a position to give evidence, this incident happened in a ward called Clumber where Verity was the nurse we were summoned to come and assist as a response team. I used to work in a ward called Rufford and on the particular day of the incident that's where i was am sure those who were in Clumber ward would be in a very good position to know how it all started i remember there was some colleagues and their names are [a colleague] and Witness 2 maybe they might assist as they were all there much earlier than i did. Thank you."

25. *Despite their efforts, the NMC has been unbale to secure further engagement from Mr 1.*

26. *Of course, submissions and comment can made in relation to weight.*

27. *The NMC submits that the Panel should allow exhibit [Witness 1]/13 to be admitted as hearsay.*

Conclusion

28. *It is submitted in all of the circumstances, that the evidence relied upon by the NMC should be admitted into evidence.'*

Ms Molyneux submitted that the evidence in question is the hearsay evidence of four witnesses. She submitted that, although all these documents are relevant, it would be unfair for any of them to be admitted.

Ms Molyneux submitted that almost all the evidence the NMC has produced is hearsay and therefore that this evidence cannot be challenged or explored.

Ms Molyneux submitted that the reason why none of the documents are sole and decisive is because there are a number of them, which are all hearsay. She submitted that this hearsay evidence is sole and decisive on a number of charges.

Ms Molyneux submitted that three out of the four witnesses have not given statements to the NMC and that the evidence in question is interview minutes from the local investigation. She submitted that the documents themselves are multiple hearsay as they contain a minute taker's interpretation of what was said. She submitted that there is no way of ascertaining how accurate these documents are as the minute taker nor the witness cannot be cross examined.

Ms Molyneux submitted that Ms 2 indicated that the information included in the interview minutes document is not reliable and that there is an amended document which has not been obtained by the NMC. In light of this, Ms Molyneux submitted that there is potential that none of the interview minutes are accurate.

In response to Ms Molyneux's submissions, Ms Paisley submitted that the NMC is able to say that there is no fabrication of evidence contained in this hearsay evidence.

Decisions and reasons on admitting hearsay evidence

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor also referred the panel to *El Karout v The Nursing and Midwifery Council* [2019] EWHC 28 (Admin).

The panel considered paragraph 105 of *El Karout*, and also referenced section 4 of the Civil Evidence Act 1995. This is headed, *"Considerations relevant to weighing of hearsay evidence"* and provides*:*

> *"s.4(1) In estimating the weight (if any) to be given to hearsay evidence in civil proceedings the court shall have regard to any circumstances from which any inference can reasonably be drawn as to the reliability or otherwise of the evidence.*
>
> *(3) Regard may be had, in particular, to the following:*
> *a) whether it would have been reasonable and practicable for the party by whom the evidence was adduced to have produced the maker of the original statement as a witness;*
> *b) whether the original statement was made contemporaneously with the occurrence or existence of the matters stated;*
> *c) whether the evidence involves multiple hearsay;*
> *d) whether any person involved had any motive to conceal or misrepresent matters;*
> *e) whether the original statement was an edited account, or was made in collaboration with another or for a particular purpose;*
> *f) whether the circumstances in which the evidence is adduced as hearsay are such as to suggest an attempt to prevent proper evaluation of its weight."*

Firstly, the panel took into account that Ms 1, Ms 2, Ms 3 and Mr 1 were all present on 7 and 8 November 2018. The panel also noted that all the witnesses were made aware of the reason for the interviews taking place was in order to assist the local investigation and that these written minutes were produced contemporaneous to the incident alleged.

In light of this, the panel determined as accepted by both counsel that this hearsay evidence is relevant.

The panel also noted that the interview minutes of Ms 1 and Ms 3 are signed and dated in November 2018.

In relation to Ms 2's interview minutes, it considered that these are not signed or dated. It did however take into account her subsequent witness statement which is signed and dated 3 November 2022.The panel considered that the witness statement of Ms 2 reaffirms what is already included in the interview minutes which was unsigned at the time. The panel noted that this document confirms that they are her the interview minutes and does not include any additional information.

With regard to fairness, the panel decided that these interview minutes were not the sole or decisive evidence in this case and that the hearsay evidence is supported by the CCTV footage which will be placed before the panel in due course.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Ms 1, Ms 2 and Ms 3 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

With regard to the hearsay evidence of Mr 1, the panel noted that his interview minutes has not been signed or dated by him and there is no subsequent witness statement. The panel also considered that Mr 1 has not provided any further details or assistance despite the NMC's efforts to contact him. It considered in any event that, even if it found this evidence to be acceptable hearsay, it would not be able to give it any weight at the fact-finding stage.

The panel therefore decided not to admit Mr 1's interview minutes into evidence.

Submissions on disputed redactions

Ms Molyneux referred the panel to a list of disputed redactions sought by the Royal College of Nursing (RCN).

Ms Molyneux submitted that Prevention Management of Violence and Aggression (PMVA) training is something that falls into the category of expert evidence and that there are areas of expert opinion in Witness 1's and Witness 3's evidence. She submitted that Witness 1 and Witness 3 are not qualified experts to give this opinion evidence. Ms Molyneux told the panel that Witness 1 does not have up to date training in this area and that Witness 3 is no more of an expert than you.

With regard to the redactions sought in [Witness 1]/08, Ms Molyneux submitted that this is hearsay evidence and should not be taken into consideration.

With regard to the redaction sought in [Witness 1]/20, she submitted that a conclusion has been made by another body which strays into the arena of the panel's decision making. She submitted that this should not be relied on by the panel and that it is not admissible.

Ms Molyneux submitted that paragraphs 13-26 of Witness 1's witness statement provides her subjective opinion on the CCTV footage. She submitted that it is inappropriate that the witness provides commentary on an exhibit which the panel will view in due course. With regard to paragraph 43, she also submitted that some of the statement includes speculation and opinion evidence.

With regards to paragraphs 66-70 of [Witness 1]/08 Ms Molyneux submitted that this is a document from months after the incident, is therefore irrelevant and would not assist in determining the facts.

Ms Paisley submitted that the NMC witnesses are qualified to comment on the matters that they do.

Ms Paisley submitted that Witness 1’s evidence is relevant. She submitted that this witness is entitled to comment on the CCTV footage and the panel can accept or reject the evidence of Witness 1 once it has viewed the footage will make its own determination.

Ms Paisley accepted that some parts of paragraph 26 should be redacted.

With regard to [Witness 1]/07, Ms Paisley submitted that this document provides context for the panel and that it is helpful for the panel to have the full picture.

With regard to [Witness 1]/08, Ms Paisley accepted that it is hearsay however it is not sole or decisive in relation to any charges. She submitted that it is relevant, it provides context to the incident and that it would be fair to admit it.

Decisions and reasons on redactions

The panel heard and accepted the legal assessor’s advice on the issues it should take into consideration in respect of this application. This included that Rule 31(1) provides that, so far as it is ‘fair and relevant’, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor also referred the panel to *Towuaghantse v General Medical Council* [2011] EWHC 681 (Admin). Mostyn J observed at paragraph 36:

> *“in regulatory proceedings of this type there are no procedural rules regulating the adducing of expert evidence. To adduce expert evidence you do not need permission.”*

The panel took into account the NMC guidance as directed by both counsel with regard to expert evidence (reference INV-5). It had particular regard to the following:

> *‘We don’t always need independent expert evidence. We sometimes need help to understand the basic facts of what happened, and whether it was serious*

enough to cause concerns about the nurse, midwife or nursing associate's fitness to practise. We can usually discuss these issues with professionals at a local level who have the qualifications and technical expertise to help us with these issues.

Sometimes, however, we'll need the opinion of an independent expert during our investigation, and because of the issues involved, it's proportionate for us to instruct one.

We'll usually do this if we need:

- *specialised knowledge or expertise that we cannot obtain locally*
- *an independent opinion*
- *evidence to help us decide whether a nurse, midwife or nursing associate's actions were directly responsible for patient death or serious harm'.*

The panel asked itself whether Witness 1, Witness 2 and Witness 3 were sufficiently qualified to comment on the PMVA techniques used at the material time. In light of all the information before it, the panel determined that the witnesses are local and have local knowledge, and they are not put forward by the NMC as expert witnesses. It determined that these witnesses are qualified to give opinion evidence on processes that take place locally and based on their personal and professional experience.

The panel therefore determined that it would be fair to admit this evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Further, the panel was of the view that Witness 1's commentary on the CCTV footage is admissible.

In light of the above, the panel found that all the relevant parts of Witness 1 and Witness 3's statements highlighted on the list of disputed redactions are relevant. The panel

considered that Witness 1 and Witness 3 are due to give live evidence and can therefore be challenged or provide further clarification.

The panel considered that some of the evidence is relevant to the allegations and the wider background. It therefore decided that the relevant parts of [Witness 1]/07 and [Witness 1]/08 of the exhibit bundle are admissible in that they provide context to the allegations.

During its deliberations, the panel reminded itself of the NMC guidance found at DMA-5. It had particular regard to the following:

> *'Often, another organisation or body will have carried out some form of investigation into the matters being considered by the panel. The underlying evidence relied on by another organisation or body is admissible and can be presented to a panel (and form part of the bundle) if relevant to the allegations or the wider background.*
>
> *The weight that a panel will give to this evidence, which can include statements of fact and expressions of expert opinion, will be up to the FtP committee to decide using its expertise and experience as an independent panel.'*

The panel reminded itself how to deal with findings of other organisations or bodies which is found in DMA-5 of the NMC guidance. In the circumstances of the case, the panel decided that it would be appropriate to disregard the conclusions found in [Witness 1]/20. It decided that it would not be fair to admit this into evidence and it has excluded the conclusions of the report.

The hearing recommenced on 23 February 2023.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Molyneux that there is no case to answer in respect of all the charges against you. This application was made under Rule 24(7).

Ms Molyneux provided written submissions which are as follows:

*'**The Application:***

1. *This application is made at the close of the NMC's case against the Registrant, and is made on all the charges, specifically, 1, 2(a), 2(b), 3, 4, 5, 6, 7, 8, 9, 10(a), 10(b), 11(a), and 11(b). It is said that there is no case to answer on any of these matters.*

The Law:

2. *The well rehearsed test for submissions of no case to answer is derived from the case of Galbraith, 73 Cr. App. R 124:*

   "(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty - the judge will stop the case.

   (2) The difficulty arises where there is some evidence, but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.

   (a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.

   (b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury. "

3. *Application is made under Rule 24 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended:*

   "(7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and - (i) either upon the application of the registrant, or (ii) of its own volition, The Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.
   (8) Where an allegation is of a kind referred to in article 22(1)(a) of the Order, the Committee may decide, - (i) either upon the application of the registrant, or (ii) of its own volition, to hear submissions from the parties as to whether sufficient evidence has been presented to support a finding of impairment, and shall make a determination as to whether the registrant has a case to answer as to her alleged impairment."

General Submissions:

Failed to independently assess whether the seclusion of Patient A was justified:

4. *This is a limb 1 argument as there is simply no evidence relating to this issue. The NMC's initial evidence for this was simply derived from [Witness 1] assumption, having viewed the CCTV, that the Registrant had not made her own clinical decision.*

5. *It is to be remembered [Witness 1] was not present at the time, does not work on the ward, nor have any familiarity whatsoever with Patient A. She made the assumption that a decision had been made by Carers to seclude Patient A simply because they are seen to put on blue gloves before the Registrant arrives – which is speculative in the extreme (she suggested in her written statement which she later resiled from that she took this to mean they were*

getting ready to handle Patient A to move her to seclusion).

6. *There is nothing to say that the Registrant was simply going along with a suggestion from the Carers, and, in fact, there is evidence to support that she made a careful clinical assessment before making decisions as she reports in [Witness 1]/08 at pg. 67.*

7. *Furthermore, the evidence from both [Witness 3] (her manager at the time), and [Witness 2] is that she was a very good Nurse, who always did things properly, and for whom they had never had any doubts about her abilities/judgements/actions.*

Failed to a) consider and or b) use alternative less restrictive options to calm Patient A before making a decision to seclude them:

8. *It would appear that this again is entirely based on assumptions made by [Witness 1] in her assessment of the CCTV and failure to read all of Patient A's documentation in her flawed and limited investigation of the matters.*

9. *There is clear evidence that the Registrant did actively consider, and attempt less restrictive measures, firstly there is evidence she offered PRN medication – this can be seen in the entry on pg. 34 [Witness 1]/04, and also referenced in Ms 3's witness statement at pg. 95, as well as reported by the Registrant in her initial account at pgs. 160 and 161.*

10. *It is submitted that it is clear also, that de-escalation techniques were being used in an attempt to avoid seclusion, the Registrant arrives at 01:31 and is attempting verbal de-escalation along with the team up and until Patient A assaults [Witness 2] at 01:53. Other staff report that verbal de-escalation techniques were attempted, and [Witness 2] in evidence also agreed that he had attended to assist in trying to de escalate.*

11. *Furthermore, again, it is highlighted that the NMCs own witnesses who*

worked with the Registrant stated that she would always do things properly, with [Witness 2] saying 'she would always explore all avenues first'.

Made a decision to seclude Patient A when that decision was not clinically justified:

12. *The NMC's evidence on this comes from [Witness 1] and [Witness 3] initially, although it is observed that [Witness 3] in his oral evidence completely reneged on alleging any wrongdoing/inappropriate behaviour by the Registrant. [Witness 1] suggested it was not justified however she was not at the scene, is not familiar with Patient A having never met her let alone cared for her with her complex and highly volatile presentations.*

13. *There is clear evidence in the LTS and [Witness 1]/03, along with the testimony/interviews of all the staff who were present, that Patient A was a very dangerous and high-risk individual. She had a history of serious assaults and threatening behaviour, including knocking a staff member unconscious, and leaving permanent scars on another.*

14. *She had been moved into LTS due to her deteoriating behaviour on the ward after it was concluded that she could not be nursed there safely due to level of her violence/aggression/impulsive actions.*

15. *The LTS itself states very clearly at pg. 4 "at times of acute behaviours disturbance and to contain the risk of immediate harm to others she would need to be nursed in the seclusion room". There was no requirement for her to have actually assaulted anyone before being secluded, it was clear that escalations in her behaviour, when recognised by the nursing team, could warrant seclusion at earlier stages.*

16. *Due to Patient A's injured arm causing an even higher level of unpredictable behaviour, the serious threats she was making to staff, and her pervious history, the Registrant would have been clinically justified in deciding to*

seclude upon her arrival, or at the time Patient A actually assaulted [Witness 2].

17. *The CCTV, and the Registrant's rationale further bolster the fact that is a total lack of evidence of this charge.*

Caused or permitted Patient A to be restrained when this was not clinically justified:

18. *The restraint was only mobilised following an actual assault on staff at 01:53, and it is submitted at this stage, with Patient A's history, and the circumstances as outlined in the paragraphs above for the previous charge, that restraint was totally justified.*

19. *Both NMC witnesses that knew Patient A and worked with her – [Witness 3] and [Witness 2] in their live evidence did not give any criticism of the restraint.*

20. *Furthermore, [Witness 4], who is an expert in restraint and whose report is in evidence, concluded very clearly at pg. 9 section 7 of his report "she was working in line with the care plan during the physical restraint".*

21. *[Witness 1] suggestion that there were simply 'slight signs of agitation' is misconceived and clearly wrong, the evidence on this charge is inherently weak.*

Caused or permitted Patient A to be restrained on the bed and or on the floor when restraining a patient in those places should have been avoided:

22. *This charge is inherently flawed, as it suggests the only appropriate place to restrain must be when standing – which is clearly not correct.*

23. *The NMC have failed to show any evidence to support that restraining on the bed or floor is wrong other than [Witness 1] suggestion that it is. It is*

repeated, she is not an expert, she was not present, and indeed, her PMVA training is at least 20 years out of date.

24. *No expert evidence has been provided on this point, and it is clear, that should the NMC wish to establish this point, it is a matter for an expert.*

25. *Furthermore, [Witness 4] analysis is highlighted, section 6.1 pg. 10 "there was no inappropriate physical techniques used" and "there was a proportionate level of physical intervention used"*

Caused or permitted Patient A to be placed in the prone position twice on the floor during the said restraint:

26. *The NMC rely on the assertion that the Registrant somehow was able/influenced the position of Patient A in this way but there is no evidence to demonstrate this.*

27. *Indeed, [Witness 1] accepted the second instance of Patient A in prone is when she puts herself in that position.*

28. *The first time Patient A is in prone is when there is a dynamic, fast-moving restraint being attempted with a highly violent Patient, who is actively trying to resist and struggling. It is wrong to suggest the Registrant put her or caused her to be in prone.*

29. *The Registrant is on Patient A's head position, holding it, she certainly could not have exercised physical control to move her in this way, nor do any of the other staff who were there suggest they were directed to put Patient A in prone.*

30. *In her account t pg. 164 the Registrant explains how she actively made the other staff change positions when it was noted Patient A was in prone.*

Caused or permitted Patient A to be dragged or pushed along the floor during the said restraint:

31. Again, there is no evidence that suggests the Registrant was actively involved in intentionally having Patient A be dragged or pushed and indeed, it is again observed that this was a difficult and highly dynamic restraint with a number of staff, a strong, heavily resistant and dangerous Patient, who was at many stages, causing herself to be moved.

32. The only witness who suggests any wrongdoing of this nature attributed to the Registrant is [Witness 1] who for reasons rehearsed, is simply not a witness to place any real weight to her opinions.

33. There is nothing the Registrant did in her actions that can be said to have either caused or permitted any dragging or pushing.

34. [Witness 4] analysis is again rehearsed, there was nothing inappropriate or disproportionate in the actions he saw the Registrant involved with.

Failed to maintain Patient A's dignity by failing to take adequate steps to ensure her body was covered for as long as possibly during the said restraint:

35. It is argued that there is no evidence of this charge at all, and indeed, evidence positively of the opposite being true.

36. Patient A removes her clothes during the incident.

37. The Registrant actively tries to give her a duvet to cover herself at various times in the CCTV, and after she is in the seclusion room.

38. The NMC have failed to suggest what exactly the 'other steps' could possibly be, and it is evident the Registrant was trying to do her best in the circumstances whilst keeping everyone safe. For it to be a failing there has to

be a positive duty and a positive standard the NMC can point to, they cannot do so.

39. *[Witness 4] confirms the position at section 5.9 pg. 10 "Attempted to uphold her dignity".*

Failed to admonish ad or stop more junior colleagues who had taken part in the seclusions of Patient A from laughing and or making celebratory gestures:

40. *Again, it is highlighted the charge is a 'failure' requiring the NMC to point to a positive duty that has been breached.*

41. *There is no policy, nor rule that the Registrant can said to have 'failed'*

42. *Furthermore, it is clear on the footage that the Registrant is not in the room at all times after the seclusion whilst staff are there.*

43. *For the parts she is there, it is not clear the context, what is being said done with no sound, and the NMC have failed to show that the Registrant should have acted in any way differently.*

Failed to provide sufficient detailed or accurate written reasons to justify the decision to seclude Patient A in their seclusion documentation in that a) you recorded 'assaults on staff' on form H as a reason for seclusion when no such assault had taken place at the time of the decision to seclude Patient A, and b) in the event you considered alternative, less restrictive options before resorting to seclusion, you failed dot record those options and why they had not been used:

44. *This evidence comes from [Witness 1] and is flawed from the outset as the quote in a) does not fully reflect the comments written on the form, and also again, this is charged as a 'failure' meaning that there must be a policy or rule the Registrant has fallen short of, yet none have been put forward.*

45. [Witness 1] is not a Nurse who works on the ward and is not used to the custom and practice of how these forms are completed so cannot comment with authority that this form is defectively lacking in detail to the point of a 'failure'. No concerns were raised by any other party who reviewed the document, nor the other NMC witnesses.

46. It is submitted that the details on the seclusion documentation are sufficiently detailed when reviewing the forms.

47. The box the entry is written in is small and clearly only intended for a short amount of text. What is written is an answer both to what the reason for seclusion was, and the reason for not utilising less restrictive methods.

48. Furthermore, this document is to be read in conjunction with other records made at that time – ALL of which would go into Patient A's record, and together, provide a very full picture, [Witness 1]/04, [Witness 1]/07, [Witness 1]/08.

49. It should also be considered the circumstances the Registrant was working within that shift as well when considering whether there was a 'falling short' in her duties, when it was clear that she was having to do the shift with several significant handicaps – new staff, only one nurse on shift etc

Failed to ensure that a second nurse carried out the nursing reviews of Patient A's seclusion at a) 3:20am, b) 5:20 am

50. This charge arises simply from the fact the forms do not have a second nurse written entry.

51. The Registrant cannot be said to have failed when she has completed her sections and ensured a second nurse was with her carrying gout the reviews.

52. *[Witness 2] in evidence accepts he may well have done the reviews with her and in those circumstances, it can't be said that this charge has any evidence supporting it.*

Failed to carry out the 6 hourly nursing review at 7:20am:

53. *The Registrant was the only nurse on her ward, in difficult circumstances and suggests due to her having to prioritise other matters such as filing in the incident form, she asked [Witness 2] and '[a colleague]' to do this review.*

54. *In evidence he accepts this may have been the case, which if so, cannot be said to be a failure on the Registrant's part if this was then not completed or written up correctly by another Nurse who had taken on the responsibility for this.*

55. *As such there is no evidence to support a failure by the Registrant.'*

Mr Slack submitted that limb two of *Galbraith* is engaged in this case. He submitted that charges 1, 2, 3 and 4 relate to seclusion of Patient A, charges 4 to 8 relate to restraint, the techniques used and the responsibility of the nurse in charge, charges 9 and 10 deal with discrete issues, and charges 11 and 12 relate to the carrying out of reviews.

Mr Slack submitted that the evidence before the panel is not so inherently weak, vague or inconsistent that it cannot properly find the facts proved on the balance of probabilities.

Mr Slack first addressed the lack of independent assessment, use of less restrictive options and clinical justification in terms of seclusion of Patient A. He submitted that the decision to seclude was made prior to the attempted assault on Witness 2, and that it was his evidence that he was asked by you to assist with seclusion. The CCTV footage that points towards the seclusion room, as well as moving bedding into the room, and indicated that the seclusion decision was made prior to this attempted assault. He submitted that the CCTV shows no further attempts to administer PRN medication, and

the statements admitted as hearsay evidence suggest PRN medication was not attempted, which could have avoided the escalation or the need for restraint of Patient A. He submitted that no other options were explored at this point, seclusion was decided on too early and it was not clinically justified.

Mr Slack submitted that, with regard to the restraint not being clinically justified, the evidence was that, had Patient A been left alone, the issues that arose from the restraint could have been avoided.

Mr Slack submitted that, with regard to the techniques of restraint used, in particular the prone position, it was Witness 1's evidence that this was dangerous. He submitted that this should not have occurred or should have been rectified quickly. He referred to Witness 4's report, and that you did not address the safety of restraining a patient face down, and the only evidence available about this matter is from Ms 1 and Witness 1. He submitted that it is important to read Witness 4's report fully and the panel should not speculate what he may have said in relation to other staff members. Mr Slack reminded the panel that you were the nurse in charge during this time, and there were serious mistakes made that you did not address or rectify in the moment. He submitted that you administered inappropriate techniques such as restraining on the bed, in the prone position, and dragging along the floor.

Mr Slack addressed the issue of laughing/celebrating by other staff members. He submitted that this is not a vague charge and the CCTV shows junior members of staff laughing, dancing and celebrating after the seclusion has occurred. He submitted that this is not to be confused with trying to 'have a laugh' with Patient A during the restraint as a de-escalation technique. He submitted that Ms 1 admitted that Patient A probably heard the laughing and celebrating after she had been secluded which was a clear lack of professionalism that was not stopped in any way.

Mr Slack addressed the issue of documentation. He reminded the panel that it has Witness 1's evidence on this and it was clear that she expected proper detail to be put in all of the documents, and this was not this case.

Mr Slack addressed the issue of carrying out reviews. He submitted that Witness 2 was ‘patchy’ in his recollection but stated that, had he completed the reviews, he would have signed them. Witness 2 remembered returning to check on wounds, but he made it clear that this was not a review as was necessary at 03:20 and 05:20 hours. He submitted that Witness 2 recalled only returning once, so he could not have carried out both reviews, and that it is the responsibility of the nurse in charge to carry out the check at 07:20 which you failed to do.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel considered the term ‘failure’ used in some of the charges. A failure is linked to policies/procedures of the Hospital, as well as ’The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code), and requires the NMC to prove that you did not complete the tasks as highlighted in the charges above. As the nurse in charge during the time of the alleged incidents, you would have duties and obligations upon you.

Charge 1

The panel took account of all of the evidence before it and considered that there is no evidence about this matter specifically. The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of this charge proved, considering it would not know what you were thinking and whether you had independently assessed Patient A.

The panel therefore decided that there is no case to answer with regard to charge 1.

Charge 2a and 2b

The panel took account of all of the evidence before it. The panel considered that it does have evidence from available records, witness statements from a number of individuals, and your own account of the matter that you provided locally.

The panel was of the view that there had been sufficient evidence to support the charge at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 2a and 2b.

Charge 3

The panel took account of all of the evidence before it. The panel considered that it does have evidence from a number of witnesses with their own interpretation of the incident, the CCTV footage, and available records.

The panel was of the view that there had been sufficient evidence to support the charge at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 3.

Charge 4

The panel took account of all of the evidence before it. The panel considered that it does have witness evidence on this matter, written evidence from your expert witness, and the CCTV footage.

The panel was of the view that there had been sufficient evidence to support the charge at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 4.

Charge 5

The panel took account of all of the evidence before it. The panel considered that it had evidence from available records, your expert witnesses' report and other witnesses.

The panel was of the view that there had been sufficient evidence to support the charge at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 5.

Charge 6

The panel took account of all of the evidence before it. The panel considered that there could be a dispute about how many times Patient A was placed in the prone position during the restraint. The panel does have evidence of witnesses on this matter, evidence from your expert witness' report, and the CCTV footage.

The panel was of the view that there had been sufficient evidence to support the charge at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 6.

Charge 7

The panel took account of all of the evidence before it. The panel does have evidence of witnesses on this matter, evidence from your expert witness' report, the CCTV footage, and the available exhibits in the NMC bundle.

The panel was of the view that there had been sufficient evidence to support the charge at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 7.

Charge 8

The panel took account of all of the evidence before it. The panel does have evidence from witnesses and your expert witness' report on this matter, as well as the CCTV footage.

The panel was of the view that there had been sufficient evidence to support the charge at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 8.

Charge 9

The panel took account of all of the evidence before it. The panel does have evidence of the CCTV footage, and the evidence of witnesses on this matter.

The panel was of the view that there had been sufficient evidence to support the charge at this stage and, as such, it was not prepared, based on the evidence before it, to

accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 9.

Charge 10a and 10b

The panel took account of all of the evidence before it. The panel does have evidence from witness statements, documents within the NMC exhibit bundle, and evidence from witnesses who were present at the time of the incident.

The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 10a and 10b.

Charge 11a and 11b

The panel took account of all of the evidence before it. The panel does have evidence from witnesses who were present at the time of the incident, and the evidence contained within the NMC exhibit bundle.

The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 11a and 11b.

Charge 12

The panel took account of all of the evidence before it. The panel does have evidence from witnesses who were present at the time of the incident, and the evidence contained within the NMC exhibit bundle.

The panel was of the view that there had been sufficient evidence to support the charge at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore decided that there is a case to answer with regard to charge 12.

The hearing resumed on 10 July 2023.

Decision and reasons on application to amend the charge

Following suggestions raised by the panel, of its own volition, in relation to amending charges 2 and 6, Mr Slack made an application on behalf of the NMC to amend the wording of charges 2 and 6.

The proposed amendment was to amend the wording of charges 2 and 6 to instead say:

2. *Failed to*
    a) *consider and/or*
    b) *use*

    ***sufficient** alternative less restrictive options to calm Patient A before making a decision to seclude them.*

    …

6. *Caused or permitted Patient A to be placed in the prone position ~~twice~~ on the floor during the said restraint.*

These amendments were applied for to provide further clarity upon hearing evidence given by the witnesses.

Ms Molyneux submitted that this is a matter for the panel, and that her position remains neutral on this application. She submitted that although it is right that there has to be a mind for charges to not fail on simple technicalities, but the panel should not look for a way to find the charges proved, and that they should reflect the evidence that has been heard.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to provide clarity and reflect the evidence that has been heard from witnesses.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Slack on behalf of the NMC and by Ms Molyneux.

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

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

- Witness 1: Regional Hospital Director and Investigator; Stockton Hall Hospital
- Witness 2: Site Manager; the Hospital
- Witness 3: Ward Manager; the Ward

The panel also heard evidence from the following witness, called on your behalf:

- Witness 4: Therapeutic Crisis Intervention Trainer; Expert Witness

The panel also heard evidence from you under affirmation.

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

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

Charge 2

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

2. *Failed to*
    a) *consider and/or*

b) use
sufficient alternative less restrictive options to calm Patient A before making a decision to seclude them.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage. The panel considered charges 2a and 2b together.

The panel considered that the world ‘failed’ as charged would suggest that there had to have been a duty on you to undertake a task at the time. The panel considered that it was your duty to consider alternative methods under the Priory Seclusion Healthcare Policy.

The panel considered the CCTV footage, which does not include audio, so it is unclear whether you offered Patient A alternative options at the time. In your oral evidence, you told the panel that you offered methods, such as Pro Re Nata (PRN) medication which you stated was something that you offered for this patient to calm her down.

The panel heard evidence that the use of music or watching TV were also commonly used as alternative options for Patient A. However, the panel did not see the TV being used to calm down Patient A; the only time the TV remote appeared to be used from the CCTV footage was when one of the care assistants sat down to watch it for herself at the beginning of the CCTV footage.

The panel could see that you spoke to Patient A for a short period of time once you entered the room, you then left the room and came back with a number of other staff. You all proceeded to put on gloves at the same time. Shortly after, there were nine staff in the room and staff were gesturing Patient A to the seclusion room. This indicates that a decision was likely made at that point to seclude Patient A. The panel also considered that there were a number of staff members surrounding Patient A’s bed at the time, with

one staff member putting her foot on the bed, would likely have been intimidating and overwhelming for Patient A.

The panel agreed that PRN medication was offered, as per the evidence heard from yourself, witnesses and the documentation before it, however it did not feel that other methods were offered to Patient A. From the footage, the panel did not see you actively trying to encourage the use of TV or music in the room. It also considered Patient A's care plan which states that *'The team have option to disengage and move away…'*, when it is clear that this was not attempted to calm Patient A.

The panel also considered the evidence of Witness 4 who emphasised the importance of considering alternative options.

In light of the above and on the balance of probabilities, it is more likely than not that you failed to consider and/or use sufficient alternative less restrictive options to calm Patient A before making a decision to seclude her.

The panel therefore finds charges 2a and 2b proved.

Charge 3

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

3. *Made a decision to seclude Patient A when that decision was not clinically justified.*

This charge is found proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage. The panel noted that its reasons for charge 3 are similar to that in charge 2.

The panel considered that, having watched the CCTV footage and taking into account the documentary evidence, Patient A appeared to be relatively calm in the beginning, with only two members of staff in the room at the time. They only began to get concerned when Patient A started to hit her arm but, even at that stage, her behaviour was not affecting anyone and her composure remained calm.

The panel considered that once you and additional staff entered the room and surrounded the bed, Patient A appeared to become more agitated. As stated in charge 2, the decision to seclude Patient A was likely at the point that you and staff members entered the room and started putting on gloves in anticipation of having physical contact with Patient A.

The panel considered Patient A’s care and LTS plan, which listed a number of behaviours to be aware of, and these include:

- *Urinating*
- *Damage to property*
- *Shouting*
- *Screaming*
- *Foul and abusive language*
- *Odd and sexualised behaviour*
- *Ongoing aggression*
- *Disruptive behaviour*

The panel considered that Patient A did not appear to be displaying any particularly troubling behaviours at the time when staff were seen preparing for engagement with Patient A. She was sitting on the bed talking to herself, she was seen hitting her own arm on one occasion, sometimes she could be seen lifting her head and may have shouted at staff. She did not get up from her bed, she was not physically agitated, no physical gestures threatening staff could be seen and no assaults were visible. The panel accepts your evidence and that contained in the documentation that Patient A was high-risk and had attacked staff before. However, it did not accept that the risk was high in that situation, not least because, as the incident progressed, staff are seen

standing close by Patient A, with both male and female stretching out their hands to her and touching her on occasion – they would not have done that if they felt in immediate physical danger. The panel considered that if other options were considered at the time, for instance, staff could have waited outside or kept their distance, the situation may have de-escalated. The panel could see that Patient A's duvet was also pulled away from the bed. Although she was high risk, the panel considered that Patient A's behaviour at that time did not warrant a decision for seclusion.

Witness 2 also said in his statement:

> *'I recall that the decision to seclude Patient A had already been made by the time I was asked to assist, and it was this specifically that Verity was requesting my help with…'*

Patient A's LTS plan makes it clear that the decision of seclusion was your responsibility as it states:

> *'She may be relocated to a safe environment… if her risks cannot be managed in her designated room. Such decision shall be made by the nurse in charge.'*

In light of the above and on the balance of probabilities, it was more likely than not that you made a decision to seclude Patient A when that decision was not clinically justified.

The panel therefore finds charge 3 proved.

Charge 4

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

4. *Caused or permitted Patient A to be restrained when this was not clinically justified.*

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage.

The panel considered that the behaviour Patient A presented with at the time was likely due to response to external stimulation, such as a large number of staff surrounding her bed. From looking at the documentation before it, including Patient A's care plan, the staff had the option to disengage and move away from Patient A to calm her down, but this did not appear to have happened.

The panel considered that Patient A had attempted to assault Witness 2 from the CCTV footage, but no physical contact was made.

Witness 2 in his statement also said:

> *'The staff reported to me that Patient A had been "kicking and biting" but I did not observe this myself. I tried to talk to Patient A but it was at this point that she tried to hit me, although she did not make contact with me'.*

The panel considered that, in your oral evidence, you were clear in that from where you were standing in the room at the time, it had looked like Patient A made contact with Witness 2. You knew Patient A well, and that she had a history of violence against staff, and the panel could also see staff examining their bodies following the restraint to check for injuries on the footage.

The panel considered that based on the evidence before it, you were more likely than not reacting to the situation based on what you could see at the time from your standing position, and may have considered the restraint to be clinically justified.

In light of the above, and on the balance of probabilities, the panel found charge 4 not proved.

Charge 5

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

5. *Caused or permitted Patient A to be restrained on the bed and/or on the floor when restraining a patient in those places should have been avoided.*

This charge is found proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage.

The panel has heard evidence from Witness 4 that restraining a patient on a bed should be avoided as it can be dangerous for both the patient and the staff members. The panel considered that Witness 4 informed the panel that a patient can be restrained on the floor, and has heard evidence as such, although staff have to be careful of doing so and make use of equipment such as beanbags to protect themselves and the patient.

The panel considered that, from the CCTV footage, although you were not the person to initiate the restraint on Patient A, the panel can see that you do get on the bed at one stage during the restraint. The panel considered that you would have had the authority, time and opportunities to ask staff members to step back, given the length of time the incident went on, as the nurse in charge of the ward.

The panel considered that there is evidence before it to find this charge proved in relation to the word ‘permitted’ only. It did not consider that you ‘caused’ Patient A to be restrained on the floor or the bed.

In light of the above, and on the balance of probabilities, the panel finds charge 5 proved in that you permitted Patient A to be restrained on the bed and/or on the floor when restraining a patient in those places should have been avoided.

Charge 6

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

6. *Caused or permitted Patient A to be placed in the prone position on the floor during the said restraint.*

This charge is found proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage.

The panel considered that, from the CCTV footage, Patient A was in the prone position for a significant period of time before she was repositioned. It considered that, on the first occasion, it appears that Patient A was placed in that position by staff members when moved from the bed. However, on the second occasion, Patient A appeared to have rolled over to the prone position herself.

The panel considered that the first occasion could have been avoided and staff could have acted promptly to change Patient A's position, but this did not appear to have occurred and it was a long period of time before it was corrected.

The panel heard oral evidence from you, in which you said that when Patient A was on the floor, she was not being restrained and they were just holding her at that stage, but the panel considered that the footage shows a different situation. The panel considered that you were present at the time and were in a position of authority as the nurse in charge of the Ward to ensure that Patient A was not in the prone position.

The panel also considered Patient A’s care plan that stated the prone position should be avoided at all times.

The panel considered that there is evidence before it to find this charge proved in relation to the word ‘permitted’ only. It did not consider that you ‘caused’ Patient A to be placed in the prone position on the floor during the said restraint.

In light of the above and on the balance of probabilities, the panel finds charge 6 proved in that you permitted Patient A to be placed in the prone position on the floor during the said restraint.

Charge 7

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

7. *Caused or permitted Patient A to be dragged or pushed along the floor during the said restraint.*

This charge is found proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage.

The panel considered your oral evidence in which you spoke about the ‘sit to stand’ technique that is taught during training, and you said that this is what you and staff were trying to achieve at the time with Patient A.

The panel considered the footage and saw evidence of dragging and pushing. For example, it noted that at time stamp 02:07, Patient A’s legs were pulled towards the seclusion door. At time stamp 02:14, it appears that there was an attempt to undertake

the ‘sit to stand’ technique, and that Patient A appears to have been pushed into the seclusion room. The panel considered that at that stage, staff should have been asked to step back to allow Patient A to calm down.

Witness 4 in his evidence said that the movements carried out by staff could be described as dragging and pushing, and that it was a dynamic intervention that took place. Witness 4 in his oral evidence then stated that he had seen Patient A being pulled off the bed to the floor from watching the footage.

The panel considered that there is evidence before it to find this charge proved in relation to the word ‘permitted’ only. It did not consider that you ‘caused’ Patient A to be dragged or pushed along the floor during the said restraint.

In light of the above and on the balance of probabilities, the panel finds charge 7 proved in that you permitted Patient A to be dragged or pushed along the floor during the said restraint.

Charge 8

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

8. *Failed to maintain Patient A’s dignity by failing to take adequate steps to ensure that her body was covered for as long as possible during the said restraint.*

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage.

The panel considered that the world ‘failed’ as charged would suggest that there had to have been a duty on you to undertake a task at the time. The panel considered that it was your duty to ensure that Patient A’s dignity was maintained.

The panel considered the CCTV footage, and was of the view that you did, on various occasions, attempt to cover Patient A with a duvet or a towel. The panel considered that you also gave Patient A’s pyjamas back to her at some stage, to encourage her to put them back on.

In light of the above, the panel considered that you did not fail to maintain Patient A’s dignity by failing to take adequate steps to ensure that their body was covered for as long as possible during the said restraint. The panel therefore finds charge 8 not proved.

Charge 9

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

9. *Failed to admonish and/or stop more junior colleagues who had taken part in the seclusion of Patient A from laughing and/or making celebratory gestures outside the seclusion room following Patient A’s seclusion.*

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage.

The panel considered that the word ‘failed’ as charged would suggest that there had to have been a duty on you to undertake a task at the time. The panel considered that it was your duty to ensure that staff were acting appropriately, as the nurse in charge of the ward.

The panel considered that, from the CCTV footage, it could see a staff member raising her hands in a celebratory gesture once Patient A was in the seclusion room and that staff were seen laughing on other occasions. However, it does not know if you saw these gestures being made. The panel also noted that you were looking through the seclusion window at times or were out of the room and may not have observed some of the actions.

You also said in evidence that you were shocked when you watched the footage back.

In light of the above and on the balance of probabilities, the panel considered that you did not fail to admonish and/or stop more junior colleagues who had taken part in the seclusion of Patient A from laughing and/or making celebratory gestures outside the seclusion room following Patient A's seclusion. The panel therefore finds charge 9 not proved.

Charge 10

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

10. *Failed to provide sufficiently detailed or accurate written reasons to justify the decision to seclude Patient A in their seclusion documentation in that:-*
    a) *You recorded "assaults on staff" on Form H as a reason for seclusion when no such assault had taken place at the time of the decision to seclude Patient A;*
    b) *In the event that you considered alternative, less restrictive options before resorting to seclusion, you failed to record those options and why they had not been used;*

This charge is found proved in its entirety.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage. The panel considered charges 10a and 10b together.

The panel considered that the world 'failed' as charged would suggest that there had to have been a duty on you to undertake a task at the time. The panel considered that it was your duty to ensure that you provided detailed and accurate reasons to justify the decisions made, as the nurse in charge of the ward.

Charge 10a

You said in evidence that you had a large amount of documentation to complete following the incident, and the panel considered that there were other care documents containing more information. However, the panel focused on what was recorded in the seclusion documentation specifically in accordance with the charge. The panel considered that 'assaults on staff' was not the reason Patient A had been secluded, as the decision had been made earlier as explained in Charge 2 and not when Patient A lashed out at Witness 2.

The panel noted that 'assaults' as written by you suggests more than one assault occurred, when it only appeared to be one attempt to assault Witness 2.

In light of the above, the panel therefore finds charge 10a proved.

Charge 10b

You said in oral evidence that you did consider alternative options for Patient A, namely offering PRN medication, TV and music.

The panel considered that, from the documentation before it, you typed 'PRN' on another form, but you did not state this specifically on the seclusion form that was handwritten. When considering the seclusion form, you completed the first section of it

in relation to the reasons that led to seclusion, but you had not stated whether any alternative methods were considered at the time, and it is blank.

In light of the above, the panel therefore finds charge 10b proved.

Charge 11

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

11. *Failed to ensure that a second nurse carried out the nursing reviews of Patient A's seclusion at*
    a) *03.20 am on 8 November 2018;*
    b) *05.20 am on 8 November 2018.*

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage. The panel considered charges 11a and 11b together.

The panel considered the word 'failure' as charged, and considered that as the nurse in charge, there was a duty on you to carry out the nursing reviews at 03:20 and 05:20 am.

The panel has heard evidence that two nurses were required to undertake the nursing reviews, and it is clear that you had signed the documentation, but it is blank in relation to the second nurse. You told the panel that Witness 2 was with you at the time and you completed these reviews together, and you had regrettably not realised that Witness 2 did not sign the forms.

The panel noted that there was only one nurse on the ward at the time, when there should have been two. Witness 2, in his statement, said that he may have been present

for the nursing reviews at the time. The panel considered that Witness 2’s evidence was unclear in relation to this incident and his evidence was somewhat conflicting.

The panel considered that the NMC has not provided enough information in order to find this charge proved.

In light of the above, the panel therefore finds charge 11 not proved.

Charge 12

That you, a registered nurse, whilst nurse in charge of Clumber Ward on the nightshift on 7 to 8 November 2018:-

> *12. Failed to carry out the six hourly nursing review at 7.20 a.m.*

This charge is found proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, in addition to the CCTV footage.

The panel considered the word ‘failure’ as charged, and considered that as the nurse in charge (and the only assigned nurse on the ward), there was a duty on you to carry out the six hourly nursing review at 07:20am.

The panel considered the form in relation to the nursing review, and can see that this form is blank and has clearly not been completed.

The panel considered that in your oral evidence, you stated that you had delegated this task to another member of staff at the time, namely Witness 2 and another nurse. The panel considered that, although the task had been delegated, it would have been your responsibility as the nurse in charge to ensure that this was completed.

In light of the above, the panel therefore finds charge 12 proved in that you failed to carry out the six hourly nursing review at 7.20 a.m.

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

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

Mr Slack invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of

practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

Mr Slack referred to a number of cases, namely: *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Calheam V GMC* [2007] EWHC 2606 (Admin).

Mr Slack also referred to sections of the Code that have been breached in this case, namely: sections 8.5, 10, 11 and 19.

Mr Slack submitted that you were the nurse in charge of the Ward that night, and you allowed dangerous restraint techniques to be used on a vulnerable patient. He submitted that your actions fell far short of what is expected of a registered nurse. He submitted that you also failed to ensure other responsibilities were completed following the restraint, in relation to record keeping.

Mr Slack submitted that another healthcare professional would find these actions to be deplorable and invited the panel to make a finding of misconduct.

Ms Molyneux reminded the panel that these charges all arose from a single incident that occurred four and a half years ago. She submitted that you are someone who has never had any issues or complaints raised against you before and, since the incident, no other incidents of any kind have been raised. She submitted that this was an unfortunate one-off isolated incident that you and a number of other staff members were involved in.

Ms Molyneux submitted that not every mistake is going to be sufficient to amount to misconduct. She reminded the panel that registrants are human and can make mistakes.

Ms Molyneux submitted that the panel are required to look at each charge found proved separately, and decide on whether this action amounted to misconduct. She submitted that the position is, when looking at the charges individually, there may be a few matters that the panel may be of the view amounts to misconduct. However, she submitted that the majority of these charges do not amount to misconduct. She submitted that, when

looking at the charges that may be capable of misconduct, they do not equal impairment.

Ms Molyneux addressed the charges in turn. She submitted that charges 2, 3, 10 and 12 cannot be capable of amounting to misconduct in isolation. In relation to charge 2, she submitted that this does not meet the threshold of misconduct, especially when looking at how the panel have found it proved. She reminded the panel that it did consider options were offered, albeit this did not go far enough.

In relation to charge 3, Ms Molyneux submitted that this relates to a single occasion of making a decision to seclude a patient once. When looking at the circumstances, she reminded the panel that it did not find that this was grossly wrong or an error of judgement, but simply that the decision was overzealous and premature. She reminded the panel that it acknowledged the risk Patient A posed.

In relation to charge 10, Ms Molyneux submitted that this is a charge that, in isolation, would not be misconduct. She submitted that this charge relates to a single incident in which you had not completed parts of a form that you should have. She reminded the panel that it accepted that you did so in other documentation, that would have been read in conjunction with the seclusion form, and that this is a minor incident when considering the circumstances.

In relation to charge 12, Ms Molyneux submitted that this relates to a single incident of failing to ensure that you followed up on someone you delegated the task to at the time. She reminded the panel that your evidence was accepted and, considering the context, this was not a serious departure of professional standards.

Ms Molyneux submitted that charges 5, 6 and 7 relate to the physical restraint of Patient A as it was happening. She submitted that the panel found that you permitted these actions, rather than caused, and that there were other staff members involved. She submitted that these charges were found proved based upon the presumption that, as the nurse in charge at the time, you could have influenced more control over the situation. She submitted that she is not accepting that these charges amount to

misconduct, but invited the panel to consider them carefully. She reminded the panel that there is no evidence that there was any harm caused to Patient A, other than a care assistant putting their hands around her neck. She submitted that this cannot be linked to you.

Ms Molyneux referred to the case of *Professional Standards for Health and Social Care v NMC and X* [2018] EWHC 70 (Admin), and invited it to carefully consider this case when making a finding of misconduct. She reminded the panel that its role is to uphold standards of the profession and mark seriousness as appropriate. She submitted that you were faced with an internal investigation and subsequently lost your job, but was reinstated. She submitted that you were then charged with these matters, and it has taken some years to be fully investigated.

Submissions on impairment

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

Mr Slack submitted that limbs a, b and c of *Grant* are engaged in this case. He submitted that all of the staff members involved were responsible for Patient A, although you allowed dangerous restraint techniques to be used, which resulted in a risk of harm towards Patient A.

Mr Slack submitted that you observed the unsafe treatment towards Patient A, when other methods could have been considered, which brings the profession into disrepute. He submitted that fundamental tenets of the profession have subsequently been breached.

Mr Slack submitted that you have had ample time to demonstrate reflection and insight, and you have been deflecting blame upon others in relation to the concerns.

Mr Slack invited the panel to find that your fitness to practise is currently impaired on the grounds of public protection and otherwise in the public interest.

Ms Molyneux submitted that, should the panel not agree with her primary submission in respect of misconduct, she addressed the issue of impairment. She reminded the panel that this is a forward-looking exercise and focuses on your current impairment to date.

Ms Molyneux submitted that this is a single incident, and it is in relation to the restraint technique used, minor documentation issues and issues of patient care. She submitted that these actions are capable of remediation.

Ms Molyneux submitted that the panel have various pieces of reflective work undertaken by you, and it is unfair of the NMC to state that you have not taken ownership of the situation and to seek to blame others. She submitted that this incident has shaken your life in a negative way over a number of years since, and you have sought to help the panel understand what happened that shift. She reminded the panel that it has accepted your evidence, albeit there were some shortcomings.

Ms Molyneux reminded the panel that you continued to work without any restriction against your practice in the same role and environment for a year after the incident occurred, and no further issues arose. You were working on the same ward and with the same patient, and she submitted that it would be an insult to the public protection to consider that this is a nurse who is any risk to the public. She submitted that the NMC could and should have sought an interim order to limit or stop your practice before if this was the case. She reminded the panel that you left your role voluntarily.

Ms Molyneux submitted that, in relation to public interest, the public would know about your unblemished record, in addition to how you gave honest and credible evidence. She submitted that the public would know about the training you have undertaken and the numerous reflections. You have also engaged and cooperated throughout this

process, and worked in other roles. She referred back to the number of positive character references, and submitted that these colleagues have willingly provided these references that speak to your good and safe practice.

Ms Molyneux submitted that there is no public interest in making a finding of impairment based on charges that are four and a half years old, when considering the circumstances, your remediation, insight and reflection. She submitted that there is more of a public interest in keeping a registrant in practice and allowing you to provide services as a nurse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cheatle v GMC* [2009] EWHC 645 (Admin), *Cohen v GMC* [2008] EWHC 581 (Admin), *Calhaem v GMC* and *Roylance v GMC.*

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

> ***'8 Work cooperatively***
> *To achieve this, you must:*
> ***8.5*** *work with colleagues to preserve the safety of those receiving care*
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***
> *To achieve this, you must:*

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel considered each of the charges individually:

Charge 2

The panel considered that you did not consider other obvious options before deciding on seclusion for Patient A. The panel highlighted the clear options set out in Patient A's care plan, that were clearly not considered beforehand. The panel considered that this was a significant failure, and you did not step away, disengage, or reduce the number of people in the room at the time of the incident. The panel was of the view that, because you did not consider other alternative options, the impact of this was that other serious actions followed, which are linked to later charges. The panel considered that other options could have been taken to handle the situation differently.

The panel considered that a fellow professional would consider that your actions fell seriously short of what would be expected of a registered nurse. The panel therefore found that your actions in charge 2 amounted to misconduct.

Charge 3

The panel highlighted that its reasons for charge 3 are similar to that in charge 2. The panel considered that this action was serious, as Patient A's behaviour at the time did not warrant a decision for seclusion. The panel has heard and seen evidence that seclusion is always a last resort, and that it was a significant decision to make. The panel reminded itself that this decision was made very early on.

The panel considered that a fellow professional would consider that your actions fell seriously short of what would be expected of a registered nurse. The panel therefore found that your actions in charge 3 amounted to misconduct.

Charge 5

The panel reminded itself that this charge was proved in relation to 'permitted' only. It considered that once Patient A was restrained on the bed, while you permitted this to continue, once the situation was in flow, your lack of intervention, while not expected practice, did not in and of itself amount to misconduct. It also noted that you did not initiate the restraint to begin with. The panel took account of Witness 4's evidence, in which he said that restraining a patient on the bed is not best practice, although it can and does happen in unpredictable situations.

The panel considered that, although the situation could have been handled differently at the time, this action would not amount to misconduct, when considering the context and overall circumstances.

Charge 6

The panel reminded itself that this charge was proved in relation to 'permitted' only. It considered that, once the situation was in flow, your lack of intervention to prevent the patient being put in a prone position, while not expected practice, did not in and of itself amount to misconduct. It highlighted that Patient A was eventually repositioned.

The panel considered that, for the same reasons as charge 5, the panel also found that your actions in charge 6 did not amount to misconduct when considering the context and overall circumstances.

Charge 7

The panel considered that, for the same reasons as charge 6, the panel also found that your actions in charge 7 did not amount to misconduct when considering the context and overall circumstances.

Charge 10

The panel considered that the information needed to manage the risk was present at the time, and all staff members would have had access to that information. The panel considered that there were other pieces of documentation provided in relation to this charge, and there is no suggestion that you completed the form dishonestly.

Therefore, the panel considered that charge 10 does not amount to misconduct, when considering the context and overall circumstances.

Charge 12

The panel considered that this was a one-off incident, and you had delegated the task to someone else, and it is regrettable that it was not completed by that person or followed up by you. The panel acknowledged that the shift in question was busy, that you were the only nurse on duty and, the record keeping software was also down at some point of the shift.

Therefore, the panel considered that charge 12 does not amount to misconduct, when considering the context and overall circumstances.

The panel considered that the key misconduct lay in the decision to seclude without trying alternative options in line with charges 2 and 3. This decision led to one long incident which gave rise to further charges. Whilst the further charges do not in themselves amount to misconduct, it determined that taken cumulatively, all charges (apart from charges 10 and 12) amount to misconduct.

The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

d) …

The panel finds that Patient A was put at risk as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered that these concerns arose as you, at the time, raised the incident in relation to observing one of the care assistants place their hands around Patient A's throat during the restraint. Following an internal investigation, you were referred to the NMC and dismissed from your role. You were then reinstated in your role following your successful appeal, and you worked in the same environment for a year without any further issues being raised. The panel acknowledged that you have worked without restriction on your practice.

The panel then considered all of the oral, documentary and CCTV footage before it. It noted that you were young and a relatively newly qualified nurse who was put in a challenging situation of authority. It acknowledged that you have shown some insight, reflection and remorse for your actions by way of the various reflective pieces, evidence of training and character references provided. It highlighted that you have taken steps to address the concerns and you have made attempts to strengthen your practice. The panel was assisted by your participation and evidence in these proceedings. [PRIVATE].

However, the panel was of the view that you have not yet shown a level of objective insight into the situation that occurred at the time, from the evidence it has seen and heard. The panel again acknowledged the reflective pieces before it, especially the one that refers to the PMVA training you had undertaken, however it appears that you seem to focus more on the actions you took at the time of the incident and the impact it had on you, as opposed to addressing what you could have done differently at the time and the level of impact from the patient's perspective, particularly in emotional and psychological terms.

The panel considered that the conduct in question is remediable, and you have begun to take significant steps to address the concerns, however it felt that your level of insight at this stage is still limited. [PRIVATE].

Therefore, the panel is of the view that there is a risk of repetition based on its reasoning as highlighted above. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because a well-informed member of the public would be shocked if they were to view the CCTV footage (as you yourself accepted in your evidence) and observe the actions that occurred at that time. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

The panel had sight of the Notice of Hearing, dated 15 November 2022, and noted that the NMC had advised you that it would seek the imposition of a suspension order for a 6-to-12-month period, if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that a 12-month conditions of practice order is more appropriate in light of the panel's findings.

Mr Slack submitted that the most appropriate sanction, in light of the panel's findings, is a 12-month conditions of practice order.

Mr Slack submitted that to take no further action or to impose a caution order would not be appropriate in the circumstances, as it would not address the seriousness of this case.

Mr Slack referred to the NMC's guidance in consideration of a conditions of practice order, namely the points below:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*

- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

Mr Slack submitted that all of the above factors are true in this case. He submitted that it is entirely a matter for the panel as to what conditions of practice it deems appropriate in this case. He suggested that conditions relating to a Personal Development Plan (PDP), mentorship, and structured training in restraint techniques could be appropriate.

Mr Slack submitted that a suspension order and a striking-off order would be disproportionate in the circumstances.

Ms Molyneux submitted that she is partially in agreement with Mr Slack in so far as she accepts, based on the findings of the panel, that a conditions of practice order would be the most appropriate sanction to deal with the case, as it would mark the seriousness and give you an opportunity to continue working as a nurse. She submitted that she disagrees with the suggested conditions put forward by the NMC, and that it is a matter for the panel as to what conditions of practice it deems fit. She reminded the panel that any conditions imposed must be measurable, proportionate and necessary.

Ms Molyneux submitted that the panel has found it does not feel you have complete insight into your actions at this stage. She submitted that this seems to be an issue which only relates to public protection, and that the public interest is based on your potentially incomplete insight.

Ms Molyneux submitted that a conditions of practice order for 12 months would seem appropriate. However, if you complete the requirements in your conditions of practice

earlier, then it could be scheduled for an early review. She submitted that you do not need any further training in PMVA. She reminded the panel that it has not found your training and techniques were deficient in any way at the time, and this related to one incident which occurred a long time ago, in which you made some mistakes by not using your authority to direct others. She submitted that this is not indicative of someone who is deficient in training

Ms Molyneux reminded the panel that you continued to work in your role for a year after the incident, and you would have exercised a number of restraints and seclusion. She submitted that you were well trained at the time and you have undertaken training since, in addition to numerous reflective pieces, which address this.

Ms Molyneux submitted that the only requirements that should be put forward as suggested conditions would be to complete [PRIVATE], and to provide a full updated reflective piece which addresses what you could have done differently, what you recognised others did wrong and how [PRIVATE]. She submitted that no other conditions would apply, apart from possibly working in a role that prevents you from undertaking restraint techniques.

Ms Molyneux submitted that the panel need to consider the risk and how to appropriately mitigate that risk. She submitted that a 12-month conditions of practice order is appropriate, but not in the way the NMC has suggested, as it would be disproportionate. She accepted that there is some further work to be undertaken by you, but not to that level.

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 Sanctions Guidance (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:

- Patient A had multiple vulnerabilities;
- Conduct that put Patient A at risk of harm.

The panel also took into account the following mitigating features:

- A challenging working environment on a busy night shift which was short staffed;
- Your willingness to whistle blow and uphold standards;
- You were a young nurse in a new role of responsibility;
- Some level of insight and commitment shown by you, in order to prevent future incidents occurring, through training undertaken;
- [PRIVATE]; and
- Remorse and reflection demonstrated.

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

The panel 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 issues identified. 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 mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG and the related bullet points as previously indicated.

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with any conditions of practice imposed.

The panel acknowledged your efforts, commitment and the steps you have taken since the incident to address the concerns and strengthen your practice. You have also shown a level of remorse, reflection and insight into your actions, albeit your insight at this stage remains limited, as previously highlighted. The panel considered that you have recognised your need for [PRIVATE], and you have expressed a wish to return to nursing [PRIVATE]. The panel again considered that, you may be unable to address the concerns fully and demonstrate full objective insight, until [PRIVATE].

The panel agreed with Ms Molyneux in that it does not feel you need any further training at this stage, when considering the circumstances.

The panel had regard to the fact that this incident happened approximately four years ago and that, otherwise, you have had an unblemished record in your early career as a nurse to date. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case, for the same reasons as previously highlighted.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

<u>'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.'</u>

1. [PRIVATE].

2. Following [PRIVATE], you must provide a full and updated reflective piece that address the following, prior to the review hearing:
   - What you could have done differently;
   - What you recognise that others did wrong;
   - The impact of the incident from the patient's perspective;
   - The impact of the incident on the profession; and
   - [PRIVATE].

3. You must keep us informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

4. You must keep us informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.

b) Giving your case officer the name and contact details of the organisation offering that course of study.

5. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).
   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
   e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

6. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

7. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your continued engagement and attendance at the next hearing.
- References/testimonials, whether from paid or unpaid work.
- Evidence of your continuous professional development.

This will be confirmed to you in writing.

Interim order

As the conditions of practice 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 interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Slack. He submitted that an interim conditions of practice order should be imposed, on the same terms as highlighted above, for a period of 18 months to cover the 28-day appeal period.

The panel also took into account the submissions of Ms Molyneux. She submitted that it is usual in these proceedings that interim orders are imposed at this stage to cover a possible appeal. She submitted that it is a matter for the panel to consider whether one

is necessary and, if so, it should be imposed under the same terms as previously highlighted 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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be inconsistent with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover the 28-day appeal period.

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

That concludes this determination.