Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 25 – Friday 28 July 2023
Monday 31 July – Tuesday 1 August 2023
23 October 2023, 26 – 27 October 2023

Virtual Hearing

Name of Registrant:	**Chi Keung Chan**
NMC PIN	12I0872S
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nurse – Level 1 – September 2015
Relevant Location:	Renfrewshire
Type of case:	Misconduct
Panel members:	Paul O'Connor (Chair, Lay member) Sally Underwood (Registrant member) Stacey Patel (Lay member)
Legal Assessor:	John Moir (25 – 31 July 2023, 1 August 2023, 23 October 2023) Gareth Jones (26 October 2023) Charles Apthorp (27 October 2023)
Hearings Coordinator:	Dilay Bekteshi (25 – 28 July 2023, 23 October 2023, 26 – 27 October 2023) Elena Nicolaou (31 July and 1 August 2023)
Nursing and Midwifery Council:	Represented by Anna Leathem, Case Presenter
Mr Chan:	Not present and not represented at the hearing
Facts proved by admission:	Charges 3 and 23
Facts proved:	Charges 2, 10, 11, 12, 14 and 20

Facts not proved:	Charges 1, 4, 5, 6, 7, 8, 9, 13, 15, 16, 17, 18, 19, 21 and 22
Fitness to practise:	Currently impaired
Sanction:	Suspension order (6 months)
Interim order:	Interim suspension order (18 months)

Representative's non-attendance

Ms Leathem, on behalf of the Nursing and Midwifery Council (NMC) informed the panel that neither Mr Chan nor his representative are in attendance. She told the panel that Mr Chan's representative had been instructed by the Royal College of Nursing (RCN) that a representative is not to attend where the registrant is not attending. Ms Leathem referred the panel to the correspondence between her and Mr Chan's representative where his representative confirms that those are her instructions and that she will not be attending the hearing physically, but she requests to send in written submissions at each stage of the proceedings.

The panel heard advice from the legal assessor. He advised the panel that there is no prohibition against the representative appearing without the registrant in person. He also advised that the proposal for the representative to make further written submissions is a matter for the panel's consideration in regulating its own proceedings in a manner that is fair to both the NMC and Mr Chan.

The panel determined that it was Mr Chan's representative's choice not to be in attendance. It has been pointed out to them by the NMC that the representative can attend irrespective of Mr Chan's non-attendance. The panel also decided that if the representative wishes to provide written submissions during the three stages, should the hearing get that far, then that is for them to do so.

Proposed redactions made on behalf of Mr Chan

Ms Leathem referred the panel to the 'Preliminary Issues' document submitted by Mr Chan's representative on day 1 of the hearing. Ms Leathem said that the document deals with Mr Chan's objections to parts of the bundle including Colleague A and Witness 2's evidence. She told the panel that Mr Chan's representative made reference to parts of the Local Investigation Meeting Minutes dated 25 February 2020 and stated the following in her written submissions:

> *"This should be redacted because it refers to abuse which extends the scope of the allegations and the nature of the allegations and is not mentioned specifically within the allegations, nor has it been directly charged. This is therefore prejudicial to my client and the seriousness of the allegations asserted against him which he denies. It may be asserted by the NMC that the registrant's immediate reactions to the allegations is relevant. This is not relevant as the local investigation when carried out has different parameters than the NMC investigation and the registrant has not been charged with abusing residents. If this is what the NMC has alleged, then this should have been charged from the outset. This terminology has been put the registrant in a different context and setting and therefore cannot be the backdrop to the NMC case where the charges and parameters are different. The case of Enemuwe v NMC [2015] EWHC 2081 (Admin) make it clear that local investigations can only be admissible to assist in the context of a case and the findings of those other investigations should not themselves be admitted ore relied upon. It is my submission that this terminology extends the extent and scope of the allegations that has been charged against the registrant and that he has not had fair notice to directly respond to the implied position of the NMC. Given the implications of such assertions, the NMC should have charged this if there had been allegations of abuse. The panel will also have in mind that there has been no police intervention or care commission if there had been allegations of abuse."*

Ms Leathem submitted that Mr Chan's immediate reaction to the allegation that he abused the resident does not extend the scope or nature of the allegations. She submitted that Mr

Chan's initial reaction to the concerns of abuse within the context of that interview is relevant to the charges. She submitted that this is merely part of the evidence, and it is not their finding that abuse took place and that it is simply Mr Chan's reaction to that allegation being put to him. Ms Leathem therefore submitted that it is of relevance to what the panel is considering in this case.

Ms Leathem further referred the panel to the witness statement of Witness 1, in particular paragraphs 42, 43, 44, 45, 53 and exhibit [Colleague A]/12 'Resident A Support and rest assessment' 15 January 2019. Mr Chan's representative invited the panel to redact paragraphs 42, 43, 44, 45, 53 and stated the following:

In respect of paragraphs 42 – 45: *"This has not been charged and is not featured in the allegations and therefore is not relevant. To include is prejudicial and seeks to extend the scope of the allegations. The supporting exhibits should also be redacted as they not relevant to the allegations as charged and their inclusion is prejudicial. The NMC may assert this underpins their case in respect of being probative to the registrant struggling and in that he thought the registrant exercising attention seeking behaviour which has not been charged and if there had been this assertion this should have been explicitly charged."*

In respect of paragraph 53: *"This should be redacted as it is not featured in the allegations, and they seek to extend the scope of the allegations. Furthermore, they are the opinions of a person who was not a direct witness to alleged behaviour which my client does not accept. She is not an expert, and this opinion is prejudicial as it extends the scope of the character of the allegations. There has been no allegations of violence or assault towards any residence. The person who makes this statement did not directly witness this behaviour and therefore is not relevant to the direct actions if they happened or not, she is merely at a local level offering her opinion without having seen the actions and has arrived at this terminology second hand and should therefore be disregarded."*

Ms Leathem submitted that the paragraphs 42 – 45 in Witness 1's statement refer to Mr Chan stating that Resident A was displaying attention seeking behaviour by calling out a nurse and screaming. She submitted that it is the NMC's case that the charges are underpinned by Mr Chan's attitude towards Resident A. She therefore submitted that this is a relevant consideration for the panel. Ms Leathem further submitted that exhibit [Colleague A]/12 is relied upon by Colleague A as supporting the fact that Resident A likes to be asked by staff if they would like to get up. She therefore submitted that this would go towards the panel's consideration in charge 12.

Ms Leathem further submitted that it is the representative's position that paragraph 53 of Witness 1's statement should be redacted as it is not a feature of the allegations. However, Ms Leathem submitted that violence or abuse is underpinned by a significant number of charges either in the form of the words or physical actions such as the alleged slapping.

Ms Leathem further referred the panel to the witness statement of Witness 2, in particular parts of paragraph 23. She told the panel that Mr Chan's representative submits that it is hearsay evidence which is not alleged and is prejudicial in manner. In Mr Chan's representative's written submissions, it states the following: "*This is hearsay evidence which is not alleged and is prejudicial in nature. The person who is deemed to have said it has not provided a witness statement nor are they being called as a witness and therefore the context of the hearsay statement cannot be explored. It therefore should be deleted. It may be asserted by the NMC that it explains why the witness did not explain it, yet she states that she did not understand what the person [colleague] meant by this, therefore there is no context to this, and "[colleague]" is not available to provide live evidence or a witness statement.*"

Ms Leathem submitted that paragraph 23 of Witness 2's witness statement is evidence of what was said to Witness 2 by another colleague. As such, any questions about what was said to Witness 2 can be explored by way of questions during her evidence. Ms Leathem therefore submitted that this does not prejudice Mr Chan.

In closing submissions, Ms Leathem submitted that the preliminary issues raised by Mr Chan's representative and the redactions they are seeking are the ones that the NMC and the representative could not agree with in advance. She therefore invited the panel to consider the proposed redactions sought by Mr Chan's representative.

The panel heard and accepted the advice of the legal assessor.

In respect of the issue of redactions, the panel has agreed to redact paragraphs 43, 45 and 53 from Witness 1's witness statement because it is of the view that Witness 1's evidence related to conclusions she had reached as fact finder in the local disciplinary hearing which was not appropriate for it to have regard to.

In terms of Witness 2's witness statement, the panel agree that the sentence proposed in paragraph 23 should be redacted as it is based on hearsay evidence, it is prejudicial, and it cannot be tested. On that basis, the panel decided to redact that portion of paragraph 23 as it is unfair.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Chan was not in attendance and that the Notice of Hearing letter had been sent to Mr Chan's registered email address by secure email on 22 June 2023.

Further, the panel noted that the Notice of Hearing was also sent to Mr Chan's representative at the RCN on 22 June 2023.

Ms Leathem submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Chan's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Chan

The panel next considered whether it should proceed in the absence of Mr Chan. It had regard to Rule 21 and heard the submissions of Ms Leathem who invited the panel to continue in the absence of Mr Chan. She submitted that Mr Chan had voluntarily absented himself. Ms Leathem referred the panel to the documentation where Mr Chan and his representative confirmed that they will not attend. Ms Leathem said that Mr Chan and his representative have submitted a 'Registrant's Bundle' outlining Mr Chan's position. She submitted that this alleviates any concern with Mr Chan not being able to properly present his case.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mr Chan. In reaching this decision, the panel has considered the submissions of Ms Leathem, the representations made on Mr Chan's behalf, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Chan;
- Mr Chan and his representative have informed the NMC that Mr Chan has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- Mr Chan has provided a 'Registrant's bundle' and further written submissions will be provided at each stage of the proceedings;

- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Two witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019 and 2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

The panel considered that there may be some disadvantage to Mr Chan in proceeding in his absence, as although the evidence upon which the NMC relies will have been sent to him at his registered address, Mr Chan will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf.

However, in the panel's judgement, this can be mitigated as the panel has received Mr Chan's responses to the charges and his representative has proposed that she will be sending written submissions at each stage of the proceedings to outline Mr Chan's position. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Chan's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Chan. The panel will draw no adverse inference from Mr Chan's absence in its findings of fact.

Details of charges (in the notice)

That you, a registered nurse:

1) On 22 December 2019, failed to complete a safeguarding referral form and/or incident form after Resident A suffered a fall.

   On 08 January 2020:

2) Contrary to Resident A's care plan which did not allow for her movement to be managed in this way, restrained Resident A by placing two chairs either side of her as a form of barricade

3) Told Resident A to "shut up".

4) Failed to complete neurological checks on Resident A every 30 minutes for the first 6 hours following her fall.

5) Failed to call NHS 111 for assistance in managing resident A's injury.

6) Failed to ensure that Resident A had a crash mat when in bed and/or sleeping in the chair to minimise the risk of injury to Resident A.

7) Failed to make a RADAR Report entry on the in house reporting system for Resident A.

8) Failed to document in Resident A's care notes that she did not wish to sleep in her bed.

9) Failed to update Resident A's care plan with regards to her mobility needs and/or her sleeping habits and/or her care needs

10) Said to Resident A “I warned you about this, you will fucking die tonight” or words to that effect.

11) Repeatedly slapped Resident A’s hand away when she tried touching her eye, when you were attempting to clean her eye following a fall.

12) Threated Resident A by telling her “she would be staying on the floor, she does this all the time” or words to that effect.

13) Refused to help Resident A get off the floor.

14) Told Resident A “no, you’re staying on the floor, that’ll teach you” or words to that effect.

15) Incorrectly told colleague A that Resident A fell from her bed when she did not.

16) Your actions at charge 15) were dishonest as you knew Resident A did not fall from her bed and you were seeking to cover up the fact that you had let her sleep in a chair in the quiet room.

17) Failed to complete a safeguarding referral form for Resident B following Resident B’s altercation with another resident.

18) Restrained Resident B by pushing against Resident B in a “chest to chest” manner

19) On unknown dates, failed to attend to calls for assistance from Resident A

20) On 20^{t} January 2019, did not update Resident C’s rest and care plan.

21) Incorrectly stated to Colleague A that you had updated Resident C's rest and care plan.

22) Your actions at charge 15) were dishonest as you knew you had not updated Resident C's rest and care plan and you were attempting to give a misleading account of the care that you had provided.

23) On an unknown date, told Resident D to 'fuck off' or said words to that effect.

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

Decision and reasons on application to amend the charges

The panel heard an application made by Ms Leathem to amend the wording of charges 1, 2, 8, 9, 10 and 22. It was submitted by Ms Leathem that the proposed amendments would provide clarity and more accurately reflect the evidence.

Original wording of charge 1

1. *On 22 December 2019, failed to complete a safeguarding referral form and/or incident form after Resident A suffered a fall.*

Proposed amendment to charge 1

1. *On 22 December 2019, failed to complete a safeguarding referral form and/or incident form after Resident A ~~suffered a fall.~~ was observed to have an injury on her face and blood on her hands and face.*

Original wording of charge 2

2. *Contrary to Resident A's care plan which did not allow for her movement to be managed in this way, restrained Resident A by placing two chairs either side of her as a form of barricade.*

Proposed amendment to charge 2

2. *Contrary to Resident A's care plan which did not allow for her movement to be managed in this way, restrained Resident A by placing a couch or sofa on one side of Resident A's chair with a wall to the other side of the chair ~~two chairs either side of her~~ as a form of barricade.*

Original wording of charge 8

On 08 January 2020:

8. *Failed to document in Resident A's care notes that she did not wish to sleep in her bed.*

Proposed amendment to charge 8

8. *On an unknown date, failed to document in Resident A's care notes that she did not wish to sleep in her bed.*

Original wording of charge 9

On 08 January 2020:

9. *Failed to update Resident A's care plan with regards to her mobility needs and/or her sleeping habits and/or her care needs*

Proposed amendment to charge 9

9. *On an unknown date, failed to update Resident A's care plan with regards to her mobility needs and/or her sleeping habits and/or her care needs*

Original wording of charge 10

10. *Said to Resident A "I warned you about this, you will fucking die tonight" or words to that effect.*

Proposed amendment to charge 10

10. *Said to Resident A "I warned you about this, you will fucking die tonight" or words to that effect. [no change to this charge but insertion of 'On 8 January 2020' before it].*

Original wording of charge 22

22. *Your actions at charge 15) were dishonest as you knew you had not updated Resident C's rest and care plan and you were attempting to give a misleading account of the care that you had provided.*

Proposed amendment to charge 22

22. *Your actions at charge ~~15)~~ 21 were dishonest as you knew you had not updated Resident C's rest and care plan and you were attempting to give a misleading account of the care that you had provided.*

The panel considered the written submissions by Mr Chan's representative in respect of the proposed amendments by the NMC. Mr Chan's representative accepted the proposed amendments for charges 2 and 22 to ensure clarity and to correct the typographical error in charge 22. However, in respect of charges 1, 2, 8, 9 and 10, Mr Chan's representative opposed the amendments and stated the following:

> *"Charge 1 - This is not simply to amend the charge for clarity, the underpinning action that the registrant has been charged with not following procedures was originally around the action of the registrant haven fallen. This has been put to him in the local investigation, the NMC investigation, the Case Examiner's Response, and any other correspondence. The amended allegations have not been directly put to him and this is a completely different action that the NMC are proposing to amend the allegations to which contrary to fairness. If it had been the NMC position to charge misconduct for an injury, the original allegation makes no reference to an injury at all and is centred on the proposition of a "fall". For this reason we oppose this amendment.*

Charge 8/9 - We oppose the amendment to this allegation. The previous framing of the allegation provided specification to a date which had been listed in the original allegation as being "08 January 2020" which is the date the registrant has always responded to in terms of his recollection of events and is a firm anchor point for reference. It is the registrant position that removing the specific frame makes the charge ambiguous and given that the registrant has worked there for a significant period of time, leaves this allegation spanning his entire employment with this Unit. This is also contrary to fairness and breaches the principal of fair notice given to registrants. The original allegation which has been anchored to this date, the registrant was able to respond adequately to and removal of this date leaves the charge open ended, and responding to a general obligation and beyond the scope upon which it has been charged, which is to that period of time.

Charge 10- This is already the case as the overarching limb refers to "On 8 January 2020". There is no requirement for change and is an arbitrary request on behalf of the NMC."

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

Charge 1 - The proposed amendments were sent to Mr Chan and his representative during the hearing on 25 July 2023 and the panel was asked to consider the amendments on 26 July 2023. The panel was of the view that it is far too late in the day for the proposed amendment to be presented to Mr Chan by the NMC, given all the history and correspondence that has taken place with this case. It determined that the further amendment as applied for, was not in the interest of justice and that the amendment at this stage would be unfair to Mr Chan. The panel rejected Ms Leathem's application in this instance.

Charge 2 - The panel heard that both the NMC and Mr Chan are in agreement. The panel determined that it was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy. The panel was therefore satisfied that there would be no prejudice to Mr Chan and no injustice would be caused to either party by the proposed amendment being allowed.

Charges 8 and 9 - The panel decided to reject the proposed amendments. It was of the view that the proposed amendment to change '8 January 2020' to 'an unknown date' is unjust given the openness and ambiguity that is created by referring to an unknown period of time and provides a lack of specification which would effectively cover the entirety of Mr Chan's employment.

Charge 10 - The panel determined that the proposed amendment for charge 10 is unnecessary as the panel has rejected the proposed amendments to charge 8 and 9.

Charge 22 - The panel noted that both sides acknowledge that this it is a mere typographical error, and therefore it accepted the amendment. The panel was therefore satisfied that there would be no prejudice to Mr Chan and no injustice would be caused to either party by the proposed amendment being allowed.

Details of charge (as amended)

That you, a registered nurse:

1) On 22 December 2019, failed to complete a safeguarding referral form and/or incident form after Resident A suffered a fall.

   On 08 January 2020:

2) Contrary to Resident A's care plan which did not allow for her movement to be managed in this way, restrained Resident A by placing a couch or sofa on one side of Resident A's chair with a wall to the other side of the chair as a form of barricade

3) Told Resident A to "shut up".

4) Failed to complete neurological checks on Resident A every 30 minutes for the first 6 hours following her fall.

5) Failed to call NHS 111 for assistance in managing resident A's injury.

6) Failed to ensure that Resident A had a crash mat when in bed and/or sleeping in the chair to minimise the risk of injury to Resident A.

7) Failed to make a RADAR Report entry on the in house reporting system for Resident A.

8) Failed to document in Resident A's care notes that she did not wish to sleep in her bed.

9) Failed to update Resident A's care plan with regards to her mobility needs and/or her sleeping habits and/or her care needs

10) Said to Resident A “I warned you about this, you will fucking die tonight” or words to that effect.

11) Repeatedly slapped Resident A’s hand away when she tried touching her eye, when you were attempting to clean her eye following a fall.

12) Threated Resident A by telling her “she would be staying on the floor, she does this all the time” or words to that effect.

13) Refused to help Resident A get off the floor.

14) Told Resident A “no, you’re staying on the floor, that’ll teach you” or words to that effect.

15) Incorrectly told colleague A that Resident A fell from her bed when she did not.

16) Your actions at charge 15) were dishonest as you knew Resident A did not fall from her bed and you were seeking to cover up the fact that you had let her sleep in a chair in the quiet room.

17) Failed to complete a safeguarding referral form for Resident B following Resident B’s altercation with another resident.

18) Restrained Resident B by pushing against Resident B in a “chest to chest” manner

19) On unknown dates, failed to attend to calls for assistance from Resident A

20) On 20th January 2019, did not update Resident C’s rest and care plan.

21) Incorrectly stated to Colleague A that you had updated Resident C's rest and care plan.

22) Your actions at charge 21) were dishonest as you knew you had not updated Resident C's rest and care plan and you were attempting to give a misleading account of the care that you had provided.

23) On an unknown date, told Resident D to 'fuck off' or said words to that effect.

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

Background

Mr Chan was employed as a Registered Nurse at the Braemount Care Home (the Home), caring for people with dementia. He was referred to the NMC on 19 March 2020 by the Regional HR Manager for Advinia Healthcare Ltd, following receipt of an anonymous referral submitted to Advinia on the 15 January 2020.

On 21 - 22 December 2019 Resident A suffered a cut to her face. Mr Chan was on duty and made an entry in the patient notes but it is alleged that he did not complete a safeguarding referral form, an incident report nor entered the incident on the reporting system (RADAR).

On 8 January 2020 in the Quiet Room, it is alleged that Mr Chan restrained Resident A in her chair by pushing another piece of furniture up against one side of her chair, trapping her in and restricting her freedom to move.

Later the same evening at 23:00 Resident A was found on the floor in the Quiet Room. She had fallen from the chair. Mr Chan was present. Mr Chan is alleged to have told Resident A to “shut up” and proceeded to slap her hand on two or three occasions and become verbally aggressive towards her. Furthermore, it is alleged that Mr Chan did not complete observations immediately following the fall nor did he take appropriate steps. Mr Chan completed his notes stating the resident missed the crash mat in her bedroom when it is alleged there was no crash mat in place, and further asserted that the incident took place in Resident A's bedroom as opposed to the Quiet Room.

It has also been alleged Mr Chan suggested Resident A slept on the floor for the night, refused to allow care staff to assist Resident A off the floor and allegedly failed to wake Resident A while she was sleeping to perform observations.

In the lounge area, it is alleged Resident B had an altercation with another resident about his glasses. It is alleged Mr Chan went “chest to chest” with Resident B pushing him backwards causing him to fall back into his chair.

Mr Chan suggests in his local interview that he completed the care plan for Resident C. The care plan was checked at the disciplinary and found to be completed by another staff member in January 2019.

Decision and reasons on facts

At the outset of the hearing, the panel was presented with a Case Management Form (CMF) which was signed and dated by Mr Chan on 20 March 2023. In this CMF, Mr Chan made full admissions to charges 3 and 23.

The panel therefore finds charges 3 and 23 proved in their entirety, by way of Mr Chan's admissions.

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 Ms Leathem on behalf of the NMC and documentary evidence and submissions provided by Mr Chan's representative.

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

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:

- Colleague A / Witness 1: Home Manager at Elderslie Care Home at the time;

- Witness 2: Care Assistant at Braemount Care Home at the time.

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 Mr Chan.

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

Charge 1

1) *On 22 December 2019, failed to complete a safeguarding referral form and/or incident form after Resident A suffered a fall.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered the term ’failure’ as worded in the charge, which would suggest that Mr Chan had a duty upon him to complete the task described in the charge.

The panel considered that there is no evidence that Resident A had actually fallen, as she was found sitting on the side of her bed.

The panel considered that the only evidence before it is from Colleague A who said that she was there to simply undertake a disciplinary meeting, and that she did not know how the manager ensured staff were made aware of the policies and procedures, and she did not have those in front of her during the disciplinary meeting.

The panel was of the view that the NMC, on the balance of probabilities, have not satisfactorily demonstrated that there was a duty on Mr Chan in the first place to complete the safeguarding referral form and/or incident form. The panel considered that this was an unwitnessed event and Mr Chan used his judgement at the time to come to a conclusion

that seemed reasonable about how the injury appeared on Resident A. The panel could see how Mr Chan reached his judgement that Resident A had not suffered a fall.

The panel considered that the NMC has failed to produce specific policies and procedures for the Home that were applicable at the time, and whether it was required of Mr Chan to complete a form following this event. Further, Mr Chan's interpretation of what may have led to Resident A's small injury to her face and blood on her hands is one that appears consistent and believable given Resident A's tendency to scratch and pick at her skin. There is no link between his interpretation of how the event happened and whether or not a safeguarding referral and/or incident form was required. The panel noted that Mr Chan did record Resident A's injury in her notes, and he made reference to this during his handover in that he passed it on as being self-inflicted by Resident A.

The panel also considered the training records that were referred to by Ms Leatham, but these did not assist the panel in demonstrating that a duty upon Mr Chan existed.

Therefore in light of the above, and on the balance of probabilities, the panel finds charge 1 not proved.

Charge 2

On 08 January 2020:

2) *Contrary to Resident A's care plan which did not allow for her movement to be managed in this way, restrained Resident A by placing a couch or sofa on one side of Resident A's chair with a wall to the other side of the chair as a form of barricade*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that there is clear evidence from Witness 2 about how she found Resident A's chair up against the wall with the sofa pushed against it. During the disciplinary interview, Mr Chan admitted to performing this manoeuvre at the time.

The panel believed that Mr Chan had no malicious intent in this manoeuvre, and that he was just trying to maintain Resident A's safety in the circumstances following her earlier accident. Nevertheless, Mr Chan did undertake a manoeuvre that was not included in her care plan. The panel considered that this had not been assessed as being safe to undertake.

Therefore in light of the above, the panel finds charge 2 proved.

Charge 4

4) *Failed to complete neurological checks on Resident A every 30 minutes for the first 6 hours following her fall.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it. It considered that its reasons for its findings on charge 4 are similar to those in charge 1.

The panel considered the term 'failure' as worded in the charge, which would suggest that Mr Chan had a duty upon him to complete the task described in the charge.

The panel considered that, based on the evidence before it, it is not clear whether there was a duty upon Mr Chan to complete the neurological checks. It considered that the NMC have not provided enough evidence to suggest that this was the case, especially in the absence of any policies or procedures. The panel was satisfied that it was appropriate that Mr Chan had used his clinical judgement.

Therefore, in light of the above, the panel found charge 4 not proved.

Charge 5

5) *Failed to call NHS 111 for assistance in managing resident A's injury.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it. It considered that its reasons for its findings on charge 5 are similar to those in charge 4.

The panel considered the term 'failure' as worded in the charge, which would suggest that Mr Chan had a duty upon him to complete the task described in the charge.

The panel considered that the NMC have not provided enough evidence to indicate that there was a duty upon Mr Chan to ensure that NHS 111 was called. Mr Chan does have professional capacity and he made that judgement at the time of the incident, in that he did not believe he needed to call NHS 111. The panel have not seen anything on the contrary to suggest he should have done otherwise. The panel has noted that Mr Chan undertook a full top-to-toe assessment of Resident A, which he signed.

Therefore, in light of the above, the panel finds charge 5 not proved.

Charge 6

6) *Failed to ensure that Resident A had a crash mat when in bed and/or sleeping in the chair to minimise the risk of injury to Resident A.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered the term 'failure' as worded in the charge, which would suggest that Mr Chan had a duty upon him to complete the task described in the charge.

The panel has heard evidence that it was not routine to provide crash mats for residents sleeping in chairs, as it would be an obstruction and a falls risk. The panel has heard evidence that Resident A did have a crash mat and pressure sensor when she was in bed.

Colleague A, in her oral evidence, stated that although assessments were on an individual basis regarding the use of pressure sensor mats for chairs which trigger an alarm when the resident leaves the chair, there is no evidence that Resident A had been assessed for one or required one.

The panel considered that there is no direct evidence before it to suggest that there should have been a crash mat, when Resident A was sleeping in a chair.

Therefore, in light of the above, the panel found charge 6 not proved.

Charge 7

7) *Failed to make a RADAR Report entry on the in house reporting system for Resident A.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that the NMC have not discharged the burden of proof in order to find this charge proved. Mr Chan had no log in details to record the RADAR entry at the time. The panel also noted the NMC's comments on this charge that support the panel's decision.

Therefore, in light of the above, the panel found charge 7 not proved.

Charge 8)

8) *Failed to document in Resident A's care notes that she did not wish to sleep in her bed.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered the term 'failure' as worded in the charge, which would suggest that Mr Chan had a duty upon him to complete the task described in the charge.

The panel considered that there is no evidence before it that suggests Mr Chan had written that Resident A wished to sleep in her bed in the care notes. The panel also noted that it does not have sight of Resident A's care notes.

Colleague A's evidence was that Mr Chan should have asked Resident A directly if she wished to sleep in her chair and encouraged her to sleep in her bed, rather than remain in her 'bucket chair' in the quiet room. Witness 2 said that Mr Chan did not ask Resident A about this, and that he would always put her in her chair and take her to the quiet room which was across from the nurses station, as she did not like being alone. Witness 2 continued to say in direct evidence that Resident A could settle in her chair and get a good night's sleep. The panel noted that Resident A's preference to sleep in the quiet room was recorded in her care plan. The panel noted that Colleague A did not directly work at the Home and admitted that she had limited knowledge of the procedures at the Home.

The panel considered that there is insufficient evidence to suggest that Mr Chan failed to document the above in Resident A's care notes.

Therefore, in light of the above, the panel found charge 8 not proved.

Charge 9

9) *Failed to update Resident A's care plan with regards to her mobility needs and/or her sleeping habits and/or her care needs*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it. The panel considered that its reasons for its findings on charge 9 are similar to those in charge 8.

The panel considered the term 'failure' as worded in the charge, which would suggest that Mr Chan had a duty upon him to complete the task described in the charge.

For the same reasons above in charge 8, the panel considered that there is no direct evidence that relates to this charge, and it is unclear what should have been included in the care plan. It considered that the NMC have not provided sufficient evidence to indicate what was actually required of Mr Chan in relation to Resident A's care plan.

The panel noted Colleague A's evidence in which she stated that information about the residents sleeping patterns could be included in the care plan by a Healthcare Assistant.

Therefore, in light of the above, the panel found charge 9 not proved.

Charge 10)

10) *Said to Resident A "I warned you about this, you will fucking die tonight" or words to that effect.*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered the clear evidence of Witness 2, in that she was adamant this is what was said by Mr Chan. Mr Chan's evidence is that Witness 2 described this in two different ways during the local investigation and in her NMC witness statement. However, when Witness 2 was asked during her oral evidence if Mr Chan made the comment in an angry/threatening way, she said that he had, and she was shocked to hear this as she had never heard him swear before or become angry or irritated with residents.

The panel considered Witness 2's evidence to be consistent and credible. She spoke highly of Mr Chan's care of Resident A generally. It was apparent that Witness 2 had no animosity towards Mr Chan.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 10 proved.

Charge 11

11) Repeatedly slapped Resident A's hand away when she tried touching her eye, when you were attempting to clean her eye following a fall.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

Witness 2 was clear in her evidence that there was nothing obstructing her view at the time of the incident and she was kneeling next to Resident A who was on the floor. She could clearly see Mr Chan slapping Resident A's hand away as he was trying to clean her eye. The panel heard evidence that there were other methods of dealing with Resident A at the time, and Witness 2 said she could have assisted Mr Chan if he has asked for help. In fact, Witness 2 did eventually take Resident A's hands in hers to assist Mr Chan.

The panel considered however that Witness 2 stated Mr Chan did not slap Resident A's hand hard, and it would not have been forceful enough to leave a bruise.

The panel considered Witness 2's evidence to be consistent and credible.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 11 proved.

Charge 12

12) *Threated Resident A by telling her "she would be staying on the floor, she does this all the time" or words to that effect.*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

Witness 2's evidence was that Resident A was on the floor for 20 to 30 minutes following her fall, and she felt that Mr Chan's comment to Resident A was inappropriate. The panel considered Witness 2's evidence to be consistent and credible and noted that she was shocked to hear his comment as she had never heard him talk to residents in such manner before, or become angry or irritated with residents.

The panel considered that, taking into account the evidence it has already seen and heard in relation to Mr Chan swearing at Resident A and slapping her hand, he more likely than not did make this comment.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 12 proved.

Charge 13

13) Refused to help Resident A get off the floor.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that, from hearing evidence that Resident A was on the floor for 20 to 30 minutes, it would have likely taken that amount of time to wash Resident A's eye wound, undertake her observations, check for injuries, and ensure that she was sufficiently fit to be assisted back into her chair. The panel did not consider it to be unreasonable not to assist Resident A off the floor until after that time had passed and those checks had been done.

The panel felt that, despite what Mr Chan said to Resident A, he did not intend to leave her on the floor for a significant amount of time. The panel considered that, as Resident A had fallen, he would not have been able to assist her up straight away in any event as he would need to check for any injuries first.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 13 not proved.

Charge 14

14) *Told Resident A "no, you're staying on the floor, that'll teach you" or words to that effect.*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it. The panel considered that its reasons for its findings on charge 14 are similar to those in charge 12.

The panel considered that Witness 2 was clear and consistent in her evidence about this incident, in that when Resident A was on the floor, Mr Chan had made the comment as charged above. The panel considered that this also links with Witness 2's witness statement.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 14 proved.

Charge 15

15) Incorrectly told colleague A that Resident A fell from her bed when she did not.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered Witness 2's evidence, in which she was adamant that this incident occurred in the quiet room, and was descriptive about this. Mr Chan's evidence is that Resident A fell from her bed.

The panel considered that Mr Chan described alarms sounding from Resident A's bedroom as well as the timing of the incident, which is inconsistent with Witness 2's evidence. The alarms are located around the Home and record the time and location when activated. The panel has not had the opportunity of hearing Mr Chan provide live evidence, although he has provided a detailed explanation for this event in his written submission.

The panel considered that Mr Chan stated he witnessed this incident occur in Resident A's bedroom. There is no clear evidence before the panel that he told Colleague A that Resident A fell from her bed, as he denies the accuracy of the disciplinary hearing notes and had not had an opportunity to correct them or sign them at the time.

Colleague A was not taken to this aspect during her oral evidence, and there is no evidence that this document was used by her during the disciplinary meeting. The panel considered that the fact Mr Chan has documented this on the form does not prove that he had that conversation with Colleague A.

The panel considered that there is insufficient clarity around this incident about what was implied and what was actually said for the NMC to prove this charge. There is also no evidence from cross examination of the witnesses to corroborate this information.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 15 not proved.

Charge 16

16) *Your actions at charge 15) were dishonest as you knew Resident A did not fall from her bed and you were seeking to cover up the fact that you had let her sleep in a chair in the quiet room.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that as charge 15 was found not proved, charge 16 is also found not proved.

Charge 17

17) Failed to complete a safeguarding referral form for Resident B following Resident B's altercation with another resident.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it. The panel considered that its reasons for its findings on charge 17 are similar to those in charge 1.

The panel considered the term 'failure' as worded in the charge, which would suggest that Mr Chan had a duty upon him to complete the task described in the charge.

The panel considered that the NMC have not provided sufficient evidence to indicate that there was a duty upon Mr Chan to complete a safeguarding referral form.

The panel considered Colleague A's evidence that she would usually be the person to complete the referral forms in her workplace, and that she would not expect a nurse to undertake this task. Colleague A also told the panel that there were differences between the Home's as to who was responsible for completing the forms. The panel considered that there is no evidence from Colleague A to indicate that there was any duty on Mr Chan to complete this form.

The panel considered Witness 2's evidence in that she said she was too far away and did not did clearly see what happened at the time. In relation to needing a form to be completed in the first place, the panel have not been given any evidence to indicate that this should have happened, and it was satisfied that there was no physical contact between the two residents.

The panel has also seen evidence from the internal investigation report that two healthcare assistants were on the scene at the time, and they had no concerns.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 17 not proved.

Charge 18

18) Restrained Resident B by pushing against Resident B in a "chest to chest" manner

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered Colleague A's evidence in which she said that Mr Chan demonstrated a chest-to-chest movement during the disciplinary meeting, but in her oral evidence she referred to it as toe-to-toe.

The panel considered Witness 2's evidence in that she said Mr Chan had reacted well and had a duty to both of the residents. The panel noted that Mr Chan had no training from Advinia in dealing with challenging behaviour, but he had undertaken regular practice sessions with BUPA. Mr Chan's evidence is that he felt it was appropriate at the time.

The panel considered that it could not see what else Mr Chan could have done at the time, as he had medication and a drink in his hand.

Witness 2 also said that she did not see any physical contact, and that she would have seen this clearly had it been a chest-to-chest movement. The panel also noted that it had no evidence from any witness who saw the incident first hand.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 18 not proved.

Charge 19

19) On unknown dates, failed to attend to calls for assistance from Resident A

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that this charge in itself is vague, as it covered the whole period of Mr Chan's employment with Advinia. It considered the evidence of Colleague A who explained how Resident A would often call out for assistance, although it noted that Colleague A had never worked with or met Resident A.

The panel heard evidence from Witness 2 that Resident A would call out, and that this was something she did often for attention. She said it would not be considered a failure if nobody attended to Resident A every time as she usually did not need assistance. She told the panel that there were many residents in the Home and not enough staff, and she said Resident A was not always distressed when she called out.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 19 not proved.

Charge 20

20) On 20th January 2019, did not update Resident C's rest and care plan.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that Mr Chan did not commence his employment with the Home until July 2019, so he could not have been the person to update Resident C's plan at the time. Mr Chan could not have had anything to do with this resident or updating the care plan. The panel considered that this charge is factually correct, but it is not a fault of Mr Chan.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 20 proved.

Charge 21

21) Incorrectly stated to Colleague A that you had updated Resident C's rest and care plan.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that Mr Chan had stated that he completed a new 'night support plan' during the investigation meeting, which is also known as a 'sleep and rest plan'. Mr Chan stated that he updated the care plan, however there is no evidence to suggest that what Mr Chan said is incorrect, as the NMC has produced no evidence to indicate that this is the case.

The panel considered that although Mr Chan stated that he had updated the night support plan, the panel have not had sight of this document. The panel noted that it has had sight of a 'rest and support plan', dated 6 February and 6 March 2019, but this again predates Mr Chan's employment with the Home. The panel have not had sight of an up-to-date plan.

The panel considered that the charge refers to a plan that does not appear to exist from the evidence before it. However, it noted that Mr Chan refers to updating a plan which Colleague A accepted, in response to panel questions, was not searched for by the Home during the investigation.

Therefore in light of the above, and on the balance of probabilities, the panel found charge 21 not proved.

Charge 22

22) *Your actions at charge 21) were dishonest as you knew you had not updated Resident C's rest and care plan and you were attempting to give a misleading account of the care that you had provided.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that as it found charge 21 not proved, it also finds charge 22 not proved.

Decisions and reasons on an application to adjourn the hearing

The panel received an application to adjourn the hearing, via email, from Mr Chan's representative following the panel's decision on the facts.

The written submissions are as follows:

1. *'This matter was originally tabled Friday 4th August and it is the NMC which amended the time table offering less days for this matter to be heard and it is no fault of the registrant that this hearing cannot be considered in one diet.*

2. *The Facts stage has now been concluded and the determination having been handed down substantially alters the original position asserted by the NMC, I have not had the full chance to read the panels 39 page determination, nor have I had the chance to take instruction on the matter for stage 2.*

3. *Each of the stages is a discrete stage, and case law is clear that they must all be considered separately. I therefore would like to reserve the position to take instruction as there is another 3 dates listed for the end of October with the NMC not calling any further witnesses. Given that stage 2 is a professional matter for the panel, stage 2 is important for any registrant to demonstrate their insight in relation to the proved facts and at this moment I am unable to do that. Therefore, to proceed without giving the registrant the opportunity to review the finding of the panel and potentially attend the next diet or offer a fresh reflection would be contrary to the concept of fairness and would be prejudicial to my client's position to assert that he is not impaired, giving that he has always maintained that his practice is not impaired.*

4. *The original diet of nearly two weeks, resulted in him having to be away from his place of employment for 9 days (almost two working weeks), was an economic barrier to attending the hearing, however, he maybe able to attend one of the*

other days to give live evidence as this may not be considered such a barrier objectively.

5. *The registrant is currently suspended on an interim order which was based on a risk assessment made at the time of the allegations which mirrored those the panel decided on, having heard and considered the evidence. Given the time lapse, it is entirely plausible and possible that the registrant may wish to make an application for a review of this interim order to obtain a lesser restriction on his practice, considering the findings of this panel and may wish to return to nursing to provide further evidence of insight and strengthening of practice to assist the panel in their consideration at stage 2.*

6. *Therefore, to proceed on this basis without granting an adjournment when three later days have already been finalised would rob him the opportunity to do so.*

7. *My alternative proposal to proceeding formally to stage 2 today, would be for myself to take instruction in the interim period, then one week before the hearing, update the NMC if the registrant is going to give evidence, provide and updated reflection and also written submissions in advance so that panel have been afforded the opportunity to read these before moving on to the next stage to deliberate.'*

Ms Leathem submitted that the NMC remains neutral on this application. She submitted that it is unusual in this case, in that the panel have been receiving correspondence from Mr Chan's representative for each stage, despite neither Mr Chan nor his representative attending in person. She reminded the panel that it did decide to proceed in Mr Chan's absence at the outset of the hearing, and as such the panel could decide to proceed, if it agrees it is appropriate to do so.

Ms Leathem submitted that, should the panel reject the application to adjourn, she would be able to provide submissions on the next stage of the hearing. However, if the panel do

agree with the application, she submitted that she would reserve her submissions until the case recommences in October 2023.

Ms Leathem submitted that she agreed with paragraph seven of Mr Chan's representative's submissions, namely that Mr Chan's representative should inform the NMC a week before the hearing resumes as to whether Mr Chan will be attending the hearing, and if he will be giving oral evidence for the next stage.

The panel accepted the advice of the legal assessor.

The panel has taken into account the submissions provided by the NMC and Mr Chan's representative on an application to adjourn the hearing at this stage.

The panel noted that this hearing was originally listed for nine days, but was subsequently shortened to six days by the NMC, due to panel availability and scheduling issues. It considered that Mr Chan has decided not to attend the hearing in person, despite his continued engagement with these proceedings via his representative.

The panel considered that Mr Chan's representative made relevant points regarding this hearing and how it should proceed going forward into the next stage. It agreed that it would not cause any unfairness or injustice to the parties to grant this adjournment, and it would allow both Mr Chan's representative and the NMC time to take instructions and prepare for the next stage of the hearing. It did not believe the public interest in the expeditious disposal of the case would be affected by the adjournment, as the panel was not satisfied that it would complete the next stage of the hearing today in the time that is left.

The panel agreed with paragraph seven of Mr Chan's representative's submissions, namely that Mr Chan's representative should inform the NMC a week before the hearing resumes as to whether Mr Chan will be attending the hearing, and if he will be giving oral evidence for the next stage.

The panel therefore decided to allow the application to adjourn the hearing.

This hearing will resume on 23 October 2023.

Decision and reasons on service of Notice of Hearing of resuming hearing

The panel was informed that Mr Chan was not in attendance and that the letter confirming the resuming dates had been sent to Mr Chan and his representative's registered email address by secure email on 13 September 2023

Ms Leathem, on behalf of the NMC, submitted that it had complied with the requirements of Rules 11 and 32(3) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the letter provided details of the allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Chan's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all of the information available, the panel was satisfied that Mr Chan has been served with the letter in accordance with the requirements of Rules 11 and 32(3).

Decision and reasons on proceeding in the absence of Mr Chan

The panel next considered whether it should proceed in the absence of Mr Chan. It had regard to Rule 21 and heard the submissions of Ms Leathem who invited the panel to continue in the absence of Mr Chan.

Ms Leathem referred the panel to email correspondence between the NMC and Mr Chan's representative. On 14 September 2023, Mr Chan's representative said that neither Mr Chan nor his representative would be attending this hearing. His representative will provide written submissions to be considered as an alternative on 23 October 2023 at approximately 11:00. She submitted that given the clear indication that he is not attending, an adjournment is not likely to secure his attendance at a future date. She therefore invited the panel to proceed in the absence of Mr Chan.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mr Chan. In reaching this decision, the panel has considered the submissions of Ms Leathem, the representations made on Mr Chan's behalf by his representative, Mr Chan's email correspondence with the NMC on 16 October 2023 and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mr Chan's representative made it clear that they would not be attending this stage of the hearing;

- There was no application to adjourn this stage of the proceedings;
- Mr Chan has therefore voluntarily absented himself from the hearing;
- Mr Chan's representative has provided written submissions on misconduct and impairment which the panel will take into account during its decision making; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Chan. The panel will draw no adverse inference from Mr Chan's absence in its consideration of misconduct and impairment.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Chan's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct and impairment

The panel took into account Ms Leathem's written submissions on misconduct and impairment, which states:

> *"MISCONDUCT*
>
> *The Law/Guidance*
>
> *4. The panel will be aware of the various case law on misconduct. It is suggested that Roylance v GMC (No.2) [2000] 1 AC 311 and Nandi v General Medical Council [2004] EWHC 2317 (Admin), are a useful starting point. 5. In Roylance v GMC [2000] 1 AC 311 it was stated that:*
>
> *Misconduct is 'a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances'.*
>
> *6. In Nandi v GMC [2004] EWHC 2317 (Admin), Collins J indicated that the test of seriousness must be given its proper weight:*
>
> *'…in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree.'*
>
> *7. It is submitted that ultimately the question of misconduct is a matter for the judgment of the panel. Lord Justice Clark in Mallon v General Medical Council [2007] ScotCS CSIH17 at [18] emphasised the element of judgment that was central to a finding of professional misconduct:*

'The statute does not lay down any criterion of seriousness; nor does the case law. Descriptions of serious professional misconduct such as "conduct which would be regarded as deplorable by fellow practitioners" … tend, we think, to obscure rather than assist our understanding. In view of the infinite varieties of professional misconduct, and the infinite range of circumstances in which it can occur, it is better, in our opinion, not to pursue a definitional chimera. The decision in every case as to whether the misconduct is serious has to be made by the Panel in the exercise of its own skilled judgment on the facts and circumstances and in the light of the evidence…'

8. In R (on the application of Remedy UK Ltd) v General Medical Council [2010] DWHC 1245 (Admin) at 37, after a review of the authorities, ten principles were identified to assist in determining whether the conduct in question constituted misconduct. The relevant principles are as follows:

'(1) Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur out with the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession.

(2) Misconduct falling within the first limb need not arise in the context of a doctor exercising his clinical practice, but it must be in the exercise of the doctor's medical calling. There is no single or simple test for defining when that condition is satisfied.

(3) Conduct can properly be described as linked to the practice of medicine, even though it involves the exercise of administrative or managerial functions, where they are part of the day to day practice of a professional doctor. These functions include the matters identified in Sadler, such as proper record keeping, adequate patient communication, proper courtesy shown to patients and so forth. Usually a

failure adequately to perform these functions will fall within the scope of deficient performance rather than misconduct, but in a sufficiently grave case, where the negligence is gross, there is no reason in principle why a misconduct charge should not be sustained.

(4) Misconduct may also fall within the scope of a medical calling where it has no direct link with clinical practice at all. Meadow provides an example, where the activity in question was acting as an expert witness. It was an unusual case in the sense that Professor Meadow's error was to fail to recognise the limit of his skill and expertise. But he failed to do so in a context where he was being asked for his professional opinion as an expert paediatrician. Other examples may be someone who is involved in medical education or research when their medical skills are directly engaged.

(5) Roylance demonstrates that the obligation to take responsibility for the care of patients does not cease simply because a doctor is exercising managerial or administrative functions one step removed from direct patient care. Depending upon the nature of the duties being exercised, a continuing obligation to focus on patient care may co-exist with a range of distinct administrative duties, even where other doctors with a different specialty have primary responsibility for the patients concerned.

(6) Conduct falls into the second limb if it is dishonourable or disgraceful or attracts some kind of opprobrium; that fact may be sufficient to bring the profession of medicine into disrepute. It matters not whether such conduct is directly related to the exercise of professional skills.

(7) Deficient performance or incompetence, like misconduct falling within the first limb, may in principle arise from the inadequate performance of any function which is part of a medical calling. Which charge is appropriate depends on the gravity of

the alleged incompetence. Incompetence falling short of gross negligence but which is still seriously deficient will fall under section 35C(2)(b) rather than (a).

(8) Poor judgment could not of itself constitute gross negligence or negligence of a high degree but it may in an appropriate case, and particularly if exercised over a period of time, constitute seriously deficient performance.

(9) Unlike the concept of misconduct, conduct unrelated to the profession of medicine could not amount to deficient performance putting fitness to practise in question. Even where deficient performance leads to a lack of confidence and trust in the medical profession, as it well might - not least in the eyes of those patients adversely affected by the incompetent doctor's treatment - this will not of itself suffice to justify a finding of gross misconduct. The conduct must be at least disreputable before it can fall into the second misconduct limb.

(10) Accordingly, action taken in good faith and for legitimate reasons, however inefficient or ill-judged, is not capable of constituting misconduct within the meaning of section 35C(2)(a) merely because it might damage the reputation of the profession.'

9. The panel are also referred to the following NMC guidance:
Serious concerns which are more difficult to put right (ref FTP-3a)
Serious concerns which could result in harm to patients if not put right (ref FTP-3b)
Serious concerns based on public confidence or professional standards (ref FTP-3c)

The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates

10. Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the NMC's Code of Conduct 2015 ("the Code").

11. At all relevant times, the Registrant was subject to the provisions of the Code. The Code sets out the professional standards that nurses must uphold. These are the standards that patients and members of the public expect from health professionals. On the basis of the charges found proved, it is submitted that the following parts of the Code have been breached in this case (the charges being considered both individually and cumulatively):

Charge 2
'1 Treat people as individuals and uphold their dignity…
1.2 make sure you deliver the fundamentals of care effectively
1.5 respect and uphold people's human rights'.

'3 Make sure that people's physical, social and psychological needs are assessed and responded to…
3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages.'

'19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice…
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place.'

12. Whilst the panel did not find any malicious intent in this manoeuvre and the Registrant was trying to maintain Resident A's safety in the circumstances following her earlier accident, it is submitted that undertaking a manoeuvre not included in the care plan put Resident A at risk of suffering harm. As it was not included in the

care plan, it had not been assessed as being safe to undertake and the associated risks would have been unknown.

Charges 3, 10, 12, 14, 23

'1 Treat people as individuals and uphold their dignity…
1.1 treat people with kindness, respect and compassion 1.5 respect and uphold people's human rights'.
'2 Listen to people and respond to their preferences and concerns…
2.6 recognise when people are anxious or in distress and respond compassionately and politely.'

'7 Communicate clearly…
7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs.'

13. The facts found proved represent repeated abuse of a vulnerable patient on 8 January 2020 and verbal abuse of another resident on a different occasion. This conduct caused an unwarranted risk of psychological harm being suffered by vulnerable patients. Further, Witness 2 felt the comment to the resident at the centre of charge 12 to be inappropriate and that she had been shocked to hear this comment. It is submitted that, irrespective of Witness 2's evidence that the comments from Mr Chan were out of character, the potential for patient harm could have been avoided had basic human compassion been extended to Resident A.

Charge 11
'8 Work co-operatively…
8.5 work with colleagues to preserve the safety of those receiving care.'

14. It is submitted that in addition to the breaches outlined above, charge 11 also represents a breach of working co-operatively with colleagues. Witness 2's evidence was that she was able to assist if the Registrant had asked for help and did eventually take Resident A's hands in hers to assist Mr Chan. It is submitted that the Registrant did not work cooperatively with Witness 2 in respecting the contribution she could have made, and went on to make, to preserving the safety of Resident A.

15. It was Witness 2's evidence that Mr Chan did not slap Resident A's hand hard and it would not have been forceful enough to leave a bruise. It is submitted that slapping a vulnerable patient's hand away, irrespective of the force used, fell far below what would be proper in the circumstances and considered deplorable by fellow practitioners. Witness 2's evidence was that there were other methods of dealing with Resident A at the time. Whilst Mr Chan was trying to provide care for the resident by cleaning their eye, it is submitted that slapping their hand away was not a proportionate response particularly given the specific vulnerabilities of Resident A.

Charge 20

'10 Keep clear and accurate records relevant to your practice…
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.'

16. The panel may consider charge 20 does not cross the high threshold for serious misconduct on the basis of its findings at the facts stage that Mr Chan was not at fault in relation to this charge.

17. Finally, in respect of all of the charges, it is submitted that Mr Chan breached the following principles of the Code:

'20 Uphold the reputation of your profession at all times…
20.1 keep to and uphold the standards and values set out in the Code
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'

18. In summary, it is submitted that the actions found proved are serious. The concerns are both clinical and behavioural, all of which had the potential to significantly impact the patients in Mr Chan's nursing care. An assault on a patient (charge 11) and verbal abuse of residents (charges 3, 10, 12, 14 and 23) are very serious breaches of the trust and confidence placed in Mr Chan as a professional. The actions are a serious departure from the standards expected of a registered professional who occupies a position of privilege and trust in society and is expected at all times to be professional and to treat patients with care and compassion. Patients and families must be able to trust registered professionals with their lives and the lives of their loved ones.

IMPAIRMENT

19. Impairment needs to be considered as at today's date, that is whether Mr Chan's fitness to practise is currently impaired. There is no statutory definition of impairment. The NMC Guidance on impairment (re DMA-1) poses the question 'can the nurse, midwife or nursing associate practise kindly, safely and professionally'.

20. It is a forward thinking exercise looking at the risk Mr Chan's practice poses in the future. It is submitted that the Registrant's fitness to practise is currently impaired on public protection and public interest grounds.

21. Matters which can properly be taken into account in making a determination on fitness to practise were set out in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 which adopted the well known formulation of Dame Janet Smith in the Fifth Shipman report:

'Do our findings of fact in respect of the doctor's … (misconduct) … show that his/her FTP is impaired in the sense that he/she:

a. has in the past acted and / or is liable in the future to act as so 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 [nursing] profession into disrepute; and / or
c. has in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and / or
d. has in the past acted dishonestly and / or is liable to act dishonestly in the future'

22. It is submitted that the first three limbs are engaged. The Registrant's conduct had the potential to compromise patient safety and cause harm. His actions can be said to have brought the profession into disrepute and breached one of the fundamental tenets of the nursing profession, namely to prioritise people, preserve safety and promote professionalism and trust. Whilst it is acknowledged that not all breaches of the Code require a finding of impairment, where a breach of the Code involves breaching a fundamental tenet of the profession, the Committee are entitled to conclude that a finding of impairment is required. The finding of impairment would be required to mark the profound unacceptability of the behaviour, emphasise the importance of the fundamental tenet breached, and to reaffirm proper standards or behaviour.

23. In considering whether Mr Chan is impaired on public protection grounds, the NMC guidance adopts the approach of Silber J in the case of R (on application of

Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions where the concern is easily remediable, whether it has in fact been remediated and whether it is highly unlikely to be repeated. The guidance 'Insight and strengthened practice' (ref FTP-13) asks the following questions:

- *Can the concern be addressed?*
- *Has the concern been addressed?*
- *Is it highly unlikely that the conduct will be repeated?*

Can the concern be addressed?

24. In considering whether the concern can be addressed, the NMC Guidance 'Can the concern be addressed' (ref FTP-13a) outlines that there should be focus on the conduct that led to the outcome and consider whether the conduct itself, and the risks it could pose, can be addressed by taking steps such as training courses or supervised practice. A comparison is drawn between clinical failings and those that are attitudinal in nature which may be harder to put right:

'Decision makers need to be aware of our role in maintaining confidence in the professions by declaring and upholding proper standards of professional conduct. Sometimes, the conduct of a particular nurse, midwife or nursing associate can fall so far short of the standards the public expect of professionals caring for them that public confidence in the nursing and midwifery professions could be undermined. In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.

Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:…

- *violence, neglect or abuse of patients.'*

25. It is submitted that charges 3, 10, 11, 12, 14 and 23 are so serious and display a deep-rooted attitudinal issue that is harder to address through insight, training and a period of safe practice.

Has the concern been addressed?

*26. The panel will need to consider the Registrant's updated reflective piece dated 17 August 2023, the Registrant Bundle (pages 213-224) and updated reflection incorporated into the written submissions under 'Finding of Fact and the Charges'. It is submitted that the reflective pieces do not fully address the matters found proved. It is submitted that there would be a risk of repetition if Mr Chan does not fully and deeply demonstrate an understanding of what he has done wrong. For example, the panel may find that there is a lack of accountability in respect of his communication, attributing a misunderstanding of his communication to English not being his native language. It is submitted that words used such as 'f*** off', 'shut up' and 'you will f*****g die tonight' cannot be misconstrued or put down to an issue with a 'language barrier' or needing to lower the speed of his speech. Whilst Mr Chan recognises and accepts that he must work on his understanding and practice of communication (in his reflection dated 17 August 2023) and provides assurance that the conduct will never be repeated (in his reflection within the written submissions), it is submitted that he has not identified what he can do to achieve this or indeed demonstrated to the panel that he has in fact taken any practical steps to address concerns around his communication.*

27. It is submitted that the panel may find less weight can be attributed to this reflection and assurance whereby there are no examples of how he has applied any learning to his practice or training to reinforce the learning. This submission is made in accordance with the NMC Guidance 'Has the concern been addressed' (ref FTP-13b) under 'Sufficient steps to address the concern'.

28. References are provided within the Registrant Bundle. The panel will need to determine how much weight to place upon these given they do not all relate to his practice as a nurse, are of some age, not all signed and dated, and pre-date the allegations. It is submitted that less weight should be attached where they do not address the factors outlined under 'assessing evidence' within the guidance 'Has the concern been addressed?' (ref FTP-13b).

Is it highly unlikely that the conduct will be repeated?

29. The facts found proved relate to repeated abuse of vulnerable patients. It is submitted that this is indicative of an attitudinal issue and carries with it the risk of repetition and harm to vulnerable patients.

30. Mr Chan has not worked as a registered nurse since his dismissal and, since September 2021, has been unable to work due to his interim suspension order (as referred to in the Registrant's Bundle, page 85). Despite this restriction, it is submitted that Mr Chan has not demonstrated any learning of any kind such as additional relevant training.

Public Interest

31. In addition to public protection, the panel will need to consider the comments of Cox J in Grant at paragraph 74:

'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.'

32. It is submitted that abuse of patients is so serious that, even if Mr Chan addressed the behaviour, a finding of impairment is required to uphold the proper standards of conduct and to maintain public confidence in the profession. The public expect nurses to act with care and compassion so that patients and their family members can trust registered professionals."

The panel also took into account the documents provided by Mr Chan's representative which includes written submissions, reflection from Mr Chan and an email from Mr Chan. The written submissions on misconduct and impairment states the following:

"Submissions on Misconduct and Current Impairment

The panel have the updated reflection from the registrant in light of the findings on fact.

The registrant and his representative accept the findings in full of the panel and have also allowed for further consideration of the registrant and the opportunity for further reflection.

The registrant and his representative ask the panel to read these submissions along with the reflection to take account of the registrant's position as further updated have been provided to the registrant's representative as the registrant is unable to attend for previous personal circumstances as had been narrated to the panel at the last session and no adverse inferences or disrespect should be drawn from this.

These submissions also contain further reflection and instructions given to the representative and would be grateful if the panel accepted these as coming directly from the registrant, particularly the undernoted (Finding in Fact and the Charges) as English is not the first language of the registrant and has been recorded as the result of a meeting.

Finding of Fact and the Charges

The registrant accepts the finding of charge 2 and is grateful for the commentary that there was no maliciousness of the part of the registrant. He accepts this was not the correct thing to do and was contrary to the sanctioned practices and policies. He maintains that he was operating in the best interests of Resident A in that she would become alarmed if she was left alone and his intension was to provide her with a secure place to feel comfortable and settle without increasing her anxiety. He accepts that he should have followed the correct practice and if he found himself again in this situation, he would review the local practices and polices were adhered to promote patient safety and wellbeing.

In relation to charge 3, the registrant admitted to this and explained in his previous reflections that there was a language barrier, but accepts that the use of this language even when heightened and stressed is unacceptable and is sorry for any distress that his language caused and upon reflection would never use this language again and would remain professional as he recognises that all patients, staff and the general public expect nurses to act in a professional manner to promote dignity and this language did not meet that standard.

In relation to charge 10, and accepts this and upon reflection must have said this in the heat of the moment, due to the concern that he had for the resident. He has always sought to care and promote the welfare of each of the residents as he recognised the vulnerability of the patients, and particularly this one. The registrant maintains that there may have been a language barrier that caused tone and frustration to be misconstrued and that it was never directly aimed at anyone, particularly resident A. He was heighted by the situation and not at the resident herself. He accepts that is unacceptable behaviour and may result in the resident being alarmed and upset as well as language. This was very out of character for the registrant and he wishes to apologise and would never repeat that again if he

found himself in the same situation again and is grateful for the further platform to explain his intention and circumstances as the home was a very stressful and understaffed place to work and the registrant felt as although he was at his wits end due to being over stretched. Whilst this is not an excuse, it does provide the background to the working conditions which he was the lead nurse trying to provide the best care that he could. Often he felt this fell to him personally rather than it being part of the working caring environment that he would have expected and to have been fostered by senior management.

In relation to charge 11, and the registrant accepts this as well as reinforcing that if his action resulted in any harm or alarm for that he is truly sorry. It was never his intension to 'slap' away the hand of the resident and he was trying to protect the resident from further injuring herself as she had a history of self harm. He was trying to attend to the attend to the injury/ eye and was trying to prevent the resident from making the injury worse. He accepts that he should not have done that in a way that was construed at 'slapping' or hitting as that is never acceptable and he notes that he should always tend to the residents in a careful and controlled manner which should never endanger them or make it worse.

In relation to charge 12 and accepts the findings of the panel in their entirety and apologieses for this behaviour. He did not intend for the Resident to be told that she would be staying on the floor as to upset her, but that she was to be treated on the floor due to the fact that it was safer. It was never his intension to have threatened or to appear to any other people as being threatening, but that given the heightened situation can accept this is how it may have been perceived which is contrary to his intension and his training. The registrant has always prided himself in being cool and calm and not being aggressive and for this very sorry and can assure the panel that there would never be a repetition of this in any other setting, within a registered setting or otherwise.

In terms of the finding of charge 14, the registrant also accepts that and apologies profusely as with the incident at Charge 12 this was never the intension of the registrant and he did not mean for it to come out like this and upon reflection was said in the heat of the moment with English not being his primary language. It was not mean in a malicious manner or used to effect distress and he is sorry if that did so and also to his colleague as he accepts that they were shocked and that was out of character for him when he read the transcript of the evidence provided by the NMC and is horrified that is what was said and also that was received and would never repeat these words again. He contends this does not reflect there being an attitudinal problem or that he is an aggressive person or professional.

The registrant accepts the finding of the panel and contends that at all junctures, when he was required to update patient care plans and records that he did so and actually took great pains to stay late and update the records even after his shift finished. He understands the importance of keeping ensuring all documentary evidence is update to date to ensure continuity of care across each team and that the patient is cared for an a voice is provided for vulnerable patients when they do not have one sometimes due to the effects of deteriorating illness and age.

The registrant admitted to allegation 23 and accepts that he should never have used that language that it completely unacceptable and unprofessional to do so and would never repeat this language again.

<u>Submissions on misconduct</u>

Having heard from the registrant further reflection and further submissions on the context of the finding of facts. I would urge the panel to consider both misconduct separately. Therefore I submit that the findings taken in their unique context within the parameter of such a limited day are regrettable, but they do no amount to misconduct as per would be viewed by the regulator.

There is no statutory definition of misconduct, nor is it defined in the Nursing and Midwifery Council (NMC) rules. The case law provides the following assistance:

Roylance v General Medical Council (No 2) [2000] 1 AC 311 at [331B-E]

'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances… Secondly the misconduct is qualified by the word 'serious'. It is not any professional misconduct which will qualify…'

And

Nandi v General Medical Council [2004] EWHC 2317 (Admin) at [31], Collins J stated:

'…The adjective serious must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners, it is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree.'

Johnson and Maggs v Nursing and Midwifery Council (No 2) [2013] EWHC 2140 (Admin) at [105]

'… To find misconduct, however, the Committee had been advised and had accepted that the failure had to be such as would be seen as 'deplorable' by fellow practitioners and as involving a serious departure from acceptable standards and that gross professional negligence could fall into this category if it rose above the level required to give rise to civil liability…'

Taking into the comments in the above findings, it is my respectful submission that giving the explanation of the registrant and his intensions and reasoning, if a reasonable person or professional took all of that into account, the circumstances and also his intensions that they would not find the conduct as deplorable or at such a level that the regulator would have to make a finding of misconduct. All professionals are people too who err and make mistakes and they are also a bi product of the environment which they are working in. The panel have heard in evidence from other witnesses about the environment in which these charges were found proved. And also the support that he had from junior colleagues and how he was well regarded. These were errors of judgement made in on one night in a busy wards where the registrant was not that well supported and he accepted he made errors of judgement. None of the behaviour was intentional, deliberate or meant to cause harm.

Therefore we ask the panel when taking all of the above into consideration in all of the reflections and evidence that they do not make a finding of misconduct.

<u>Submissions on current impairment</u>
If the panel was not with me on a non finding of impairment we would urge the panel to make a finding of not currently impaired which looks at impaired at todays date and takes all of the circumstances into account in this determination. This is a professional judgement for this professional panel.

In considering the matter of current impairment, I would urge the panel to consider the case of Grant:

Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant <u>[2011] EWHC 927 (Admin)</u> at [74] and [76]

'… [I]n 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…'

'…[A]t paragraph 25.67 [Dame Janet Smith's Firth Report from Shipman] she referred to the following as an appropriate test for panels considering impairment of a doctor's fitness to practice, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes:'

'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) has in the past acted dishonestly and/or is liable to act dishonestly in the future….'

It is our submission that the specific isolated circumstances of the events and the one of basis of them being tied to a particular date when held against the backdrop of a previously unblemished career and also taken into account the positive evidence that the panel heard in direct evidence that the registrant accepts his regrettable wrong doing and his ill judgement and has

demonstrated insight into his behaviour that they would never be repeated again and therefore does not engage in the above limbs that would result in a panel making a finding of current dishonestly.

The NMC may maintain that the registrant whilst not working in a registered role that he is not able to demonstrate insight or strengthen practice to this panel. We contend that the panel can take his reflections and the engagement as much as he can that all lessons have been learned. The impact that this has had for him in the detriment to his professional identity and character caused him to leave the profession for the moment as he was so impacted by this as he held himself to such a high standard and always tried his hardest that this failure, investigation and Fitness to Practice hearing has left him bereft. He is grateful for the opportunity to put his position to the panel and for there to be closure as a result of this hearing and was also grateful to read some of the positive things said in live evidence. He was further ashamed of how his actions were perceived and that he may have caused harm or alarm to a vulnerable patient or to have impacted on his colleagues in any manner, that was never his intension and would change that night if he ever got the chance to do so. However, what he has seen is this is an opportunity to learn and amend practice and also be open to how others are perceiving his body and oral language and to be mindful of how it is received and its impact." [sic]

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

Decision and reasons 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.'*

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

Charge 2

In the facts stage, the panel determined that Mr Chan did not have any malicious intent in his actions. It noted that Mr Chan acknowledged the impropriety of his actions. Mr Chan argued that his primary concern was Resident A's welfare, aiming to provide her with a secure and comforting environment to avoid causing her distress or anxiety that could arise from being left alone. The panel also took into account the evidence of Witness 2 who stated that this was Resident A's preferred manner of sleeping and that she could get a good nights rest this way. In retrospect, Mr Chan recognises that he should have taken steps to modify the care plan to align with his actions and clearly state the reasons for doing so. The panel decided that although this incident should not have taken place before discussions and amendment to Resident A's care plan, it does not deem it serious enough as to amount to misconduct.

Charges 3, 10, 12 and 14

In respect of charges 3, 10, 12 and 14, the panel determined that Mr Chan's actions were part of a course of conduct during one isolated shift involving one resident. This fell significantly short of the standards expected of a registered nurse, and that Mr Chan's actions amounted to a breach of the Code. Specifically:

> ***1.1*** *treat people with kindness, respect and compassion*

2.6 *recognise when people are anxious or in distress and respond compassionately and politely*

7 *Communicate clearly*
7.2 *take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs*

20.1 *keep to and uphold the standards and values set out in the Code*
20.3 *be aware at all times of how your behaviour can affect and influence the behaviour of other people*
20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*
20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

The panel carefully considered the language used towards Resident A and the overall context. The panel emphasised the fundamental expectation for nurses to demonstrate a high level of professionalism in their interactions. Engaging in the use of such language towards a vulnerable patient not only undermine these professional standards but also erodes the trust and respect that patients should have for their healthcare providers. Moreover, the panel recognised that such language could exacerbate stress and anxiety, potentially causing emotional harm to the individual.

The panel considered Witness 2's credible evidence, specifically her statement that Mr Chan was "angry and threatening". However, when Mr Chan responded by suggesting a language barrier, the panel did not accept this explanation.

Mr Chan, in his written reflections, acknowledged that using such language, even in times of heightened stress, is entirely unacceptable. The panel found some level of recognition from Mr Chan regarding the multiple charges against him. The panel therefore concluded

that Mr Chan's actions fell significantly below the expected standards of a nurse, resulting in serious misconduct.

Charge 11

In respect of charge 11, the panel determined that Mr Chan’s actions did fall significantly short of the standards expected of a registered nurse, and that Mr Chan’s actions amounted to a breach of the Code. Specifically:

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

In respect of charge 11, the panel took into account Witness 2's testimony, which stated that she offered assistance to Mr Chan and eventually took Resident A's hands to aid him. The panel noted that Mr Chan initially failed to work cooperatively with Witness 2, disregarding her potential contribution in ensuring Resident A's safety. Witness 2 confirmed that Mr Chan's action of slapping Resident A's hand was not forceful enough to cause a bruise. However, the panel concluded that regardless of the degree of force applied, slapping a vulnerable patient's hand away is entirely inappropriate given the circumstances. The panel took into account Witness 2's statement, suggesting that there were alternative approaches to dealing with Resident A at the time.

Additionally, the panel considered Mr Chan's response, where he acknowledged his failure to seek assistance from Witness 2. Mr Chan specifically mentioned that collaborating with Witness 2, a senior care assistant who had a strong care relationship with Resident A, could have been beneficial.

Despite Mr Chan's intention to provide care by cleaning Resident A's eye, the panel determined that slapping their hand away was an unjustifiable response, especially considering Resident A's specific vulnerabilities. The panel therefore concluded that Mr Chan's actions fell significantly below the expected standards of a nurse, resulting in serious misconduct.

Charge 20

The panel considered that charge 20 does not cross the high threshold for serious misconduct on the basis of its findings at the facts stage that Mr Chan was not at fault in relation to this charge.

Charge 23

The panel considered Mr Chan's evidence, where he described the incident in 2016: *"One night in 2016 I was walking along a badly lighted corridor of the unit doing breathing checks room by room. Suddenly I felt someone/something grasped me hard on my shoulder from behind and breathed down my neck. I was so frightened that I struggled free and said: "Fuck off" without looking back. It was an instinctive reaction without any malicious meaning or purpose. I apologized immediately after realizing that it was Resident D."*

The panel noted that Mr Chan clarified that his reaction was purely instinctive, without any malicious intent or purpose. He immediately apologised upon realising that it was Resident D. The panel was not provided with any evidence contradicting his account and concluded that his actions did not meet the threshold for misconduct, as they were not intended to be malicious or harmful.

The panel found that Mr Chan's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct only in respect of charges 3, 10, 11, 12 and 14.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

d) *…'*

The panel considered that limbs a), b) and c) of Dame Janet Smith's test as set out in the Fifth Shipman Report were engaged by Mr Chan's past actions. The panel found that Mr Chan's use of inappropriate language towards Resident A, as well as his failure to cooperate with Witness A in providing proper care, put a vulnerable individual at risk of emotional and psychological harm. The panel considered that members of the public would not expect a registered nurse, particularly when acting as the nurse in charge, to behave in such a manner. The panel therefore considered that Mr Chan's actions brought the profession into disrepute and also breached fundamental tenets of the profession.

The panel went on to consider whether Mr Chan is liable in the future to place patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession. In doing so, the panel assessed Mr Chan's levels of insight, remorse and remediation.

The panel had regard to the test set out in the case of *Cohen*. The panel determined that Mr Chan's conduct is remediable. It noted that no attitudinal concerns were identified, as Witness 2 testified to the unusual nature of his behaviour during that one shift, emphasising that it was completely out of character for him.

The panel took into consideration Mr Chan's reflections on the incidents. Notably, he demonstrated some insight into his actions by admitting that he fell short of expected standards and expressing deep regret for his behaviour. Mr Chan also maintains that his actions were neither deliberate nor intended to cause harm.

However, the panel was not provided with sufficient evidence that he had addressed his poor behaviour, such as references addressing his people management skills in his current job, albeit it not being in the nursing profession. The panel was of the view that regardless of one's occupation, it is possible to demonstrate respect and effective communication with others, even in challenging circumstances. In addition, the panel carefully examined his explanation that his actions were a result of a language barrier, citing English not being his native language. However, the panel determined that certain choice of words, such as 'fuck off', 'shut up', and 'you will fucking die tonight', cannot be misconstrued or attributed solely to a language barrier or the need to speak more slowly.

While Mr Chan acknowledges the need for improvement in his understanding and practice of communication and assures that these actions will not be repeated, he has not provided specific steps he intends to take or shown evidence of practical measures to address the concerns raised regarding his communication skills. This could include undertaking online courses focused on effective communication with patients.

The panel recognise the immense difficulties associated with the nursing profession and it acknowledged [PRIVATE] Mr Chan had experienced during that time. However, the panel have no evidence to suggest that Mr Chan has actively addressed or developed effective coping strategies for such situations. Consequently, the panel cannot be assured that this conduct will not be repeated in the future. 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 acknowledged that most of the charges for which serious misconduct was identified were as a result of isolated incidents that occurred on a single shift. It recognised that the public may have concerns regarding the use of such language, particularly when it comes from a nurse who is generally expected to be caring and respectful towards patients. However, the panel also considered that an informed member of the public, who is aware that the incident has been thoroughly investigated by the regulatory body and is knowledgeable about the surrounding context and self-reflection on the part of the nurse, would be satisfied that the public interest has been adequately addressed. The panel emphasised that although the nurse's actions were indeed wrong, it did not consider that public confidence in professional standards and the nursing profession would be undermined if no finding of current impairment were made on public interest grounds.

Having regard to all of the above, the panel determined that Mr Chan’s fitness to practise is currently impaired on public protection grounds only.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months. The effect of this order is that the NMC register will show that Mr Chan's registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Leathem provided written submissions in respect of sanction, which states:

> *"GUIDANCE*
>
> *4. The panel are referred to the published NMC guidance on sanctions as follows:*
> *Factors to consider before deciding on sanctions (ref SAN-1) 01/08/2023*
> *Available Sanctions Considering sanctions for serious cases (ref SAN-2) 02/10/2023*
> *Available sanction orders (ref SAN-3) 28/07/2017*
> *Taking no further action (ref SAN-3a) 12/10/2018*
> *Caution order (ref SAN-3b) 12/10/2018*
> *Conditions of practice order (ref SAN-3c) 21/01/2020*
> *Suspension order (ref SAN-3d) 12/10/2018*
> *Striking off order (ref SAN-3e) 10/01/2020*
>
> *5. The aims of sanctions are not designed to punish the nurse but to protect the public, maintain public confidence in the profession and the NMC and declare and uphold the proper standards of conduct and performance. Given the panel's finding at the impairment stage, the type of sanction must be designed to protect the*

public. The sanction must also be proportionate, that is finding a fair balance between the nurse's rights and the overriding objective of public protection.

AGGRAVATING AND MITIGATING FEATURES

6. As per the guidance SAN-1, the panel should consider both the aggravating and mitigating features.

7. It is submitted that the aggravating features are as follows: conduct which involved a vulnerable patient and conduct which put that patient at risk of suffering harm, including emotional and psychological harm. In so far as mitigating features are concerned, the panel found that there was 'some insight' and 'some level of recognition' into his actions.

TYPE OF SANCTION

8. The panel must consider the sanction in ascending order of seriousness and work upwards.

Taking no further action

9. The panel has discretion to take no further action, however, this is only exercised in rare circumstances. Given the panel found that the Registrant's practice is impaired for public protection reasons and there is a risk of repetition of the conduct concerned, the Registrant presents a continuing risk to patients that must be addressed by way of a more restrictive sanction.

Caution order

10. As with taking no further action, it is also submitted that a caution order would not address the panel's finding of impairment on the ground of public protection. A

caution order is only appropriate if the Committee has decided there is no risk to the public or to patients meaning the case is at the lower end of the spectrum of impaired fitness to practise and the behaviour needs to be marked as unacceptable.

11. It is submitted that this is plainly not a case at the lower end of the spectrum based on both the panel's finding of impairment for public protection reasons and the finding that the Registrant's 'actions fell significantly below the standards expected of a nurse'.

Conditions of practice order

12. It is submitted that, whilst the panel did not find the Registrant had an attitudinal problem, the concerns nevertheless do not lend themselves to conditions and it would be difficult to formulate any workable conditions. The Registrant has also not expressed a potential or willingness to respond positively to retraining.

13. Moreover, it is submitted that a conditions of practice would not mark the seriousness of verbal abuse being used against a vulnerable patient and would be to condone the violent language used.

Suspension order

14. In order to mark the seriousness of the concerns, it is submitted that a suspension order with review should be imposed. Notwithstanding the panel's finding that it was an isolated incident in so far as it took place on one shift, it is submitted that, taken together, the repeated comments towards a vulnerable patient alongside the slap of their hand are of such magnitude to warrant a suspension order. It is submitted that the comments were not minor and that a suspension order would recognise the severity of words such as 'fucking die' and 'fuck off'.

15. In addition, the NMC Guidance specifies factors of that may mean a suspension order is more appropriate, including 'a single instance of misconduct but where a lesser sanction is not sufficient', 'no evidence of harmful deep-seated personality or attitudinal problems' and 'no evidence of repetition of behaviour since the incident'.

16. In respect of insight, the panel found 'some level of recognition' and 'some insight'. It is submitted that this is relevant in the context of the age of the concerns, over three years ago. It is submitted that, if the verbal abuse was out of character, there would have been full insight demonstrated by now. Furthermore, this is a Registrant who has not found it necessary to appear before his regulator and explain himself.

17. Finally, a review would ensure that the public remain protected as the panel have found there to be a risk of repetition without the Registrant having shown practical steps to address his communication and people management issues.

Striking off order

18. Given the panel did not find impairment on public interest grounds, it is submitted that permanent erasure from the register would now be disproportionate. This sanction is to be considered when a registrant has done something fundamentally incompatible with being a registered professional. The panel are referred to the guidance, asking the following questions:
• Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?
• Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?
• Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?"

The panel also took into account the written submissions provided by Mr Chan's representative in respect of sanction, which states:

1. *'The panel, having concluded that the registrant's Fitness to Practice is currently impaired, will move on to the matter of Sanction.*

2. *The panel will have regard with the least restrictive sanction and work their way up in terms of the severity of the restrictions placed on the registrant's registration.*

3. *When considering the most appropriate action, I would respectfully urge the panel to have regard of the following matters:*

<u>Update from the registrant</u>

   a. *In terms of the language which has been used, I can assure having working in a Chinese restaurant dealing with members of the general public, I have not and do not use language that is derogatory and always insure that I stop and calm down and think then say what I intended to say so that I do not react. I can assure the panel that I have thought about the events that night and reading over of the witness and the findings of the panel and I will ensure that there is never a repetition. My strengthen of practice has come from my insight and embedding that respectful communication with everyone, family, customers and colleagues alike which has come through insight.*
   b. *In terms of the slapping away of the hands of the resident, I know this is never an acceptable action and I should have sought help at the time, I was reacting in the moment. This comes from my insight and my ability to stop, think then react rather than simply move forward blindly in the moment. I realised that another person holding someone's hand is much better than someone responding. I realise that it is never acceptable to*

hit or slap anyone, particularly someone that is vulnerable. Although I didn't appear to cause harm, it is unacceptable that I could have even potentially caused harm. That is horrible, and I would not wish anyone to think that of me. That realisation is enough to ensure the panel in all walks of life I would never engage in an action that was even perceived as being harmful and would utilise all other tools around me.

Factors

4. *I am sure the Panel is fully aware of the relevant factors that they must consider. I will proceed by taking each factor in turn and how they relate to this case.*

5. *I would respectfully remind the panel that the aim of sanction is protect the public, uphold the standards and reputation of the profession and maintain public confidence therein and therefore should be assessed against the backdrop of the case on the basis that is necessary and not merely to be punitive, and that it should be proportionate to the matters that have been admitted by the registrant.*

6. *I would refer the panel of the case of Meadow v General Medical Council [2006] EWCA Civ 1390 which stated,*

"the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The Fitness to Practise Panel thus looks forward not back.
However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past."

B. Seriousness

7. *The registrant has reflected on the seriousness of the findings and the conduct. From the beginning he has endeavoured to reflect on the allegations and to*

recollect and offer insight into the actions and take accord pf his actions including the inappropriateness of his communication and reflect on what he could have done better and would do again if he found himself in the same circumstances again.

8. *We would submit that although this conduct is serious it is not so serious that is not remediable and is not indicative of having an underlying deficit of character the NMC may contend. It is in fact the result of ill judgment and responding in a manner when he was in a heightened state and communicated in an inappropriate manner. This happened on one day in an unusual set of circumstances which caused the registrant to act in a manner that was not characteristically him and is not representative of his behaviour and must be viewed against an otherwise long career which was unblemished. This one date should not undermine his entire professional history, behaviour and reputation.*

c. Likelihood/ Risk of Reputation

9. *The registrant is ashamed of the findings of the panel, the language used and what was said and wishes to stress this was never his intension to cause harm or alarm to colleagues or a vulnerable person and had always placed great stock in his professional reputation and commitment to providing the best care to his clients in an otherwise challenging situation. He has reflected significantly and appreciates what his professional obligations were and are and has reflected on this never being repeated.*
10. *The registrant did not deny the allegations and admitted to a number of them and has made concessions on his practice in showing how he may reflect and look for a better way of doing things and endeavour to engage in a reflective practice.*
11. *It is for this reason, the context of the difficult working arrangements, the lack of support the registrant felt and which were all context specific along with the background of an unblemished career. Also, the registrant has had the benefit*

of insight as well as time to reflect on both the allegations as well as the finding of the panel in order to provide a full understanding of his conduct.

12. *In furtherance of addressing the matter of risk of repetition, the panel should consider that out with this event, the registrant has a history (see from registrant's cv) that the registrant had a history of working with vulnerable people with there being no reported instances of misconduct. One could posit if there was an attitudinal deficit of character that it may have presented in other areas where there would have been both opportunity and exposure to have carried out behaviour such as this.*

D Mitigating circumstances

13. *The registrant felt as although he was under extreme pressure as the nurse in charge to maintain the ward with a number of challenging and vulnerable patients with limited resources to support him. The registrant felt as although he was extremely stretched and there was a number of practices that were not correct there. On that particular night, the registrant reflected he was trying to do the best by everyone, including resident A, however matters did not conclude I the manner he wanted, and he did not conduct himself the way he had intended. The registrant has apologised for this and continues to apologise.*
14. *Furthermore in the absence of any further misconducts shows that these events were unusual, out of character for the registrant and in a specific context. There has now been a significant period of time has passed since these events, taken together with the unblemished history of the registrant demonstrates that this was an exceptional error of judgement which was a singular period time and is not demonstrative of his practice or character. Therefore, it is my submission that this matter has been fully remediated in terms of insight and demonstrating any repletion of future misconduct.*

Sanction

Order

24. *The Panel must also be satisfied that, when making a Sanction Order, in all the circumstances there is impairment of the workers fitness to practice which we have admitted to;*
    1. *Poses a real risk to members of the public*
    2. *Adversely affects the public interest*
    3. *Adversely affects the interest of the registrant*

And after balancing the interests of the registrant and the interest of the public that an order is necessary to protect the public against such risks.

Effect on public confidence on integrity of the regulation

25. *The registrant accepts that the role of the regulator is to both protect the public and to uphold the standards of the profession.*

26. *The registrant has engaged with the regulator and this panel through his representative to the fullest of his ability through his representative. The registrant has not worked within the nursing profession since these allegations were reported to the NMC and also the local investigation* [PRIVATE] *and the local investigation being both flawed and discriminatory in nature. The registrant has engaged with the panel in an attempt to restore his professional reputation and integrity.*

27. *The registrant is mindful of the publicity of these hearing and is mindful that this hearing is and has been open to members of the general public and also the media to attend along with the publication of the allegations, which has been published since the registrant was referred and subject to an interim order. The registrant is mindful in part of the role to protect the integrity of the profession, the NMC and may result in some adverse factors for the registrant.*

28. *It is the registrant's primary position that despite there being a finding of impairment that the publication of this matter since the imposition of the alleged*

conduct in its entirety throughout until now, that this would satisfy the public interest and act a deterrent to any other registrants from engaging in the conduct. The Fitness to Practice process by its very nature is harrowing to any registrant and the panel have the benefit of hearing directly from the registrant the impact this has had on him. [PRIVATE].

29. *It is therefore the primary submission of the registrant that the panel should make a finding of no order in this matter due to the insight developed and the registrant's engagement and the specific circumstances of the conduct.*

30. *If the panel are not with me, then it is the registrant's secondary submission that the panel could mark is unacceptability of the behaviour by making a caution order.*

31. *If the panel were not with me on the above, or third position that any risk to patient protection and the public interest could be managed by a Conditions of Practice Order that is not any more restrictive than the one in place and should only address the allegations that this substantive panel has found.*

32. *The panel may wish to consider the following suggestions helpful:*

(a) That the registrant keep a reflective journal on the following, communication with patients and staff

(b) Moving and handling procedures

These should be submitted discussed with a mentor and submitted to the NMC prior to any review of the substantive order.

33. *It is the registrant's position that both a suspension and a strike off would be grossly disproportionate to the conduct that has been found by the panel.*

34. *It is the position of the registrant that a suspension order should only be utilised where conditions of practice could not be formulated to manage the risk to public protection and patient safety, and it is our position that is the case.*
35. *It is the position of the registrant that conduct is remediable and has been remediated and does not demonstrate a deep seated failure of character.*
36. *I would urge the panel to consider the following case law:*
    (a) *Giele v GMC in 2006 (2005] EWHC 2143 (Admin) stated that the severity of the sanction required to maintain and preserve public confidence in the profession 'must reflect the views of an informed and reasonable member of the public'.*
    (b) *Healthcare at Home Limited (Appellant) v The Common Services Agency (Respondent) (Scotland), [2014] UKSC 49*

    However, the challenges of seeking to identify the view of an average member of the public when considering how to ensure that public confidence is maintained by an FtP decision are well expressed by Lord Reed in a judgment unrelated to health professional regulation, when discussing the issues with the use of the man on the Clapham omnibus: 'The Clapham omnibus has many passengers. The most venerable is the reasonable man, who was born during the reign of Victoria but remains in vigorous health. Amongst the other passengers are the right-thinking member of society, familiar from the law of defamation, the officious bystander, the reasonable parent, the reasonable landlord, and the fair-minded and informed observer, all of whom have had season tickets for many years.

    (c) *GMC v Cohen, [2008] EWHC 581 (Admin) - engagement of the three limbs and also is the matter is able to be remediated. It is our submission that the conduct engages the threshold of remediation.*
    (d) *The NMC list several specific examples of conduct which may not be possible to remedy:*
    • *criminal convictions that led to custodial sentences*

• inappropriate personal or sexual relationships with patients, service users or other vulnerable people
• dishonesty, particularly if it was serious and sustained over a period of time, or directly linked to the nurse or midwife's practice
• violence, neglect or abuse of patients

It is our position that the conduct does not engage in any of the above listed behaviour contained in the NMC guidance.'

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr Chan's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Mr Chan displayed a lack of care and compassion towards Resident A, who had experienced a fall.
- Resident A, a patient with dementia, could have experienced emotional and psychological harm as a result of the incidents.
- As the only registered nurse and a role model to the Health Care Assistants working on the shift, Mr Chan should have set a positive example.
- Mr Chan has not adequately demonstrated the actions he has taken to address insight into the reasons for him speaking and behaving unprofessionally during the shift.

The panel also took into account the following mitigating features:

- Witness 2 commended Mr Chan as a skilled nurse who actively dedicated time to training other nursing assistants. This incident was uncharacteristic of his usual behaviour.
- The panel heard evidence indicating that the Care Home had staffing and management issues.
- Mr Chan has displayed remorse and some level of self-reflection regarding his actions.
- At the outset of the hearing, Mr Chan admitted two of the charges against him.
- Mr Chan expressed profound shock at his actions upon reading the transcript, [PRIVATE].

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 also found that Mr Chan's practice is impaired on the grounds of public protection and there is a risk of repetition of the conduct concerned. It therefore determined that taking no action would not protect the public.

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 Mr Chan's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Chan's 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 next considered whether placing conditions of practice on Mr Chan's 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, in particular:

- *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.*

Upon reviewing the panel's findings, it found that Mr Chan's behaviour does not appear to be in an inherent attitudinal problem. It also noted that the incident in question was a result of the [PRIVATE] Mr Chan faced during a single shift. The concerns raised would be challenging to address through specific conditions, but not impossible. However, the panel decided that a conditions of practice order sanction would not mark the seriousness of the misconduct. Additionally, Mr Chan's representative provided written submissions, but the panel determined that these were insufficient in terms of measurability, verifiability, and addressing the seriousness of the case. Consequently, considering the nature of Mr Chan's misconduct, the panel concluded that a conditions of practice order would not adequately protect the public and mark the seriousness of the misconduct.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *….*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. The panel carefully considered the gravity of the concerns brought forward and determined that a suspension with a review is the appropriate course of action. Although the incident occurred during a single shift, when looking at the overall context, the panel found that the inappropriate language used towards a vulnerable patient, in conjunction with the act of slapping their hand, cannot be disregarded. The panel's utmost priority is to ensure the public is suitably protected and was of the view that Mr Chan should address the outstanding concerns before being allowed back into a nursing environment.

The panel also considered whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Chan’s case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Mr Chan. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct. This timeframe also allows Mr Chan an opportunity to take action and provide evidence of his commitment to addressing the panel's recommendations. During this suspension period, Mr Chan should actively work towards implementing the suggested improvements and demonstrate his dedication to rectifying his actions. By providing this time frame, the panel acknowledges the importance of giving Mr Chan a chance to make amends whilst also ensuring to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Testimonials or feedback from employer(s) that specifically address improvements in Mr Chan's language use, particularly in high-pressure situations.

- Provide evidence of proactive steps taken to address communication issues, such as completion of online training.

- A reflective piece:
    - exploring the language expected of a professional nurse when interacting with patients and expresses how he intends to adhere to these expectations.
    - reflect on what he has learned from these past experiences and outline specific actions or approaches he would employ differently in similar stressful situations in a professional manner.

- Reflect on the impact of his conduct on residents, patients, colleagues and the reputation of the profession.

Interim order

As the suspension order cannot take effect until the end of the twenty eight day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Chan's own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Leathem. She submitted that an interim suspension order should be imposed for a period of eighteen months to cover the twenty eight day appeal period and the subsequent period should an appeal be lodged. She submitted that this is necessary for the same reasons as given by the panel regarding the substantive order.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public. The panel had regard to the seriousness of the facts found proved and the public protection 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 proportionate interim order would be that of a suspension order, as to do otherwise would be inconsistent with its earlier findings that

there are no appropriate and workable conditions that could be imposed to protect the public.

Should Mr Chan decide to lodge an appeal, given the uncertainty in relation to how long any appeal may take to conclude, the panel decided that this interim suspension order shall be for a period of eighteen months.

Therefore, the panel determined to impose an eighteen-month interim suspension order on Mr Chan's registration.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order twenty eight days after Mr Chan is sent the decision of this hearing in writing.

That concludes this determination.

This will be confirmed to Mr Chan in writing.