Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Tuesday, 23 April 2024

Virtual Hearing

Name of Registrant:	Samuel Thomas Haward
NMC PIN	07F2356E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health – Level 1 (19 February 2008)
Relevant Location:	Swindon
Type of case:	Misconduct and Conviction
Panel members:	Dale Simon (Chair, Lay member) Elisabeth Fairbairn (Registrant member) Matthew Wratten (Lay member)
Legal Assessor:	Gerard Coll
Hearings Coordinator:	Nicola Nicolaou
Nursing and Midwifery Council:	Represented by Bethany Brown, Case Presenter
Mr Haward:	Not present and not represented at the hearing
Order being reviewed:	Suspension order (9 months)
Fitness to practise:	Impaired
Outcome:	**Striking-Off order to come into effect at the end of 30 May 2024 in accordance with Article 30 (1)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Haward was not in attendance and that the Notice of Hearing had been sent to Mr Haward's registered email address by secure email on 7 March 2024.

Ms Brown, on behalf of the Nursing and Midwifery Council (NMC), 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 substantive order being reviewed, the time, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Haward'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 Haward has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Haward

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

Ms Brown submitted that there had been no engagement at all by Mr Haward with the NMC in relation to these proceedings, despite all reasonable efforts being made to contact him. She referred the panel to an email from the Royal College of Nursing (RCN) dated 3 April 2024 in which they confirmed they are no longer instructed by Mr Haward and will not attend today's review hearing. Ms Brown submitted that, as a consequence, there was no

reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel decided to proceed in the absence of Mr Haward. In reaching this decision, the panel considered the submissions of Ms Brown, and the advice of the legal assessor. It had particular regard to the relevant case law and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Haward;
- Mr Haward has not engaged with the NMC and has not responded to any of the letters sent to him about this hearing, despite reasonable efforts being made to contact him;
- Mr Haward has voluntarily absented himself;
- There is no reason to suppose that adjourning would secure his attendance at some future date; and
- There is a strong public interest in the expeditious review of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Haward.

Decision and reasons on review of the substantive order

The panel decided to replace the current suspension order with a striking off order.

This order will come into effect at the end of 30 May 2024 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the first review of a substantive suspension order originally imposed for a period of 9 months by a Fitness to Practise Committee panel on 31 July 2023.

The current order is due to expire at the end of 30 May 2024.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved by way of admission which resulted in the imposition of the substantive order are as follows:

> *'That you, a Registered Nurse:*
>
> *1. On 26 February 2020 were convicted of committing an act/series of acts with intent to pervert the course of public justice at Swindon Crown Court.*
>
> *AND, in light of the above, your fitness to practise is impaired by reason of your conviction.*
>
> *2. On 17 September 2015, at Chalkdown House, did not respond appropriately and/or provide CPR to Patient A as required.*
>
> *AND in light of the above your fitness to practice is impaired by reason of your misconduct.'*

The original substantive panel determined the following with regard to impairment:

> *'The panel next went on to decide if as a result of the conviction, your fitness to practise is currently impaired.*
>
> *The panel was of the view that your lies, in telling the Trust, the police, the coroner, and ultimately a jury, that you had commenced CPR on Patient A prior to the 999 call, when you had not, breached parts of the Code. Specifically:*
>
>> ***'4 Act in the best interests of people at all times***
>>
>> ***8 Work cooperatively***
>> *To achieve this, you must:*
>> *8.2 maintain effective communication with colleagues*
>> *8.5 work with colleagues to preserve the safety of those receiving care*

8.6 share information to identify and reduce risk

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

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

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, treating people fairly and without discrimination, bullying or harassment

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

23 Cooperate with all investigations and audits

To achieve this, you must:

23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise'

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. 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> *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 found that all four limbs of the test are engaged by reason of your misconduct and conviction. It determined that Patient A was put at risk of unwarranted physical harm as a result of you not performing CPR on him prior to calling 999. The panel determined that you did not act professionally and competently, or in the best interests of Patient A. The panel found that your conduct breached the fundamental tenets of the nursing profession and had brought its reputation into disrepute.

The panel was satisfied that confidence in the nursing profession would be seriously undermined if its regulator did not find charges relating to prolonged dishonesty, that led to a criminal conviction, to be very serious. In relation to your failure to initiate CPR before the 999 call and lying about this, the panel was of the view that if put under similar pressure or facing similar circumstances, there is a risk that this could be repeated. The panel noted that you lied from the date of the incident in September 2015, up until the date of your sentence in July 2020. The panel was of the view that you only told the truth as a result of being found guilty.

The panel considered the evidence provided by Registrant B during her second police interview on 25 February 2016 when she informed the police that she wanted to tell the truth. During this interview, Registrant B was very clear that she took over from you and continued the CPR that you had commenced on Patient A. In her oral evidence, Registrant B disputed this and seemed very confused. However, the panel considered that this interview set out the actual truth of what happened and formed the basis of the criminal court case. The panel concluded that you conducted CPR after the 999-call had been made and accepted your evidence that is supported by the version of events given by Registrant B in her second police interview on 25 February 2016. The panel did not find that Registrant B was lying

during her oral evidence to get you into more difficulties but determined that her confusion was as a result of the passage of time.

On the issue of whether you put pressure on Registrant B to tell and maintain the lie that you had commenced CPR on Patient A immediately, the panel considered all the evidence before it. It noted that in her oral evidence, Registrant B said that you had asked her to lie initially and had then contacted her on a number of occasions. She said that you had contacted her on holiday, met her in Chiswick, London and phoned her on a number of occasions telling her not to change her story. When you were asked about this during your oral evidence, you totally refuted this and said you had never contacted Registrant B to discuss the matter. The panel took into account what Registrant B had told the police in her second police interview which was consistent with her oral evidence.

The panel also noted the comments made by the sentencing judge about you contacting Registrant B to continue to lie on your behalf on a number of occasions. The sentencing judge in the case of Registrant B also raised the issue and stated that you had persuaded her to mislead the authorities. The panel preferred the account of Registrant B on this issue.

The panel noted that you made no reference to this issue in your reflective piece, and you did not address how your actions affected Registrant B, who felt harassed into supporting your account. In fact, there is nothing of substance in your reflective piece that acknowledges how your lies and dishonesty may have affected your colleagues. The panel was concerned that given the Judge's sentencing remarks around how you negatively affected Registrant B you chose not to address the impact on her in your reflective account. This unresolved and non-acknowledged matter raises concerns about your insight and remorse.

In your reflective piece you stated:

> *"following my conviction, I accepted that this was a regulatory concern, and I therefore designed an action plan with a set of objectives to enable me to improve my deficit areas. To do this I had to go back to the NMC Code of*

Conduct that regulates my practice and looked at where I had breached the Code".

You then identify Section 7 and 8 of the Code as areas for you to address. These deal with communication and working co-operatively. In respect of communication, you say that you accept that your communication and that of the team was not effective on the day the incident occurred. On working cooperatively, you say that the team failed to work cooperatively, and you accept the part you played in this failure and the consequences that followed. However, there is nothing in your reflective piece that demonstrates that either of these two areas have been addressed since your conviction. The action plan was not put before the panel.

You also state in your reflective piece that you are committed to immersing yourself in current best practices and dedicating extra effort to enhance your skills in dealing with similar incidents. The certificates included in your reflective bundle demonstrate that you have completed your mandatory training, however, there is no evidence before the panel to suggest that you have undertaken further training in life support beyond the expected minimum.

Regarding insight, the panel acknowledge that you have done some additional training and mandatory refresher training since your conviction. The panel was also provided with details of the courses you had done as part of your revalidation as a nurse. However, the panel was not sufficiently satisfied that you had done enough to demonstrate that you are not likely to repeat some of your past behaviour. In addition, the panel was not reassured that you have properly addressed the matters giving rise to the concerns despite the efforts you have made so far.

The panel acknowledged the positive testimonials that you provided. You helpfully provided the panel with a reference from the Agency that currently employs you in Muckamore Abbey Hospital. The person who provided the reference does not have the opportunity to observe staff directly in practice. However, he stated that you are a valuable asset to the service area you are deployed in, and that management have noted that you are an excellent nurse "with whom they could not do without". While this is helpful, a reference from your line manager setting out what progress

you have made since commencing employment just before your sentencing would have been of more assistance. Furthermore, it could also have commented on your action plan referred to in your reflective piece. The panel acknowledges that on occasions it can be difficult for agency nurses to get references directly from the person they are working under.

The panel acknowledged your initiative in undertaking the Defibrillator course following the incident in 2015. You have included the course contents in your reflective piece. In your reflective piece you also state that you have taken proactive steps to enhance your knowledge by enrolling in recurring basic life support training sessions. However, this is not supported by the training certificates you provided to the panel.

In its consideration of whether you have full insight and have significantly strengthened your practice, the panel considered your oral evidence when asked questions about your actions. You repeatedly said you were remorseful and apologised for your actions. Your oral testimony and written reflection demonstrated some early insight, but the panel is of the view that this is still developing, particularly as regards to the impact of your actions on Patient A's family, Registrant B, your colleagues, and the wider profession. There is some evidence of you attending relevant training courses. There have been no concerns reported about you whilst you have been practising unrestricted for the past seven and a half years. You told the panel that you are now proactive in making sure you can summon help, know where CPR kits are, and what the actual policy is on the unit where you are working. The panel was of the view that you acknowledged the incident and agreed your actions were wrong, however, you have sought to put the incident behind you without fully addressing how your actions affected others including your colleagues.

The panel is of the view that there is a risk of repetition and that if you find yourself in a similar situation where there is a risk to your reputation, losing your job, or being in front of the police or a court, you could behave as you did previously. The panel determined that although you have been working unrestricted without any concerns since 2015, a finding of impairment on public protection grounds is

necessary as you have not yet demonstrated sufficient insight into your failure to commence CPR on Patient A immediately and why you lied about this. Although you have some insight as to why you did not perform CPR, you have not sufficiently addressed the issue of your anxiety, and if faced with a similar incident the panel could not be satisfied that such feelings of panic and anxiety would not reoccur. The panel therefore decided that a finding of current impairment is necessary on the grounds of public protection.

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

The panel determined that, in this case, a finding of impairment on public interest grounds was required given your prolonged period of dishonesty. It determined that your dishonest conduct has brought the profession into disrepute.

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

The original substantive panel determined the following with regard to sanction:

'The panel then went on to consider whether a suspension order would be an appropriate sanction. The NMC's Sanctions Guidance (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 and conviction were not fundamentally incompatible with you remaining on the register.

The panel then went on to consider whether a striking off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, it concluded that this would be disproportionate. Whilst the panel acknowledges that a suspension order may have a punitive effect, it would be unduly punitive in your 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 to mark the public interest and public protection issues in this case.

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

The panel considered that a suspension 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 you as a registered nurse.

In making this decision, the panel carefully considered the submissions of Mr Skinner in relation to the sanction that the NMC was seeking in this case. However, the panel took into account that you have been practising without any further clinical concerns since the incident occurred. Further, the panel was of the view that an informed member of the public who had access to all the information before the panel, including the testimonials, training certificates, your developing insight, and your engagement with the proceedings, may consider that you now understand that what you did wrong. They may also consider that you understand you need to make further improvement and undertake further training. The panel also noted that you have had no clinical concerns since the incident.

The panel noted the reference from the Director of Clinical Care and determined that such positive comments would not have been made regarding your practice if you were not considered to be a good nurse.

The panel was also of the view that it would be in the public interest for a nurse who has been able to demonstrate some insight into their failings and work towards making further improvements and has been practising for almost eight years since the failings occurred with no other concerns, to remain on the register.

The panel determined that a striking off order would be disproportionate because a suspension order is sufficient to mark the seriousness of the misconduct and give you an opportunity to demonstrate full insight building on what you have developed so far.

The panel determined that a suspension order for a period of 9 months was appropriate in this case to mark the seriousness of the misconduct and give you sufficient time to develop full insight and strengthen your practice.'

Decision and reasons on current impairment

The panel has considered carefully whether Mr Haward's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle. It has taken account of the submissions made by Ms Brown on behalf of the NMC. She provided the background to the case and reminded the panel of the original substantive panel's decision and reasons on impairment and sanction. Ms Brown submitted that the charges are very serious, and that the misconduct relates to a failure to make any attempt to resuscitate a patient in Mr Haward's care. She further submitted that the conviction relates to dishonesty spanning over five-years to mislead the police and a coroner in regard to Mr Haward's actions.

Ms Brown submitted that Mr Haward has not provided any of the information that the original substantive panel determined a future panel would be assisted by. She reminded the panel that the original substantive panel found Mr Haward to be currently impaired and submitted that there has been no information provided to today's panel to undermine the previous panel's finding of impairment.

Ms Brown submitted that Mr Haward has not provided any evidence of insight, further training, or strengthening of practice and has not made any contact with the NMC to confirm his current position. Ms Brown submitted that Mr Haward has not engaged at all with the NMC review process. Ms Brown submitted that there is no information before the panel today to suggest that there is not a risk of repetition or risk of harm to the public and submitted that the public interest is still engaged.

Ms Brown informed the panel that the Professional Standards Authority for Health and Social Care (PSA) brought forward a Notice of Motion to the High Court on 19 April 2024 to appeal the suspension order and impose a striking-off order instead. Ms Brown noted that Mr Haward was not in attendance at the appeal, and that the judge confirmed that he wished to give a written judgement in the case, and so deferred his judgement to 29 April 2024.

Ms Brown submitted that Mr Haward remains impaired by reason of his misconduct and conviction. She invited the panel to impose a further suspension order to allow Mr Haward the opportunity to engage with the NMC and provide new information regarding his current circumstances.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether Mr Haward's fitness to practise remains impaired.

The panel noted that there was no factual or material change in circumstances or compelling new evidence before it. It noted that the original substantive panel found that Mr Haward's fitness to practise was impaired at that time. The panel was mindful that the persuasive burden rests with Mr Haward and determined that there is no information before it today to suggest that he is no longer impaired.

The panel determined that this case is very serious, and as such, it was extremely concerned that Mr Haward had not engaged at all with the NMC following his suspension, despite specifically being given the opportunity to demonstrate fuller insight into the impact of his misconduct and to provide evidence of steps taken to strengthen his practice.

The panel noted the original substantive panel's recommendations that:

'…Any future panel reviewing this case would be assisted by:

- *Undertaking training in Ethics/Probity and providing the necessary certificate(s)*
- *Undertaking any additional critical thinking courses related to decision making as a nurse*
- *Attendance on an up-to-date CPR course in a face-to-face setting*
- *Up to date testimonials from your employer should you be in any paid or unpaid employment*
- *Detailed reflections to include:*
  - *the impact of your failure to act and your subsequent prolonged dishonesty upon Patient A and his family*
  - *how your actions in applying pressure to Registrant B, to tell and maintain the lie on your behalf impacted on her and your colleagues*
  - *how your failings have brought the nursing profession into disrepute and undermined public confidence in the profession…'*

Mr Haward has not provided any of the above information and has not engaged at all with the NMC. The panel determined that Mr Haward had compounded the concerns of the original panel by failing to comply with their recommendations and as such, the risk of repetition and the public interest concerns in this case have increased.

The original substantive panel determined that Mr Haward was liable to repeat matters of the kind found proved. Today's panel has received no new information to undermine this. In light of this, this panel determined that Mr Haward is still liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that Mr Haward's fitness to practise remains impaired.

Decision and reasons on sanction

Having found Mr Haward's fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the SG and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel noted Ms Brown's submission regarding the High Court appeal by the PSA but had no regard to that process in determining the issue of sanction in this 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 Haward'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 Haward'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 decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice on Mr Haward'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 bore in mind the seriousness of the facts found proved at the original hearing, and Mr Haward's lack of engagement with the NMC process and concluded that a conditions of practice order would neither be appropriate or adequately protect the public or satisfy the public interest. The panel also determined that no conditions could be formulated to adequately address the concerns relating to Mr Haward's misconduct and conviction.

The panel next considered imposing a further suspension order. The panel noted that Mr Haward has not provided any information to demonstrate strengthening of his practice or developing insight, has not provided any information that the original panel determined a future panel would be assisted by, and has not engaged at all with the NMC regarding this case. The panel determined that Mr Haward's lack of action and engagement was a new and significant aggravating feature in this case and indicative of deep-seated attitudinal problems. The panel was of the view that considerable evidence would be required to show that Mr Haward no longer posed a risk to the public or to public confidence in the nursing profession. However, to date, and despite ample opportunity to do so, no such evidence has been produced by Mr Haward. In light of Mr Haward's failure to use the opportunity already afforded to him to develop his insight and strengthen his practice, the panel determined that a further period of suspension would not serve any useful purpose. The panel determined that it was necessary to take action to prevent Mr Haward from practising in the future and concluded that the only sanction that would adequately protect the public and meet the public interest was a striking-off order.

This striking-off order will take effect upon the expiry of the current suspension order, namely at the end of 30 May 2024 in accordance with Article 30(1).

This decision will be confirmed to Mr Haward in writing.

That concludes this determination.