Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
11 – 13 October 2021

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

Name of registrant:	Ian William Watt
NMC PIN:	86K0283S
Part(s) of the register:	Nursing – Sub Part 1 RN – Mental Health (February 1990)
Area of registered address:	Hertfordshire
Type of case:	Misconduct
Panel members:	John Vellacott (Chair, lay member) Linda Tapson (Registrant member) Alex Forsyth (Lay member)
Legal Assessor:	John Donnelly
Panel Secretary:	Tyrena Agyemang
Facts proved:	Charges 1a, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 5
Facts not proved:	Charges 1b, i, ii, iii
Proved by admission	Charges 2, 3 and 4
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that Mr Watt was not in attendance and that the Notice of Meeting had been sent to Mr Watt's registered email address by secure delivery on 6 September 2021.

The panel took into account that the Notice of Meeting provided details of the allegations, the dates and venue of the meeting.

The panel accepted the advice of the legal assessor.

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

The panel considered and agreed that this case was appropriate to be dealt with at a meeting.

Details of charge

That you a registered nurse, whilst employed at the Hertfordshire Partnership Foundation Trust (the Trust) on the Aston Ward (the Ward) Mental Health Unit at Lister Hospital:

1) On the nightshift of 20/21 August 2018;

a) Instructed staff to conduct an uncoordinated physical restraint of Service User A.

b) Did not implement de-escalation strategies prior to the incident leading to the physical restraint of Service User A, in that you;

i) Did not administer any medication to Service User A, before Service User A stepped out of the Ward.

ii) Did not increase the frequency of observation on Service User A from every 30 minutes to every 15 minutes

iii) Did not adequately communicate with Service User A before instigating the physical restraint.

c) Did not adequately communicate with colleagues during the physical restraint of Service User A.

d) Did not adequately communicate with colleagues after Service User A had been physically restrained back onto the Ward.

e) Continued to physically restrain Service User A, after Service Use A had been brought back onto the Ward.

f) On one or more occasion placed your arm around Service User A's neck.

g) On one or more occasion placed your arm around Service User A's waist

h) On one or more occasion placed your arms around Service User A's knees/ankles

i) Incorrectly attempted to restrain Service User A into the prone position

2) Between 21 August 2018 & 5 May 2019, on one or more occasion without permission, accessed Service User A's Patient Records in the electronic record system PARIS.

3) Between 29 October 2018 and 5 May 2019 on one or more occasion without permission, printed copies of Service User A's patient records including;

a) Risk Assessments

b) Progress Notes

c) Care Plans

d) Service User A's Initial Assessment at Watford General Hospital

e) GP Notes

4) Between 29 October 2018 and 5 May 2019, on one or more occasion without permission removed/transported copies of Service User A's patient records from a Trust site.

5) Your actions in charges 2, 3 & 4 above lacked integrity, as you had accessed/removed/transported/copied Service User A's notes whilst knowing that this was in breach of policy.

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

Decision and reasons on facts

At the outset of the meeting, the panel noted that the NMC had asked Mr Watt his preference on whether his case should be considered at a hearing or a meeting. As there was no response from Mr Watt, on 24 March 2021 a Fitness to Practise Committee panel decided this case should be dealt with at a meeting.

Here are the reasons for the panel's decision:

24 March 2021 Fitness to Practise Committee, Notice of Referral Meeting:

The panel decided to refer this matter to a meeting.

In reaching its decision, the panel had regard to all the information available to it. This included the report from the Nursing and Midwifery Council's (NMC) Case Preparation and Presentation Team in which it recommended that a hearing be held as there is a material dispute to the charges

While Mr Watt appears to have engaged with the local investigations, the panel noted that there had been limited engagement from him with the regulatory process. Further, he has not responded to the NMC since 12 September 2019 following his voluntary removal application.

Having had regard to the information before it, and having borne in mind the recommendation of the NMC, the panel has concluded that the case be heard as a meeting.

The panel took account of Mr Watt's voluntary removal form, signed and dated 13 September 2019. Part 6.2, Mr Watt has ticked "Yes" admitting to the "facts of the allegations against you" The panel are not sure if he is admitting to the actual NMC charges that appear in the NMC bundle. However, it also noted that on the same form, Mr Watt has also ticked "Yes" admitting "That your fitness to practise is impaired."

The panel determined that Mr Watt appears to dispute the context of the incidents in question - but not the allegations themselves, and therefore that any dispute of fact is not significant as it would have limited bearing on the panel's ability to determine the charges without live evidence. Further the panel noted that Mr Watt has admitted that his fitness to practise is impaired and he wants to be removed from the Register. The panel was satisfied that it would be appropriate that this case be heard as a meeting.

The panel therefore refers this matter to a meeting.

This will be confirmed to Mr Watt in writing.

That concludes this determination.

In light of the above this panel, in reaching its decisions on the facts, took into account all the documentary evidence in this case together with the previous panel's decision, the written representations from Mr Watt, which stated he has made full admissions to all the charges and the representations made by the NMC.

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

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

- Witness 1: Child and Adolescent Mental Health Service (CAMHS) Practitioner and internal Investigation Officer

- Witness 2: Acting Matron and Ward Manager

- Witness 3: Senior Service Lead for Adult inpatient services and the Disciplinary manager.

- Witness 4: Senior Professional Lead: Violence and Aggression and work colleague

The panel also had regard to written representations from Mr Watt. The panel viewed a variety of CCTV footage of the incident.

Background

The charges arose whilst Mr Watt was working on Aston Ward, which is an Acute Psychiatric Inpatient Unit in the Lister Mental Health Unit ('the Ward'). The Ward is mixed sex and caters for adults over 18 years, who have had acute episodes of mental illness requiring inpatient treatment.

On 20 August 2018, Service User A was admitted to the Ward with a history of substance misuse and behavioural issues and was also noted as being at risk of absconding. Mr Watt confirmed he was the nurse in charge on the night shift of 20-21 August 2018. During the shift, it is alleged that Mr Watt did not use adequate de-escalation techniques, and used inappropriate restraint techniques on Service User A, including putting him in a headlock. In addition, Mr Watt failed to complete the necessary documentation following the incident.

No injuries were recorded to Service User A as a result of Mr Watt's alleged actions.

Mr Watt did attend accident and emergency shortly after the event complaining of dizziness and feeling unwell and returned to Aston Ward just before his shift ended to retrieve his bike.

Mr Watt was placed on non-clinical duties as a result of this incident and a local investigation was initiated. At a disciplinary hearing held on 8 May 2019, Mr Watt produced confidential patient documentation with regards Service User A which was a breach of the Trust's Service User Records policy. In a letter dated 25 May 2019, Mr Watt was advised

that the outcome of the disciplinary hearing was that he was dismissed with immediate effect for gross misconduct.

Mr Watt has indicated that he has now retired from nursing, and he has no intention to return to practice as a registered nurse.

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

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

Charge 1a

1) On the nightshift of 20/21 August 2018;

a) Instructed staff to conduct an uncoordinated physical restraint of Service User A

This charge is found proved.

In reaching this decision, the panel took into account the CCTV evidence, the statement and evidence from Witness 2, notes of investigating meeting with SC and Mr Watt's statements.

The panel considered Witness 2's eyewitness account of the incident to be impartial, from a safe distance, and consistent with the CCTV footage. The panel also found that Mr Watt in his interview notes, confirms that he initiated the restraint and was responsible for the coordination and that there should have been more communication from him during the incident.

The panel noted numerous eyewitness accounts within the bundle which confirmed the view that they had assumed Mr Watt was the lead nurse in the incident and that the communication was limited.

In these circumstances the panel determined that the evidence before it was sufficient for it to be satisfied that on the balance of probabilities you instructed staff to conduct an uncoordinated physical restraint, and this charge is therefore found proved.

Charge 1b)

1) On the nightshift of 20/21 August 2018;

b) Did not implement de-escalation strategies prior to the incident leading to the physical restraint of Service User A, in that you;

i) Did not administer any medication to Service User A, before Service User A stepped out of the Ward.

ii) Did not increase the frequency of observation on Service User A from every 30 minutes to every 15 minutes

iii) Did not adequately communicate with Service User A before instigating the physical restraint.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence from Witness 1, the Management of Violence and Aggression Policy, De-Escalation Policy and evidence of Witness 3. The panel also took into account the investigation interview notes dated 18 October 2018, and the investigation notes of 8 May 2018 in which Mr Watt suggested he was engaging with the Service User A and was persuading him to re-enter the ward.

The panel was satisfied that there was sufficient evidence from eyewitnesses which supported Mr Watt's account that he considered he was under threat and that Service User A had lashed out and that Mr Watt had told him that:

"He needed to come back in and that we had areas that he could take the call, after this I went to take him in a 3 arm hold, I got hit on the head."

The panel has particularly considered the Trust's De-escalation policy which states:

Incidents that occur very suddenly and without time to de-escalate or summon help may require immediate physical interventions. The use of such intervention is acceptable in law providing the amount of force is necessary and proportionate, that is sufficient to stop the attacker and/or stop injury to yourself or others.

It also considered Mr Watt's response in interview when describing the 11 second de-escalation period that he utilised and the speed with which the incident escalated. The panel is satisfied that there is insufficient evidence to support this charge.

Charge 1c)

1) On the nightshift of 20/21 August 2018;

c) Did not adequately communicate with colleagues during the physical restraint of Service User A.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Witness 1, Witness 2 and Witness 3. The panel also had regard to the CCTV evidence and Mr Watt's job description.

The panel was satisfied that Mr Watt was acting as Lead nurse in the situation and was equally satisfied that once his initial instruction had been given "to retrieve Service User A from outside" there was no further communication or clear instruction from Mr Watt to his colleagues.

The CCTV footage and the eyewitness account of colleagues presents as a disorganised and ill-disciplined event in which Service User A is eventually put to the floor.

The panel had particular regard to Mr Watt's comments during the local investigation meeting on 18 October 2018. When reviewing the CCTV footage Mr Watt was asked *"…how are you communicating to the team?"* Mr Watts replied, "I am not communicating to the team because he is very strong and I am using all my strength.

In these circumstances the panel was satisfied that on the balance of probabilities that Mr Watt did not adequately communicate with colleagues during the physical restraint of Service User A and this charge is therefore found proved.

Charge 1d)

1) On the nightshift of 20/21 August 2018;

d) Did not adequately communicate with colleagues after Service User A had been physically restrained back onto the Ward.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 2 and Witness 3, the Violence and Aggression Policy and Mr Watt's account.

The panel considered the following from the Violence and Aggression Policy which states:

d) Releasing from a Physical Intervention

Releasing a person from a physical intervention should take place at the earliest opportunity and staff should be guided by the lead person identified as above. The principles of 'Gradient Support' should be adopted by staff as per training. The service user should be informed of what is happening and why it is happening and what the expectations are from them when they are released. Staff

should obtain agreement on immediate future actions, from the service user prior to release.

29. Post Incident Review

A post incident review should take place following an incident.
This should include the following:

- *Review of Triggers and Pre-disposing factors.*
- *Review of Risk assessment.*
- *Review of care plan which should include involving the service user in taking are much responsibility as they can.*
- *Integrating the service user back into the environment.*
- *Development of a Positive Behavioural Support plan.*
- *MDT Review of service user's legal status.*

A review should also take place if the service user is moved to a more secure setting, the medicines are changed or the service user is discharged or legally charged.

The panel has not had the benefit of any incident review document whether formal or informal following the event.

The panel noted that the policy document states that a review *"should"* take place following an incident.

The CCTV footage depicts Mr Watt immediately after the incident remaining on the ward, until he was advised by another registrant colleague to attend the accident and emergency department as he felt unwell.

The panel further noted that having attended accident and emergency, Mr Watt did return to the ward shortly before the end of his shift and retrieved his bicycle before cycling home. The panel considered it was his responsibility to provide some form of review as

lead nurse and that he had an opportunity to both complete those notes and liaise with colleagues at that time.

The panel was satisfied that he did not adequately communicate with colleagues as alleged.

The panel therefore find this charge proved.

Charge 1e)

1) On the nightshift of 20/21 August 2018;

e) Continued to physically restrain Service User A, after Service Use A had been brought back onto the Ward.

This charge is found proved.

In reaching this decision, the panel took into account the Witness 1, Witness 2, Witness 3 and the CCTV footage and Mr Watt's account.

The panel viewed the CCTV footage and was satisfied that there is sufficient and reliable evidence that Service User A, once back on the ward, continued to be physically restrained by staff. The eyewitness accounts also support this evidence.

The panel also had regard to the statement of Witness 2 who states:

26. During a restraint, our responsibility is to ensure that we are continually assessing the situation. I do not believe that the restraint was necessary in the first place, but once Service User A had been brought back onto the ward, the situation should have been reassessed to work out whether restraint was still needed. The staff were collectively struggling with Service User A's strength but, whilst he was resisting the restraint, he was not being aggressive. Service User A had ample opportunity to assault staff, either by kicking or punching, but he did not do this. Even once he had been released, Service User A did not assault staff. The staff

were kneeling on the ground, which left them in a vulnerable position and unable to resist an attack, but Service User A did not do this.

27. The Registrant would have known that the techniques used during the restraining of Service User A were incorrect because he had received training on this. I believe he was up to date with his training, however, even if he was not, he was an experienced member of staff and had received a lot of training in the past about this, so would have known the restraint was not done correctly.

The panel therefore find this charge proved.

Charge 1f)

1) On the nightshift of 20/21 August 2018;

f) On one or more occasion placed your arm around Service User A's neck.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witness 1, 2 and 3, the CCTV evidence and Mr Watt's statement.

The panel viewed the CCTV footage and was satisfied that there is sufficient and reliable evidence that Mr Watt had his arm around the Service User A's neck.

The panel also considered the statement of Witness 2 which states:

24. When restraining a user, they should not be touched in the neck area, as it can restrict the individual's airway and breathing. When watching the CCTV footage, it is clear that Service User A was put into a head lock by the Registrant. This could have had severe consequences as it could have restricted service user A's airway and ability to breathe and caused them considerable distress.

The panel therefore find this charge proved.

Charge 1g)

1) On the nightshift of 20/21 August 2018;

g) On one or more occasion placed your arm around Service User A's waist

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witness 1, 3 and the CCTV footage.

The panel viewed the CCTV footage and was satisfied that there is sufficient and reliable evidence that the Mr Watt had his arm around the Service User A's waist.

The panel therefore find this charge proved.

Charge 1h)

1) On the nightshift of 20/21 August 2018;

h) On one or more occasion placed your arms around Service User A's knees/ankles

This charge is found proved.

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

The panel viewed the CCTV footage and was satisfied that there is clear evidence that the Mr Watt had his arms around the Service User A's knees/ankles.

The panel also had regard to Witness 2 statement which states:

23. It is important that when you restrain a person, the way in which you hold them does not cause any harm and is therefore safe. For example, you should not restrain them by the ankles or back of knees, as the pressure placed in these places could result in a broken bones. When watching the CCTV footage, it is clear to see that Service User A was restrained around the knees by the Registrant.

The panel therefore find this charge proved.

Charge 1i)

1) On the nightshift of 20/21 August 2018;

i) Incorrectly attempted to restrain Service User A into the prone position

This charge is found proved.

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

The panel viewed the CCTV footage and was satisfied there is sufficient evidence that Service User A was nearly put into the prone position, although not completely placed on the floor and that he is being held around his knees by Mr Watt.

The panel referred to the statement of Witness 2 which states:

25. It is also important that the person who is restrained is not put in the prone position, which is when they are placed face down on the ground. Studies have been done that show that restraining an individual in prone means that their airway becomes restricted, which can cause injuries. When watching the CCTV footage, it is clear that the Service User A is nearly placed in a prone position.

The panel therefore find this charge proved.

Charge 2 and Charge 3

2) Between 21 August 2018 & 5 May 2019, on one or more occasion without permission, accessed Service User A's Patient Records in the electronic record system PARIS.

3) Between 29 October 2018 and 5 May 2019 on one or more occasion without permission, printed copies of Service User A's patient records including;
a) Risk Assessments
b) Progress Notes
c) Care Plans
d) Service User A's Initial Assessment at Watford General Hospital
e) GP Notes

These charges are found proved by admission.

Charge 4

4) Between 29 October 2018 and 5 May 2019, on one or more occasion without permission removed/transported copies of Service User A's patient records from a Trust site.

This charge is found proved by admission.

Furthermore in reaching this decision, the panel took into account the statement of Witness 3.

For the context the panel particularly noted the context and the circumstances in which this breach took place and which Mr Watt has both admitted and apologised for his actions. The panel was particularly mindful of the following statements.

Witness 3 states:

14. During the disciplinary hearing on 8 May 2019, Mr Watt repeatedly referred to papers in front of him. Ms Woodcock and I noticed that they looked like print outs from our electronic record system, `PARIS'. Mr Watt would also say things during the hearing that caused suspicion that he had accessed the Service User's patient record after he was no longer working with him, such as providing Service User A's height and weight and details of care plans after Mr Watt was no longer working on Aston Ward. We therefore paused the hearing and the documents on the table were reviewed by myself.

15. Mr Watt had printed out a range of documents from PARIS, such as the risk assessments, the progress notes and care plans for Service User A. The documentation was from before and after the restraint occurred, dating back to the initial assessment made at Watford General Hospital A&E when Service User A was admitted to hospital. A digital copy of the documents Mr Watt printed can be found at appendix 12 of SD2. They were all printed out after he was working with Service User A and was no longer working on Aston Ward.

16. The Access to Service User Records (attached as exhibit "SD5") and Care Records Management Policy (attached as exhibit "SD6") is clear that only patient records should only be access when they are needed. The information governance training that is compulsory for all members of staff also states that patient records should only be accessed when needed. This is training that is renewed every few years, and Mr Watt's training records (see appendix 2 of SD1) show that he had completed the Information Governance training on 10 November 2018, and so was compliant with his training.

18. As a panel, it was agreed that the documents that Mr Watt was referring to during the hearing should not have been in his possession and that he had no reason to access the service user's care record on the dates they were printed. The panel also agreed that these should not have been transported from one Trust site to another. We sought advice from Senior HR representation, as we wanted to know if the hearing should be suspended to look into what was determined a data breach, or whether the hearing should continue and the breach could be looked at

separately. We were told to identify this as a data breach but make it clear that the data breach was a separate issue to the disciplinary hearing.

The panel considered this evidence and was of the view that as a nurse with over 30 years of experience, Mr Watt would have been well aware of the correct procedures in accessing patient records when he was no longer working on the ward and that removing the records without permission would have been a data breach.

The panel further noted that Mr Watt has confirmed he did access the note and the panel therefore find this charge proved.

Charge 5

5) Your actions in charges 2, 3 & 4 above lacked integrity, as you had accessed/removed/transported/copied Service User A's notes whilst knowing that this was in breach of policy.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements and Mr Watt's statements. Having found charges 2, 3 and 4 proved by admission, the panel was satisfied that Mr Watt's conduct breached the professional code for registered nurses and the higher standards which society expects from professional persons. Mr Watt had failed to live up to those professional standards and accordingly the panel find this charge 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 Watt'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 Watt's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the cases of *Roylance v GMC (No. 2)* [2000] 1 AC 311 Jackson J in *Calheam v GMC* [2007] EWHC 2606 (Admin) and Collins J in *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

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

The NMC identified the specific, relevant standards where Mr Watt's actions amounted to misconduct and state that his failings on the nightshift of 20/21 August 2018 were numerous.

The NMC submit the allegations involve Mr Watt's failure to properly communicate with Service User A and his colleagues and the use of unnecessary and excessive force when restraining the service user.

The NMC submit that these failings constitute a drastic departure from the fundamental expectations of a nurse, particularly dealing with vulnerable service users. Mr Watt's failure to satisfy these fundamentals of nursing would be viewed as deplorable by a fellow nurse, and accordingly, must constitute misconduct.

Further, the NMC submits, after the incident, Mr Watt breached basic privacy requirements, in obtaining the records of Service User A, before ultimately presenting these documents at his own disciplinary hearing for the August 2018 incident. The NMC submits Mr Watt exhibited a lack of integrity, clearly breaching the Trust's privacy and confidentiality policy and again, these failings must amount to misconduct.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the cases of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin

The NMC invited the panel to find Mr Watt's fitness to practise impaired on the grounds that he put a service user at serious risk of harm. He failed to communicate properly with the service user and colleagues. Further, he used unnecessary and excessive force in restraining said vulnerable service user. Finally, he then flagrantly breached privacy and confidentiality policies. This did put patients and service users at risk of unwarranted harm and clearly breached a number of fundamental tenets of the nursing profession.

The NMC submits that Mr Watt accepted at a local level that his restraint "techniques" were not approved, but maintained that he was being assaulted. He has provided nothing by way of remorse or evidence of remediation. His insight, such that it is, fails to address how he could have better approached the situation, the impact on Service User A and his colleagues, as well as the failings regarding the breaches of privacy and confidentiality.

This very limited insight, and lack of remorse and remediation gives rise to a serious concern of repetition, and the NMC would submit this results in a significant and unwarranted risk of future harm.

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, CHRE v NMC and P Grant [2011] EWHC 927 (Admin) and Cohen v General Medical Council [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mr Watt's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Watt's actions amounted to a breach 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*
>
> ***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*
>
> ***5 Respect people's right to privacy and confidentiality***
> *As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.*
> *To achieve this, you must:*
> *5.1 respect a person's right to privacy in all aspects of their care*

5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality

7 Communicate clearly

To achieve this, you must:

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

8 Work co-operatively

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

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges in this case constitute a drastic departure from the fundamental expectations of a nurse, particularly when dealing with a vulnerable service user.

The panel considered Mr Watt's failure to satisfy these fundamental tenets of nursing would be viewed as reprehensible by a fellow nurse, and accordingly, found that Mr Watt's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Watt'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*

The panel finds the failings of Mr Watt were serious, putting Service User A at risk of physical and emotional harm as a result of his actions. Mr Watt's misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that there is very limited insight demonstrated by Mr Watt. He has not demonstrated an understanding of how his actions put the service user at a risk of harm or demonstrated an understanding of why what he did was wrong and how this would have impacted negatively on the reputation of the nursing profession.

Mr Watt's only defence was that he had been assaulted. He states in his statement that he feels he was treated "unfairly" by his employer, there is no reflection on the service user or the impact this incident might have had on him.

The panel also noted the absence of any reflection from Mr Watt on how he would have handled the situation differently in the future. The panel noted his engagement with the local investigation, but the engagement with his regulator has been minimal.

The panel was satisfied that the misconduct in this case is capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Watt has remedied his practice. The panel noted the absence of any relevant training he has undertaken or a reflective piece addressing how he would handle the situation differently.

The panel is of the view that there is a risk of repetition based on Mr Watt's lack of insight, remorse and remediation. It noted that as Mr Watt has not practiced as a registered nurse since 2019 and has expressed a wish not to return to nursing that the opportunity for remediation is limited. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that, in this case, a finding of impairment on public interest grounds was also required. As members of the public would expect a nurse of Mr Watt's length of service and experience to be able to competently practise and adequately care for patients within his care. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Watt's fitness to practise impaired on the grounds of public interest.

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

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 Watt off the register. The effect of this order is that the NMC register will show that Mr Watt has been struck-off the register.

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

Representations on sanction

The NMC submit that the proportionate sanction in this case is strike off with the lesser sanctions of taking no action and a caution order, not adequately addressing the public protection and public interest concerns raised in this case.

The NMC submits that a conditions of practice order could be drafted to include conditions addressing appropriate restraint techniques, but it would be difficult to devise workable conditions, given the severity of Mr Watt's restraining of Service User A. The NMC submit there are a multitude of other concerns in this case that are also very serious. Conditions alone would not be sufficient in addressing the misconduct in this case, sufficiently protecting the public, or ensuring public confidence is maintained in the profession.

The NMC went on to consider a suspension order, and submits that the regulatory concerns are sufficiently serious to warrant temporary removal from the register. However, the concerns in this case highlight a number of attitudinal issues surrounding the misconduct. The SG suggests that a suspension order may be appropriate where there is:

a. a single instance of misconduct but where a lesser sanction is not sufficient
b. no evidence of harmful deep-seated personality or attitudinal problems

c. *the Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour*

In this case, there were a number of failings on the part of Mr Watt over a prolonged period of time. Firstly, during the incident in August 2018, and again in the build up to and during the local disciplinary hearing. This cannot be described as a single instance of misconduct. There is also evidence of attitudinal problems. Despite causing serious risk to Service User A, Mr Watt has failed to show insight beyond acknowledging that his methods were not those endorsed by his clinical training. Further, he has failed to show remorse or evidence of remediating his inability to deal with service users and manage staff where confrontation arises.

Moreover, the NMC submits Mr Watt's willingness to unnecessarily access patient records, carelessly transport them, and use them for his own benefit is indicative of an attitude that prioritises his own concerns over that of service users. He has given no account, insight, or reflection as to why he thought this was appropriate. Considering the attitudinal concerns, and the lack of insight and remediation, Mr Watt poses a significant risk of repeating the behaviour involved in this case.

Therefore the NMC submits that the only available sanction to adequately deal with the concerns in this case is a striking off order. Mr Watt, the nurse in charge of the shift, physically assaulted a mental health patient. He has over 30 years' experience, and was fully trained in restraint techniques and data protection / confidentiality. The catalogue of failings by Mr Watt raise fundamental concerns about his professionalism and trustworthiness and are incompatible with continued registration.

The panel also bore in mind Mr Watt's representations in September 2019 that he no longer wishes to practise as a nurse and has not practised since May 2019. Since that time, there has been no further engagement from Mr Watt and his declaration not to return to practise has not altered.

Decision and reasons on sanction

Having found Mr Watt'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:

- Vulnerable service user
- Nurse in charge with 30 years' experience, instigating physical intervention,
- Limited to no insight, remorse, and remediation.
- Abuse of his position of authority and control as the Service User was a Section 2 Mental Health Act Patient (compulsory detained)
- Conduct which put a patient at risk of suffering severe harm.

The panel also took into account the following mitigating features:

- Engagement at local level
- Previous good character
- Early admissions to the facts of the charges
- Challenging working environment
- Recent return from long term sick leave

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 Watt'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 Watt'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 Watt's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be fully addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Watt's registration would not adequately address the seriousness of this case and would not protect the public, particularly in light of his disengagement.

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 conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Watt's actions is fundamentally incompatible with Mr Watt remaining on the register. Further the panel noted there are numerous instances in the evidence that identify Mr Watt having attitudinal issues.

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?*

Mr Watt's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Watt's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mr Watt's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Mr Watt 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 Watt's own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took into account the representations made by the NMC that interim suspension order is also necessary for the protection of the public and otherwise in the public interest. Following the substantive reasons above, this order should be for 18 months to cover the 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. This is because the interim order is intended to cover an appeal period and, in the event that an appeal is lodged, there may be a significant period, pending the resolution of any such appeal.

In coming to its conclusion that 18 months is the appropriate period, the panel had regard to the length of any appeal process, noting that this includes the time likely to elapse before any appeal is listed and determined by the High Court, which may be significant.

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

That concludes this determination.