Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday 22 May – Friday 26 May 2023,
Friday 6 October 2023

Virtual Hearing

Name of registrant:	Derek Clelland Mcmahon
NMC PIN:	90Y0156S
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 1 March 2000
Relevant Location:	North Ayrshire
Type of case:	Misconduct/Conviction
Panel members:	Rachel Robertson (Chair, Lay member) Sandra Lamb (Registrant member) Frances McGurgan (Lay member)
Legal Assessor:	Fiona Barnett
Hearings Coordinator:	Monsur Ali (22 May – 26 May 2023) Daisy Sims (6 October 2023)
Nursing and Midwifery Council:	Represented by Yvonne Ferns, Case Presenter (22 May – 26 May 2023) Represented by Assad Badruddin (6 October 2023)
Mr McMahon:	Not present and not represented
Facts proved:	Charges 1a, 1b, 1c, 2, 3a, 3b, 3c, 3d, 3e, 4, 5a, 5b and 5c
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	Striking-off order

Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr McMahon was not in attendance, nor was he represented in his absence. The panel was informed that a Notice of Hearing had been sent to Mr McMahon's registered email address on 17 April 2023.

Ms Ferns, on behalf of the Nursing and Midwifery Council (NMC), informed the panel that the Notice of Hearing provided details of the allegations, the time, date, and the video conferencing details required to join the hearing. The Notice also included information about Mr McMahon's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Ms Ferns submitted that the Notice of Hearing 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.

In the light of the information available, the panel was satisfied that Mr McMahon had 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 McMahon

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

Ms Ferns drew the panel's attention to an email dated 13 May 2023 from Mr McMahon which states: *'I will not be attending the hearing'.*

Ms Ferns submitted that the email on 13 May 2023 demonstrated that Mr McMahon is aware of today's hearing and that he had voluntarily absented himself, therefore the panel could find it appropriate to proceed in his absence in these circumstances.

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 McMahon. In reaching this decision, the panel has considered the submissions of Ms Ferns, the email communications between Mr McMahon and the NMC, and the advice of the legal assessor. It 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:

- An application for adjournment has not been made by Mr McMahon;
- Mr McMahon has stated that he will not attend the hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Two witnesses are due to give oral evidence during this hearing;
- Not proceeding may inconvenience the witnesses, their employers and the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses to recall events accurately; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr McMahon in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address,

he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

Furthermore, the limited disadvantage is the consequence of Mr McMahon's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Ferns on behalf of the NMC, to amend the wording in charges 1, 2 and 3 which contained an error in the date of the incident and also to amend a minor typographical error at the end of the charges.

The proposed amendments were to change the date *'14 March 2022'* to *'14 March 2021'* and the minor typographical error. It was submitted by Ms Ferns that the proposed amendments would rectify the typographical errors and it does not change the nature of the charges nor the evidence.

The panel accepted the advice of the legal assessor.

The panel decided to amend charges 1, 2 and 3 as asked. It had regard to Rule 28 of the Rules and was satisfied that the amendments were appropriate and could be made without injustice. The charges, with the amendments, are as follows:

That you, a registered nurse:

1) On 22 March 2022 were convicted of assault causing injury to Patient A in that you, on 14 March ~~2022~~ **2021**:
    a. Pushed Patient A against a wall
    b. Twisted Patient A's arm behind his back
    c. Dragged Patient A by the arm

2) On 14 March ~~2022~~ **2021** did not seek medical assistance in returning Patient A to Kyle Ward.

3) On 14 March ~~2022~~ **2021**, following Patient A falling to the floor / use of excessive force you did not:
    a. Report the incident to Person A
    b. Seek medical assistance for Patient A
    c. Examine/assess Patient A for injuries
    d. Accurately record the incident on Patient A's care plan
    e. Provide information of the incident at handover to the night team

4) Your conduct at 3 d was dishonest, in that you knew the record was not accurate.

5) Following Patient A falling to the floor, did not complete:
    a. A DATIX report
    b. Full comprehensive report
    c. Stress/distressed reaction form

AND in light of charge 1, your fitness to practise is impaired by reason of your conviction, and in light of charges 2, 3, 4 and 5 your fitness to practise ~~if~~ **is** impaired by reason of your misconduct.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case including character references, together with the submissions made by Ms Ferns on behalf of the NMC and the emails from Mr McMahon and in particular those dated 13 May 2023, 29 September 2022 and 1 December 2022.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

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

The panel had regard to Rule 31(2) which states:

> *'Where a registrant has been convicted of a criminal offence*
> *(a) a copy of the certificate of conviction, certified by a competent officer of a Court in the United Kingdom (or, in Scotland, an extract conviction) shall be conclusive proof of the conviction; and*
> *(b) the findings of fact upon which the conviction is based shall be admissible as proof of those facts.'*

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

- Witness 1: Employed by Cumbrae Lodge Care Home as a Domestic.

- Witness 2: Employed by Cumbrae Lodge Care Home as the Deputy Home Manager at the time (Person A).

Background

The charges arose whilst Mr McMahon was employed as a registered nurse by Cumbrae Lodge Care Home ("the Home"). The Home is a care home which specialises in providing care for residents suffering from dementia and associated mental health problems.

Patient A had been a resident at the Home on Kyle Unit for many years and had advanced dementia. Mr McMahon was the registered nurse in charge of Kyle and Bute on 14 March 2021. Mr McMahon had worked shifts with Patient A on a regular basis and the allegations relate to Mr McMahon's behaviour toward Patient A on that date.

On 14 March 2021 Mr McMahon was caring for Patient A and a situation arose where Patient A became agitated and managed to kick open the fire door of Kyle Unit and got out into the main corridor. Mr McMahon then became involved and after an altercation with Patient A, assisted him to return to Kyle Unit. Witness 1 was present throughout this incident. On returning to Kyle Unit, Patient A fell to the floor.

On 15 March 2021 during the disciplinary interview Mr McMahon admitted he was heavy handed with Patient A and accepted that he used excessive force with Patient A.

Police Scotland investigated this incident and on 17 March 2021 Mr McMahon was charged with an offence of assault on Patient A.

On 22 March 2022 Mr McMahon was convicted for assault to injury on Patient A on the basis of plea of repeatedly pushing Patient A against a wall causing his head to strike the

wall, seizing him by the arm and twisting the same, and forcibly dragging him by the body to his injury.

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

Charge 1a)

On 22 March 2022 were convicted of assault causing injury to Patient A in that you, on 14 March 2021:

Pushed Patient A against a wall

This charge is found proved.

In reaching this decision the panel took into account the certificate of conviction and the basis of Mr McMahon's plea which reads as follows:

'a plea was adjusted on your behalf whereby you pled guilty to an amended Indictment by effectively repeatedly pushing [Patient A] against a wall, causing his head to strike the wall, seizing him by the arm and twisting same and forcibly dragging him by the body to his injury.'

The panel accepted this evidence and therefore found this charge proved.

Charge 1b)

Twisted Patient A's arm behind his back

This charge is found proved in part.

In reaching this decision, the panel took into account the certificate of conviction and the basis of Mr McMahon's plea. The panel noted that Mr McMahon was convicted of twisting Patient A's arm but there is nothing in the basis of plea to confirm that he twisted Patient A's arm behind his back. Therefore, on the basis of this evidence, the panel found this charge proved in so far as Mr McMahon twisting Patient A's arm but not twisting it *'behind his back'* as per the charge.

Charge 1c)

Dragged Patient A by the arm

This charge is found proved.

In reaching this decision the panel accepted the certificate of conviction and the basis of Mr McMahon's plea whereby he pled guilty to forcibly dragging Patient A by the body to his injury. It is clear from the basis of plea that the injury was to Patient A's arm. The panel therefore found this charge proved.

Charge 2)

On 14 March 2021 did not seek medical assistance in returning Patient A to Kyle Ward.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 who told the panel that she was present from the time Patient A pushed open the fire door and until Patient A had been escorted back to the unit. She stated that she did not see Mr McMahon seek medical assistance for Patient A in returning him to Kyle Ward. She said, *"he left the unit pretty much immediately".*

The panel had sight of the hand written accounts made by the two staff members from the Home who had been present at the scene of the altercation and during Patient A's subsequent fall to the floor. These accounts were requested by Witness 1 from the staff members on the day of the incidents and she received and read them on 15 March 2021. Whilst these individuals did not attend the hearing as witnesses, the panel noted that the accounts were broadly consistent with each other and with witness accounts and that they were made on the day of the incidents. They make no reference to Mr McMahon seeking medical assistance or of him asking them to do so. Further, neither Mr McMahon's care notes made on the day of the incidents nor his subsequent email accounts include any reference to him having sought medical assistance.

Charge 3a)

> On 14 March 2021, following Patient A falling to the floor/use of excessive force you did not:
>
> Report the incident to Person A

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 who was the Deputy Manager of the Home and in effect the Home Manager on the day of the incident, in the absence of the Home Manager. In her written statement she said, *'Derek never sought any form for medical assistance and neither did he approach me, in my capacity as deputy home manager, to tell me what had happened.'* Witness 2's oral evidence supported her written statement. She also referenced section 1.7 of the Home's moving and handling policy which describes how incidents are managed and should be reported. She told the panel that it was Witness 1 who informed her of the incident and after speaking with Witness 1 she found out that there were other witnesses who were members of the care assistant team. Witness 2 subsequently asked Witness 1 and the two members of the care team to provide written accounts of this incident which she received the next day.

Witness 2 stated during her oral evidence that it was unusual for an incident of such nature to be reported by a member of the domestic staff. Witness 2 told the panel that Mr McMahon passed her in the corridor *'around 20 minutes after the incident'* and he told her that Patient A had got off the unit but was now back in the unit. However, he did not report the detail of what had happened and in particular made no reference to his use of force or Patient A having fallen.

The panel noted that there is no mention of the incident being reported to Witness 2 in Mr McMahon's email accounts and there is no mention of Mr McMahon reporting it to Witness 2 in Patient A's care notes.

The panel carefully assessed all the evidence before it and concluded that this charge is found proved.

Charge 3b)

Seek medical assistance for Patient A

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 1 and 2. Witness 1 told the panel that after the altercation, Patient A had been shouting in pain whilst being accompanied back to the unit.

Witness 2 stated in her written statement '*Derek never sought any form of medical assistance'.* She confirmed this during her oral evidence. Witness 2 told the panel that the usual method of seeking medical assistance was to use the E-doc system where a non-emergency call can be telephone triaged in order to obtain a medical review. Both Witness 1 and Witness 2 indicated that the assistance from another registered nurse in duty should also be sought in the case of a suspected injury.

The panel determined that there is no evidence of Mr McMahon reporting the incident, escalating it, or seeking medical assistance of any kind for Patient A on 14 March 2021. Witness 2 told the panel that, in her view Mr McMahon should have activated the crash call as there was a fall. The panel heard that a crash call was activated earlier in the day in a different unit while Mr McMahon was caring for another patient but it is not clear who activated the call.

The panel was made aware that Mr McMahon did seek medical assistance the day after his use of force and the fall, after Patient A was assessed by Witness 2 and the Home Manager and he was instructed to do so.

The panel concluded, based on the evidence before it, that Mr McMahon did not seek medical assistance on 14 March 2021 following his use of force and Patient A's fall. The panel therefore found this charge proved.

Charge 3c)

Examine/assess Patient A for injuries

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1. During her oral evidence, Witness 1 said that Mr McMahon did not examine/assess Patient A for injuries and that he left pretty much immediately after returning Patient A to the unit. The panel also noted that there is no record of Mr McMahon examining or assessing Patient A in his care notes and he did not mention anything about examining or assessing the patient during the handover or in any of his email accounts to the NMC.

The panel had regard to the written statement of Witness 2 which she confirmed during her oral evidence. She stated in the statement:

‘I would have expected Derek to get medical treatment for [Patient A] and to provide any nursing assistance that he could. He should also have informed me of what had happened. He should also have updated the care notes to record the incident.’

In her oral evidence, Witness 2 told the panel that she would have expected a full examination of a patient after any fall, usually before the patient got up.

The panel also had regard to Mr McMahon’s email accounts to the NMC. He stated that he did not examine Patient A immediately as he wanted Patient A to calm down and felt that it may have inflamed the situation.

However, the panel noted that even after Patient A had calmed down later, Mr McMahon outlined *‘I returned to the kyle unit sometime later to see how [Patient A] was and he came up to the kitchen smiling and talking to me so I thought he was none the worse from his ordeal, this, in retrospect, was a mistake’.*

Witness 2 told the panel that she would have expected Mr McMahon to examine Patient A later that day when he had calmed down. She also said that he could have asked the carers to monitor Patient A until he was calm enough to be examined or have asked someone else to examine him.

The panel determined that there is no evidence of Mr McMahon examining or assessing Patient A after his use of force or the fall. The panel therefore concluded that this charge is found proved.

Charge 3d)

Accurately record the incident on Patient A’s care plan

This charge is found proved.

In reaching this decision, the panel took into account the patient care notes in particular there is an entry dated 14 March 2012 which states:

> *'Mood was quite confrontational, he kicked the foyer door open, trying to kick and punch staff when being escorted back to unit, tripped and fell but stopped from hitting the floor by staff member.'*

Witness 2 told the panel during her oral evidence that the signature on the above care notes was that of Mr McMahon. She said she was confident Mr McMahon should have known what to do document in this situation as he was an experienced nurse. When asked what she would have expected to have seen in the care notes, she said an accurate description of the incident, details of any possible injuries, who the incident was reported to and if it had been reported to the family members, too.

Witness 2 stated during her oral evidence that the entry, as quoted above, was not an unusual account as Patient A had been known to demonstrate similar behaviours before. She further concluded that it was not an accurate description of what had occurred.

The panel determined that there is no evidence of a medical record or care notes made by Mr McMahon which accurately recorded the incident. It noted that on 14 May 2021 he made some notes but gave no extent of the possible injuries or that he had escalated it further and the notes do not reflect what had happened. The panel therefore concluded that this charge is found proved.

Charge 3e)

Provide information of the incident at handover to the night team

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2. She told the panel that she witnessed Mr McMahon give the handover whereupon he outlined how Patient A was distressed and had tried to get out of the unit and was accompanied back. She told the panel that this was not out of the ordinary for Patient A and that there had been no mention of a fall or an injury. The handover given did not communicate to the incoming night shift that there had been an altercation or an incident of any significance.

Witness 2 also stated in her written statement that the incident was not mentioned in the handover. She stated, *'At our handover later that day, Derek mentioned something about [Patient A] getting out of the unit and that he had to get taken back but this is just his normal behaviour.'*

The panel therefore determined that this charge is found proved.

Charge 4)

Your conduct at 3 d was dishonest, in that you knew the record was not accurate.

This charge is found proved.

Dishonesty was alleged in this charge and the panel was reminded of the test in respect of dishonesty set out in the case of *Ivey (Appellant) v Genting Casinos (UK) Ltd. t/a Crockfords (Respondent)* [2017] UKSC 67, where Lord Hughes, giving judgment, stated as follows:

> *"…The fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether*

his conduct was honest or dishonest is to be determined by the fact finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest".

The panel found that Mr McMahon knew that he used excessive force and that he was heavy handed, as he admitted this the following day. He was also aware that Patient A had fallen. This demonstrates he knew that there was potential injury but did not provide the details of any of this in the care notes.

The care notes therefore do not accurately reflect the events that he knew had taken place or provide accurate clinical information for the subsequent shift. There is an omission of any detail concerning use of force, a trip or fall, and a potential injury to Patient A.

Mr McMahon has failed to account for the absence of this significant information within the care notes, and the record he made in the care notes appear to minimise the severity of the events of 14 March 2021.

The panel heard that Mr McMahon was an experienced nurse who was held in high regard by several members of the nursing staff who worked alongside him, and as a registered nurse of many years he would have known the consequences of not making an accurate record in the care notes. Witness 2 described Mr McMahon as "*a confident and professional nurse.*"

Having regard to the test in *Ivey v Genting Casinos* UK, the panel determined that ordinary decent people would have expected Mr McMahon to have made an accurate record of the incidents in the care notes. The panel concluded that the failure to record the events accurately would be regarded as dishonest by the standards of ordinary decent people.

The panel therefore found this charge proved.

Charge 5)

Following Patient A falling to the floor, did not complete:

a. A DATIX report
b. Full comprehensive report
c. Stress/distressed reaction form

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Witness 2. During her oral evidence she told the panel that she checked the system and no DATIX was completed and that Mr McMahon would have known how to do this as it was part of the induction training and *'he always did them.'*

Witness 2 stated that DATIX would be completed for falls or any incidents that are cause for concerns. The panel determined that there is no evidence before it that shows a DATIX was completed by Mr McMahon.

The panel heard from Witness 2 that the full comprehensive report was an electronic form which is required to be completed for minor, to moderate, to major incidents. Therefore, details of near misses, altercations, complaints, and structural damages need to be recorded on this form. As an experienced registered nurse, Mr McMahon was expected to complete a full comprehensive report for this type of incident as he had done before, and he would have known that Patient A was under a management plan because this was his regular unit. Witness 2 confirmed that she was confident he knew the procedure and had completed many other reports. However, Witness 2 could not find any evidence of this being completed by Mr McMahon.

During her oral evidence, Witness 2 was asked about stress/distressed reaction form. She told the panel that this form was required to be completed if there was an incident so that the Home can identify the root causes, what was going on at the time, how the stresses

were managed and any particular staff present. This assists in forming a management plan following a major incident. Witness 2 told the panel that Mr McMahon had completed these forms before. She checked Patient A's care plan and there was no stress/distressed reaction form completed by Mr McMahon which is why she knows for sure that nothing was completed.

Having considered all the evidence before it, the panel determined that on the balance of probabilities Mr McMahon did not complete any of the above forms following the fall of Patient A as he was required to do so.

The panel therefore found these charges proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr McMahon's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC guidance requires the panel to consider *'Can the nurse, midwife or nursing associate practise kindly, safely and professionally?*
If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

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 heard and accepted the advice of the legal assessor.

With respect to Charges 2 to 5, 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 McMahon's fitness to practise is currently impaired as a result of that misconduct. In relation to the conviction the panel was mindful that it only needed to decide whether Mr McMahon's fitness to practise is currently impaired by reason of his conviction.

Submissions on misconduct

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

Ms Ferns also referred the panel to the 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.
Ms Ferns reminded the panel that misconduct, in the regulatory context, must amount to serious professional misconduct. She identified several breaches of the Code to the panel and submitted that Mr McMahon's actions amounted to serious misconduct.

Ms Ferns submitted that Mr McMahon's actions individually and collectively fall seriously short of the conduct expected of a registered nurse. She therefore invited the panel to take the view that the facts found proved with respect to Charges 2 to 5 amount to serious misconduct.

Submissions on impairment

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

Ms Ferns submitted that Mr McMahon has engaged with the NMC but has demonstrated no real insight into the seriousness of his actions and produced no evidence of remediation or the steps he has taken to strengthen his practice. He has not admitted the charges and that his fitness to practise is currently impaired by reason of his conviction and his misconduct.

Ms Ferns submitted that the regulatory concerns in this case are particularly serious as a criminal conviction for the assault of a patient in Mr McMahon's care raises serious concerns about the basics of his professionalism and attitude to patients. All patients have the right to expect that nurses will treat them with kindness and compassion at all times. Ms Ferns submitted that there is a risk of harm to patients and the public if this concern is not addressed.

Ms Ferns also submitted that Mr McMahon exposed Patient A to a serious and unwarranted risk of harm and unless his failings are addressed, he could pose an ongoing risk to members of the public in the event that he is permitted to return to practise unrestricted.

Ms Ferns further submitted that record keeping is a basic element of safe and effective care and responding appropriately to a patient in pain is also an essential skill in nursing. She submitted that Mr McMahon has not complied with the duty of candour to be open and honest when things go wrong. The entry made by him in Patient A's care record was inaccurate, he would have known that it was inaccurate and his entry was dishonest. Mr McMahon's conduct in writing an inaccurate description of the incident in which Patient A suffered an injury as a result of his actions meant that medical assistance was not sought as quickly as it could have been, and Patient A continued to suffer.

Ms Ferns submitted that Mr McMahon's conviction and the conduct linked to it could be said to have fallen far below the standards expected of a registered nurse. There is also

clear evidence that Patient A suffered harm as a result of Mr McMahon's conduct and behaviour.

Ms Ferns submitted that given the seriousness of this case and the failings identified, the panel may conclude in the circumstances of this case, a finding of impairment on the grounds of public protection and also in the wider public interest is required, and that Mr McMahon's fitness to practise is currently impaired.

Decision and reasons on misconduct

When determining whether the facts found proved in Charges 2 to 5 amount to misconduct, the panel had regard to the Code.

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

'1 Treat people as individuals and uphold their dignity

To achieve this, you must

1.1 treat people with kindness, respect, and compassion,

1.2 make sure you deliver the fundamentals of care effectively,

1.3 make sure that any treatment, assistance, or care for which you are responsible is delivered without undue delay,

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay,

1.5 respect and uphold people's human rights

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

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate,

8.2 maintain effective communication with colleagues,

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm,

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers,

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

20 Uphold the reputation of your profession at all times

*To achieve this, you must**:***

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

20.2 act with honesty and integrity at all times…

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.4 keep to the laws of the country in which you are practising,

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'

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

In reaching its decision, the panel made a determination on whether charges 2, 3, 4 and 5 amount to misconduct.

The panel took the view that the breaches of the Code and Mr McMahon's behaviour and actions were particularly serious due to the vulnerability of Patient A who had advanced dementia. The panel considered the NMC guidance FTP-3 (How we determine seriousness) and FTP-3a (Serious concerns which are more difficult to put right). This guidance identifies that concerns regarding breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records are particularly serious and difficult to put right.

The panel determined that Mr McMahon breached the fundamental tenets of the profession and breached the NMC Code. The panel noted all four main themes of the Code were engaged. The panel concluded that not seeking medical assistance, not examining the patient, not reporting the incident, dishonestly not recording the events

accurately in the care notes and failing to complete other supplementary documents demonstrate significant failures on the part of Mr McMahon.

The panel found that Mr McMahon's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to serious misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

The panel had regard to the case of *R (on the Application of Cohen) v GMC* [2008] EWHC 581 Admin and considered whether the misconduct identified is capable of remediation, whether it has been remedied and whether there is a risk of repetition.

The panel found that Patient A was put at unwarranted risk of harm on 14 March 2021 and was caused physical and emotional harm as a result of Mr McMahon's misconduct, including Mr McMahon's assault of Patient A and his failure to ensure Patient A received appropriate medical assessment and treatment thereafter. He was then dishonest in his record of events which impacted on the ability of others to administer appropriate care and seek medical attention.

With respect to whether Mr McMahon has brought the profession into disrepute, the panel noted he had used excessive force, failed to examine Patient A after his use of force and Patient A's subsequent fall, failed to ensure timely medical assessment and treatment for

Patient A and had acted dishonestly. These are serious and significant failings which undoubtedly brought the profession into disrepute. The panel has already found a serious breach of the Code in this respect.

The panel has already determined, in its findings of misconduct, that Mr McMahon breached fundamental tenets of the profession.

The panel has determined that Mr McMahon acted dishonestly on 14 March 2021 and breached the professional duty of candour. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to the dishonesty aspect of the misconduct extremely serious.

The panel was not satisfied that the conviction and the misconduct in this case are capable of being easily remediated as Mr McMahon is convicted of assault of an extremely vulnerable patient and subsequently displayed a lack of kindness, care and compassion. He later behaved dishonestly in documenting the incidents. This demonstrates a total disregard to the NMC Code of conduct. The panel again referred to NMC guidance FTP-3a (Serious concerns which are more difficult to put right) which identifies *'deliberately causing harm to patients'* and breaches of the duty of candour as being particularly difficult to put right. These appear to have been isolated incidents which all took place on day and the panel had sight of several positive character references as well as hearing Witness 2's evidence that he was a *"confident and professional nurse".* However, the panel had significant concerns about the evidence of attitudinal issues that were not admitted by Mr McMahon and there is no evidence that he has reflected upon these.

The panel determined that it does not have evidence to show Mr McMahon has taken any steps to strengthen his practice. The panel noted that it does not have a reflective piece provided by Mr McMahon which could have highlighted any insight into the facts found proved and his misconduct, or how he would do things differently to reassure the panel

that these events will not be repeated. The panel therefore did not have evidence his misconduct and the conduct underlying his conviction had been remediated.

The panel next considered the risk of repetition. Whilst Mr McMahon initially admitted to having been *'heavy handed'* the day after the incident and then pleaded guilty on a basis of plea to assaulting Patient A, in his more recent emails to the NMC he has minimised his behaviour. This has included saying that *'I pleaded guilty at court because I could not take it anymore, I needed closure so I could move on…',* admitting that it was a mistake not to examine Patient A following the incident and that he was '*not at my most professional that day.'* In the circumstances, given Mr McMahon's recent minimisation of his behaviour, its effects on Patient A and Mr McMahon's apparent lack of insight, the panel could not discount a future risk of harm.

More generally, taking account of the misconduct and the conviction, the panel has not received any evidence indicating that Mr McMahon has completed any relevant training or submitted further reflections relating to the events in question on 14 March 2021. The panel had no evidence before it to persuade it that the misconduct and the conduct underlying the conviction would not be repeated. The panel therefore considered there to be a risk that he may behave in a similar way in the future.

Given the panel's findings above, it concluded that Mr McMahon was liable, in future, to put a patient at unwarranted risk of harm, breach a fundamental tenet of the profession, bring the profession into disrepute and act dishonestly. The panel was not persuaded that Mr McMahon was a registrant who could be relied upon to practise kindly, safely and professionally.

The panel bore in mind 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.

It therefore found that Mr McMahon's fitness to practise is currently impaired on the grounds of public protection. In addition, it determined that public confidence in the nursing profession and in the NMC as the regulator would be undermined if a finding of impairment were not made.

Having regard to all the above, the panel was satisfied that Mr McMahon's fitness to practise is currently impaired on the grounds of both public protection and in the wider public interest in relation to his misconduct and conviction.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr McMahon off the register. The effect of this order is that the NMC register will show that Mr McMahon has been struck-off the register.

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

Submissions on sanction

Mr Badruddin, on behalf of the NMC, submitted that a striking off order is the appropriate and necessary sanction in this case. Mr Badruddin submitted that the following aggravating factors are present:

- Mr McMahon's physical abuse of a vulnerable resident;
- Mr McMahon abused his position of trust;
- Actual physical harm to Patient A;
- Mr McMahon's attempts to cover up this assault on Patient A by falsifying records;
- Mr McMahon's attempt to minimise his conduct by shifting the blame to Patient A;
- Deep-seated attitudinal and behavioural concerns.

Mr Badruddin submitted that the only mitigating factor is that Mr McMahon admitted to the criminal charges related to this case.

Mr Badruddin took the panel through each of the sanctions available to this panel in order of least serious. He submitted that this is a serious case, referring to the NMC Guidance on Sanctions for serious cases (SAN-2), identifying that many of the factors therein were relevant. He submitted that the only appropriate and necessary sanction is that of a striking off order as Mr McMahon's practice is fundamentally incompatible with him remaining on the register. He submitted that a striking off order is necessary on the ground of public protection and is otherwise in the public interest, to maintain public confidence in the profession.

Decision and reasons on sanction

Having found Mr McMahon'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:

- Abuse of position in that Mr McMahon was the registered nurse in a specialised care home with vulnerable residents
- Actual physical harm to Patient A;
- Deliberately chose to take unnecessary risks through not seeking medical attention, delaying reporting the harm caused to Patient A, which could have increased the level of harm to Patient A;
- Whilst the panel considered Mr McMahon's responses to the NMC that he has not been able to show remediation through practise as he has been suspended, it

determined that he has shown a lack of remorse and insight particularly in regard to the injury caused to Patient A, the stress to Patient A's family and the damage to the reputation of the profession;

- Attitudinal concerns.

The panel also took into account the following mitigating features:

- Isolated incident insofar that this incident occurred over one shift;
- Mr McMahon admitted to the criminal charges related to this case.

Whilst the panel considered the positive testimonials provided by Mr McMahon. It noted that these testimonials were provided by colleagues and do not directly specify the facts found proved in this case. The panel therefore determined that this offers limited mitigation given the seriousness of the charges and the risk of repetition identified.

Before making its decision on sanction, the panel considered the NMC Guidance on cases involving dishonesty at SAN-2, particularly:

'Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*
- *direct risk to patients*
- *premeditated, systematic or longstanding deception'*

Whilst the panel noted that there is no evidence of personal financial gain or that this incident was premediated or systematic, the panel determined that the majority of the above factors are present and so determined that this is a serious misconduct case.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr McMahon'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 McMahon's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr McMahon's registration would be a sufficient and appropriate response. Whilst the panel noted that the concerns occurred in a clinical environment, it considered that many of facts found proved do not relate to specific clinical practice. The panel is of the view that there are no practical or workable conditions that could be formulated, given the finding of deliberately falsifying patient records and the physical abuse of a vulnerable patient. Furthermore, the panel concluded that the placing of conditions on Mr McMahon's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel acknowledged that this was a series of incidents of misconduct that were limited to one shift and there has been no evidence of repetition, however the panel also found that there is evidence of attitudinal problems and there is a significant risk of Mr McMahon repeating this behaviour. This case involves a serious abuse of position by Mr McMahon which includes him assaulting a vulnerable patient causing him harm and subsequently neglecting the patient by failing to examine him, report and escalate the incident. There was also evidence of attitudinal issues in his attempts to cover up this incident, thereafter, including falsifying records. There was limited evidence of Mr McMahon's remorse or insight into his behaviour and its impact on the reputation of the profession following this incident.

A suspension order would protect the public for the period of time it was in force however, given the significant aggravating factors present, the panel decided that a suspension order would not be sufficient to uphold all limbs of the NMC's overarching objective.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel considered the above and determined that the proven facts do raise fundamental questions about Mr McMahon's professionalism and his attitude. Mr McMahon assaulted and injured Patient A who was particularly vulnerable and should have been able to place his trust in Mr McMahon and expect compassionate care. He then failed to report the incident, did not examine Patient A and did not call for medical assistance. He deliberately misrepresented the incident in the appropriate records. Since then, he has engaged only to a limited extent with these proceedings, provided limited evidence of reflection and has provided no evidence of steps taken to strengthen his practice.

The panel considered that Mr McMahon had a long career as a registered nurse, with positive testimonials provided and that a striking-off order may impact Mr McMahon, financially and personally. However, it determined that Mr McMahon's actions were a grave abuse of the trust placed in him to care for patients and amount to a significant departure from the standards expected of a registered nurse. The panel concluded that his actions were fundamentally incompatible with him remaining on the register. To allow Mr McMahon to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

The panel acknowledged that a striking off order is the most serious sanction and will impact upon Mr McMahon's ability to earn his living in the profession of nursing. However,

having balanced the overarching objective of public protection with Mr McMahon's own interests, it was satisfied that a striking-off order is the only sanction which will uphold the NMC's overarching objective.

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

This will be confirmed to Mr McMahon in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Mcmahon's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Badruddin who submitted that it is necessary to impose an interim suspension order for a period of 18 months in order to adequately protect the public and otherwise in the public interest during the 28-day appeal period and any subsequent appeal period.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.