Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 12 June 2023 – Thursday, 22 June 2023

Virtual Hearing

Name of Registrant:	**Neil David Wright**	
NMC PIN	12G0365E	
Part(s) of the register:	Registered Nurse - Mental Health Nursing – 21 September 2012	
Relevant Location:	Lincolnshire	
Type of case:	Misconduct	
Panel members:	Shaun Donnellan Melanie Lumbers Anne Phillimore	(Chair, lay member) (Registrant member) (Lay member)
Legal Assessor:	Cyrus Katrak	
Hearings Coordinator:	Opeyemi Lawal	
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter	
Mr Wright:	Not present and unrepresented	
Facts proved:	Charges 1, 2, 3a – c, 4, 5a(i-ii), 5b(i-vii), 6a-b, 7a, 7b(i-ix), 8a-b	
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 Wright was not in attendance and that the Notice of Hearing letter had been sent to Mr Wright's registered email address by secure email on 9 May 2023.

Dr Joshi, 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 allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Wright'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 Wright has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Wright

The panel next considered whether it should proceed in the absence of Mr Wright. It had regard to Rule 21 and heard the submissions of Dr Joshi who invited the panel to continue in the absence of Mr Wright. He submitted that Mr Wright had voluntarily absented himself.

Dr Joshi referred the panel to the documentation from the NMC which included email correspondence between the NMC and Mr Wright over a period of time, in particular on 1 June 2023, Mr Wright responded that he will not attend.

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 Wright. In reaching this decision, the panel has considered the submissions of Dr Joshi and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Wright;
- Mr Wright has informed the NMC that he has received the Notice of Hearing and confirmed that he will not be attending;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Witnesses are due to attend to give live evidence;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Wright in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he has made no response to the allegations. Mr Wright 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 Wright's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge

That you, a registered nurse:

1. Telephoned Resident A's relative on 28 September 2016 and gave an inaccurate account about Resident A's death.

2. Your conduct, described in charge 1, was dishonest, and/or breached the duty of candour, in that you gave an account of Resident A's death which you knew to be untrue.

3. After the death of Resident A, you failed to advise their relatives that:

    a) They had choked,

    b) An emergency situation had developed,

    c) They had died following an emergency situation.

4. Your conduct, as described in charge 3, was dishonest and/or breached the duty of candour, in that you deliberately sought to mislead Resident A's relatives by withholding this information.

5. On 6 November 2019, after Resident B suffered a fall, you then failed to:

a) Undertake or record the following:

i) An assessment for injuries

ii) Clinical observations

b) Complete or ensure the following was completed:

i) An incident report form

ii) The checklist following a fall

iii) A clinical and CNS Observation record

iv) A TPR and Blood pressure chart

v) An Adult Glasgow Coma Scale and Neurological Observation Chart

vi) The Falls log

vii) A care plan update

6. On or around 6 November 2019, after Resident B had suffered a fall on 6 November 2019, you failed to:

a) Record this in the handover form

b) Verbally inform colleagues of the fall at handover

7. On 8 November 2019, after Resident B suffered a fall, you then failed to:

a) Undertake clinical observations

b) Complete or ensure the following was completed

i) An injury assessment

ii) An incident report form

iii) The checklist following a fall

iv) A clinical and CNS Observation record

v) A TPR and Blood pressure chart

vi) An Adult Glasgow Coma Scale and Neurological Observation Chart

vii) The Falls log

viii) A care plan update

ix) The Progress notes

8. On 8 November 2019, after Resident B had suffered a fall on 8 November 2019, you failed to:

    a) Record this in the handover form

    b) Verbally inform colleagues of the fall at handover

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

Background

On 10 July 2018, the NMC received a referral from Ms 1 following the death of her mother-in-law, Resident A, at Abbey Court Nursing Home ("the Home") where Mr Wright had been employed since 21 March 2016.

On 28 September 2016, Mr Wright telephoned Ms 1 at 23:38 and informed her that her mother-in-law Resident A had passed away and the Home was in the process of cleaning her and making her presentable so there was no rush. Mr Wright told Ms 1 that Resident A had been fed her supper at 22.15 and then put to bed as she seemed a little agitated. Mr Wright stated that they checked on her later and found that she had passed away.

At the time, Ms 1 had no reason to doubt what was said by Mr Wright and went to the home with her husband to say goodbye to Resident A. They arrived just before midnight, seeing the ambulance leaving. They noticed that Resident A was very white and cold. Ms 1 stated that Mr Wright was present at the Home and said very little but watched her say goodbye to Resident A.

On 29 September 2016, after having returned to the Home, to collect personal belongings of Resident A, Ms 1 states a carer told them to ask questions as they were not being told the truth about what happened. Ms 1 pursued investigations via a number of avenues and a coroner's inquest was fixed. As a result of seeing the bundle prepared for the coroner's inquest, Ms 1 states that she is 100% sure that Mr Wright lied to them on the phone as she had not been informed of the emergency situation which had resulted in Resident A's death.

Documentation shows that Resident A was being assisted to eat a sandwich by a care assistant on the evening of 28 September 2016, when she appeared to have choked. In or around 22.15 the alarm bell was sounded, Mr Wright attempted to remove the blockage with the support of other care workers and called 999. Further attempts to remove the blockage were unsuccessful. Resident A had a 'do not attempt resuscitate' (DNAR) in place, so CPR was not administered. The coroner's report gives the cause of death as choking and dementia, with a narrative as follows 'there are a number of factors which contributed to her death of which the following are likely:

- inadequacy of training,
- inadequacy of record keeping and
- general practices, processes and procedures not being robust enough'.

On 23 December 2019, the NMC received a referral from the Priory Group Limited ("the Group") in respect of Mr Wright's fitness to practice. The referral was made the manager of the Home.

The Home is a residential and nursing home with 4 different units, 2 of which are dementia units. Mr Wright was working in the Bluebell unit which is a nursing home primarily dedicated to service users diagnosed with dementia.

Resident B experienced falls on 6 and 8 November. Mr Wright was the only registered nurse on duty for the day shift in the Bluebell Unit on both dates and therefore responsible for the resident.

Ms 3 states that Resident B had dementia and mobility issues; she would often self-reposition and this would sometimes cause risk of harm. Resident B was considered high risk in terms of mobility and was unsafe to move independently. She had a sensor mat at the foot of her bed which would alert staff when she moved or fell over.

On 9 November 2019 Resident B was admitted to the local hospital due to vomiting black blood. On examination and following an x-ray in hospital, it was discovered Resident B had sustained a fracture to her hip.

As the nurse on duty at the time of the incident, Mr Wright had a duty to ensure that he followed the correct procedure following falls. Mr Wright should have provided basic first aid to assess if the resident had suffered any harm. Mr Wright should also have conducted 24-hour observations for any post fall injuries and all observations should have been documented in the resident's care records.

In respect of the fall on 6 November – there is an entry on Resident B's progress notes on 6 November 2019 which states Resident B 'has fallen off their chair twice but has been assisted back to her chair by staff.' These falls are not documented in the paperwork provided to the panel, and Ms 3 and Ms 5 confirmed that they could not find any notes, other than this entry, to show that the falls had taken place and the actions set out in the falls policy had been followed. This note in the progress report was entered by another member of staff Ms 3 and not Mr Wright. In respect of the fall on 8 November – there is no evidence from the witnesses Ms 3 and Ms 4 that Resident B fell on this date and there is no entry on Resident B's progress notes and no documentation was completed by Mr Wright.

However, this fall can be evidenced from Mr Wright's local statement dated 11 November 2019 in which he stated: "Resident B was found on the floor of her room next to the edge of her chair. I checked her over and there appeared to be no visible injury."

There is nothing documented on the resident's fall log for either fall on 6 or 8 November 2019. It was the registrant's duty as the nurse in charge to complete the required documentation, recording all incidents and clinical care undertaken.

While Mr Wright makes some admissions during the Home's disciplinary process. Mr Wright has advised the NMC he does not admit the facts of the allegation. Mr Wright has submitted the application for voluntary removal dated 29 November 2022 and advised that he does not admit the facts of the allegation against him or that his fitness to practise is impaired.

Decision and reasons on facts

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

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

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

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

- Ms 1: Resident A's Daughter in Law

- Ms 2: Clinical Lead at the Home
- Ms 3: Clinical Lead at the Home (September 2019 – January 2021)
- Ms 4: Agency nurse at the Home
- Ms 5: Deputy Manager of the Home

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

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

Charge 1

> Telephoned Resident A's relative on 28 September 2016 and gave an inaccurate account about Resident A's death.

This charge is found proved.

In reaching this decision, the panel took into account written statements, live evidence from Ms 1 and documentary evidence, including phone call record, safeguarding report and Ms 1's log of events.

During Ms 1's evidence she explained the conversation she had over the phone with Mr Wright and the situation that happened after the phone call, once she arrived at the Home. Ms 1 also stated that she had repeated the phone call to her sister-in-law, informing her of Resident A's death. Ms 1 explained that because of concerns that they had about the care being delivered to Resident A the family had, prior to this incident, already begun to make a log of their observations and interactions with the Home which they completed shortly

after each visit or interaction. On this interaction she told the panel that she had made a note of the phone call on return from her visit to the Home to say their final goodbye to Resident A. The note states:

> *'Mobile range 11:38pm on Wednesday 28 September; it was Neil (the night nurse) I said we're on our way as I assumed it was a call to say Resident A had gone downhill. He apologised and said that unfortunately Resident had already passed away and that they were cleaning her and making her presentable for us, Neil stated that they had ref Resident A her supper at 10.15 that evening and then put her to bed as she seemed a little agitated. They had checked on her later and found that she had passed away at 11:45pm.*
>
> *Paramedics had been called & funeral director had been called.*
>
> *Arrived at Abbey Court just before midnight – paramedic was just leaving.*
>
> *Resident A appeared to be very white and when I touched her to say goodbye she was very cold.'*

The safeguarding report stated that 'Mr Wright called the family to advise that Resident A had died. He could not remember what he had said. He could not recall what time he had called.'

The panel noted that Mr Wright had no recollection of what was said on his behalf and there is no written record of the conversation. The panel were shown evidence that the phone call only lasted one minute, Mr Wright could not have explained the situation in full in that short period. In a signed but undated statement from Mr Wright he wrote '*I subsequently informed the family of her death'*.

The panel preferred the evidence of Ms 1 and on the balance of probabilities the panel finds this charge proved.

Charge 2)

> Your conduct, described in charge 1, was dishonest, and/or breached the duty of candour, in that you gave an account of Resident A's death which you knew to be untrue.

This charge is found proved.

In reaching this decision, the panel took into account written statements, live and documentary evidence.

Mr Wright was fully aware of the circumstances which surrounded Resident A's death actively participating in the emergency situation which arose. He was fully aware that Resident A choked on food and attempted to resolve this emergency situation with support of other carers in the Home before calling 999, reporting the emergency and seeking help and support to resolve. He followed the advice of the 999 call handler. The panel considered that him failing to fully appraise the family of the circumstances of the emergency situation, and in fact by providing them with an inaccurate and false account, his actions would have been considered as dishonest by ordinary, decent people.

The panel had regard to the NMC guidance on the Duty of candour [NMC / GMC Guidance Openness and honesty – when things go wrong, updated Feb 2022]:

> *'Speaking to those close to the patient: [18] If something has gone wrong that causes a patient's death or such severe harm that the patient is unlikely to regain consciousness or capacity, you must be open and honest with those close to the patient.'*

Further, from the guidance:

'Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- *tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong*
- *apologise to the patient (or, where appropriate, the patient's advocate, carer or family)*
- *offer an appropriate remedy or support to put matters right (if possible)*
- *explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.'*

The panel considered that Mr Wright had not been open nor honest for the reasons set our above.

Therefore, the panel finds this charge proved.

Charge 3

After the death of Resident A, you failed to advise their relatives that:

a) They had choked,
b) An emergency situation had developed,
c) They had died following an emergency situation.

This charge is found proved.

In reaching this decision, the panel took into account written statements, live and documentary evidence.

The panel were satisfied that Mr Wright had a duty to notify Resident A's relative as to the true circumstances as to her death. The panel heard evidence from Ms 2 that it was an

expectation as the registered nurse on duty to tell the family of the entire situation relating to their relative as set out in the above wording of the charge. As set out under charge 1, Mr Wright was aware of the situation surrounding Resident A's death.

The panel determined that Mr Wright never provided details as set out in the charge and should have done so.

The panel finds this charge proved in its entirety.

Charge 4

> Your conduct, as described in charge 3, was dishonest and/or breached the duty of candour, in that you deliberately sought to mislead Resident A's relatives by withholding this information.

This charge is found proved.

In reaching this decision, the panel took into account written statements, live and documentary evidence.

Mr Wright was fully aware of the circumstances which surrounded Resident A's death, actively participating in the emergency situation which arose. He was fully aware that Resident A choked on food and attempted to resolve this emergency situation with support of other carers in the Home before calling 999, reporting the emergency and seeking help and support to resolve. He followed the advice of the 999 call handler. Mr Wright was also present at the Home when Resident A's family attended to say goodbye and did not then, or at any subsequent time elaborate on or rectify the inaccurate information he had provided. The panel considered that him failing to fully appraise the family of the circumstances of the emergency situation, and in fact by providing them with an inaccurate and false account, his actions would have been considered as dishonest by ordinary, decent people. The variety of evidence from witnesses supported by exhibits

demonstrated that the family were deliberately mislead with information withheld and inaccurate information provided.

The panel had regard to the NMC guidance on the Duty of candour [NMC / GMC Guidance Openness and honesty – when things go wrong, updated Feb 2022]:

> *'Speaking to those close to the patient: [18] If something has gone wrong that causes a patient's death or such severe harm that the patient is unlikely to regain consciousness or capacity, you must be open and honest with those close to the patient.'*

Further, from the guidance:

> *'Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:*
>
> - *tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong*
> - *apologise to the patient (or, where appropriate, the patient's advocate, carer or family)*
> - *offer an appropriate remedy or support to put matters right (if possible)*
> - *explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.'*

The panel considered that Mr Wright had not been open nor honest for the reasons set our above.

Therefore, the panel finds this charge proved.

Charge 5

On 6 November 2019, after Resident B suffered a fall, you then failed to:

a) Undertake or record the following:

i) An assessment for injuries
ii) Clinical observations

b) Complete or ensure the following was completed:

i) An incident report form
ii) The checklist following a fall
iii) A clinical and CNS Observation record
iv) A TPR and Blood pressure chart
v) An Adult Glasgow Coma Scale and Neurological Observation Chart
vi) The Falls log
vii) A care plan update

This charge is found proved.

In reaching this decision, the panel took into account written statements, live and documentary evidence including the Home's falls policy, investigation notes and a record of the relevant training Mr Wright received.

As a registered nurse Mr Wright has a duty to carry out an assessment and record any falls or subsequent injuries sustained by any patient. Additionally, Mr Wright has a duty to ensure policy is adhered to and subsequent and required observations are undertaken and recorded.

During Ms 3's oral evidence she made it clear what the nurse's duty is after a patient fall and explained the process that is conducted, including an assessment of injury and clinical observation.

The panel noted that in the investigation notes, Mr Wright stated that he *'would normally follow the falls process but didn't on this occasion'* when he was asked if he did her observation, he answered *'no'* and the follow up question of *'so there was nothing on the progress notes, paperwork or handover. Why?' He responded 'I don't know why I did it. She presented as normal.'*

The panel also noted that Mr Wright's failure to carry out the required observations and assessments or the recording of falls in any documentation, resulted in colleagues being unaware of Resident B's fall, which was an unwitnessed fall.

Therefore, the panel finds this charge proved.

Charge 6

> On or around 6 November 2019, after Resident B had suffered a fall on 6 November 2019, you failed to:
>
> a) Record this in the handover form
>
> b) Verbally inform colleagues of the fall at handover

This charge is found proved.

In reaching this decision, the panel took into account written statements, live and documentary evidence including the Home's rota and disciplinary meeting notes.

On Resident B's daily progress notes, there was no mention of the fall during the night shift, the notes only mention two falls that occurred during the day at 3pm. Also, at the daily 11am briefing with colleagues Mr Wright did not communicate that Resident B had a fall. The panel noted that previous unwitnessed falls had been documented on the falls log up until October 2019.

On the Home's rota, it shows that Mr Wright was on duty on 6 November and was the nurse in charge. Therefore, Mr Wright had a duty to record the fall and verbally inform colleagues.

On the balance of probabilities, the panel were of the view that the fall did happen and during the disciplinary meeting with Ms 5, Mr Wright accepted that Resident B did fall, and he failed to record these falls in the handover form and also failed to verbally inform colleagues.

Therefore, the panel finds this charge proved.

Charge 7

On 8 November 2019, after Resident B suffered a fall, you then failed to:

a) Undertake clinical observations
b) Complete or ensure the following was completed

i) An injury assessment

ii) An incident report form

iii) The checklist following a fall

iv) A clinical and CNS Observation record

v) A TPR and Blood pressure chart

vi) An Adult Glasgow Coma Scale and Neurological Observation Chart

vii) The Falls log

viii) A care plan update

ix) The Progress notes

This charge is found proved.

In reaching this decision, the panel took into account written statements, live and documentary evidence, including Resident B's care plan, progress record, falls log and Mr Wright's written statement.

All the evidence from the witnesses and notes from the Home suggests that Mr Wright did not undertake clinical observations and ensure the listed assessments and observations was completed.

In Mr Wright's witness statement, he wrote *'Resident B was found on the floor of her room next to the edge of her chair. I checked her over and there appeared to be no visible injuries'.* During the disciplinary meeting he also stated, *'she presented as normal'*. Mr Wright accepted that he did not carry out any observations.

In addition, the management report stated that *'NW carried out his visual observation and found no injury at the times of assessments. However, no incident forms were found to be completed on the day following the falls, nor had the base line observations been recorded or the results of the assessments. No evidence was found that the falls strategy had been followed.'* The panel also noted that the last entry of the falls log was in October 2019 and Resident B's care plan and progress notes was not updated.

The panel determined that despite Mr Wright carried around visual observation, this cannot be deemed as clinical observation.

Therefore, the panel finds this charge proved.

Charge 8

On or around 8 November 2019, after Resident B had suffered a fall on 6 November 2019, you failed to:

a) Record this in the handover form

b) Verbally inform colleagues of the fall at handover

This charge is found proved.

In reaching this decision, the panel took into account written statements, Ms 4's live evidence and documentary evidence.

During Ms 4s oral evidence, she stated that she took over from Mr Wright and did not receive a written or verbal handover and was not informed of the fall or progress of Resident B. Also, Mr Wright did not inform colleagues at the daily 11am briefings. Ms 4 confirmed that she had not received a handover of any fall, no clinical observations were undertaken, as per policy requirements which state these should be completed post fall.

The panel noted that Mr Wright accepted that he did not complete handover during the disciplinary meeting.

Therefore, the panel finds 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 Wright 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 Wright fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Dr Joshi 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.'*

Dr Joshi also referred the panel to the NMC guidance DMA-1 in relation to impairment and DMA-7 which is the NMC guidance on dishonesty.

Dr Joshi 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.

Dr Joshi identified the specific, relevant standards where Mr Wright's actions amounted to misconduct, in particular Codes 1.1, 1.2, 2.1, 3.2,7, 8, 8.2, 8.3, 10, 10.1, 14, 14.1, 17, 17.1, 20 and 20.1.

Dr Joshi submitted that Mr Wright's actions breached his duty of candour, as a result of the serious absence of recording and making sure colleagues were aware of the concerns relating to residents in the Home.

Dr Joshi also submitted that Mr Wright's lack of communication led to colleagues being unaware of the conditions residents were in and placing them at risk of harm. Dr Joshi further submitted that the continued failures fall short of the professional standards and therefore there is a need to protect the public and the wider public interest.

Dr Joshi submitted that Mr Wright's actions did amount to misconduct and invited the panel to find Mr Wright currently impaired.

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

Decision and reasons on misconduct

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

> *'**1 Treat people as individuals and uphold their dignity***
> *1.1 treat people with kindness, respect and compassion.*
> *1.2 make sure you deliver the fundamentals of care effectively.*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

2.1 work in partnership with people to make sure you deliver care effectively

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

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

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
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

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

20.1 keep to and uphold the standards and values set out in the Code
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. The panel went through each charge to assess whether Mr Wright's actions amounts to misconduct.

Charge 1

The panel determined that Mr Wrights actions did amount to misconduct due to the incorrect information given to Resident A's family; when Mr Wright was fully aware of all the facts surrounding the death of Resident A. The panel also determined that Mr Wright should have in line with his duty of candour been open, honest and candid about the situation as there was no reason for him not to be.

Charge 2

The panel determined that Mr Wright's actions did amount to misconduct as he did not tell the truth to Resident A's family surrounding her death and gave a misleading version of events, which had a detrimental effect on the family. As the registered nurse in charge, Mr Wright had a duty to be open and honest, explaining the circumstances; circumstances Mr Wright was fully aware of as he had been directly involved.

Charge 3 and Charge 4

The panel determined that Mr Wright's actions did amount to misconduct because he failed to advise Ms 1 of the true facts surrounding Resident A's death by informing her that the death followed an emergency situation. The panel took into account the context surrounding the situation, namely it being an emergency situation in a nursing home, which rarely happens. However, the panel were of the view that as a registered nurse, Mr Wright should have had the knowledge to deal with this type of situation. He did not deal with it appropriately or openly. In addition, Mr Wright did not take the opportunity to rectify the misleading information that he had provided to Ms 1 by telephone.

Charge 5 and Charge 6

The panel determined that Mr Wright's actions did amount to misconduct as he failed to follow policy or procedure of the Home, which as a registered nurse in charge of the unit was required to undertake. Areas where he failed included the assessments, clinical observations and handover to colleagues. As a result of Mr Wright's failures, Resident B did not have the required care delivered, which would have ensured timely and

appropriate action to changes in her condition, colleagues were unaware of the falls and therefore were not performing additional clinical reviews, or seeking other medical support.

Charge 7 and Charge 8

The panel determined that Mr Wrights actions did amount to misconduct because he failed in his duty as a registered nurse by not conducting a number of critical actions after a fall such as undertaking clinical observations of Resident B, failing to properly document or report the incident and failing to inform colleagues verbally or in writing, by a handover. The panel was aware that Mr Wright knew the correct procedure following a fall but failed to carry out what he needed to do, therefore, leaving a vulnerable Resident at risk.

The panel found that Mr Wright'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 Wright'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 finds all four limbs of the Grant test engaged.

Both Resident A and Resident B were put at an unwarranted risk resulted in actual harm as a result of Mr Wright's misconduct. In addition, Mr Wright's lack of candour in respect of the circumstances of Resident A's death caused her family further distress. Mr Wright's misconduct had breached the fundamental tenets of the nursing profession and therefore

brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel noted that Mr Wright made some partial acknowledgement during the Home's disciplinary process, however, since then he has not provided evidence to demonstrate that he understands how his actions detrimentally impacted the Residents A and B. The panel also determined that Mr Wright has not provided any evidence to suggest that he understands why his actions relating to both Resident A's family and Resident B was wrong and how this impacted negatively on the reputation of the nursing profession.

The panel noted that dishonesty can be more difficult to remediate but Mr Wright had opportunities for him to demonstrate that he was working towards and responding to the charges which include clinical concerns raised against him. Instead, Mr Wright has not provided the panel with any evidence to show that he has taken steps to strengthen his practice or to explain the context behind the reason for his actions or how he would handle the situation differently in the future. No insight and no remediation has been demonstrated regarding any of the charges.

This was not a single event, with charges relating to incidents occurring in 2016 and 2019. Mr Wright has had multiple opportunities to acknowledge, address or work towards some remediation, or demonstrate insight. The panel is of the view that there is a risk of repetition based on the lack of insight and remediation. 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.

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 Wright's fitness to practise impaired on the grounds of public interest.

The panel determined that a finding of impairment on public interest grounds is required.

Having regard to all of the above, the panel was satisfied that Mr Wright'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 Wright off the register. The effect of this order is that the NMC register will show that Mr Wright 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.

Submissions on sanction

Dr Joshi invited the panel to impose a striking-off order, as it found Mr Wright's fitness to practise currently impaired.

Dr Joshi referred the panel to the NMC Guidance SAN-1 in relation to sanction.

Dr Joshi submitted that despite the fact that Mr Wright had full knowledge of correct procedures and protocols, at no stage, following any of the incidents which formed the charges, did Mr Wright do the right thing.

Dr Joshi outlined mitigating and aggravating features:

Mitigating

- Personal mitigation – period of stress or illness, which the panel heard in private.

Aggravating

- Abuse of trust
- Lack of insight into failings
- Pattern of misconduct over a period of time as the incidents took place in different years.
- Conduct put patients at risk of suffering harm, resulting in actual harm in Resident B.
- Fell short of the fundamental tenets of the nursing profession.

Mr Wright's dishonesty breached the duty of candour.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr Wright'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 trust in that Mr Wright not only put vulnerable residents at risk and misled family but was also a registered nurse who should have provided leadership and guidance to the team he led at the Home.
- There was no further attempt to engage with Resident A's family to apprise them of the true facts of Resident A's death which remained unknown to the family until the coroner became involved years later.
- Very limited demonstration of remorse.
- By his actions put colleagues in difficult and professionally embarrassing situations.
- Extremely limited insight, if any regarding any of the charges, the impact on residents, relatives, colleagues and the nursing profession.
- Lack of candour and dishonesty in respect of matters relating to Resident A.
- No evidence of strategies or approaches Mr Wright will implement to avoid these failures happening again; or any that have been undertaken to date.
- Poor practice encompassing three discrete issues with some similarities in 2016 and 2019.
- Lack of meaningful engagement with the NMC investigation process.
- Mr Wright's conduct in relation to charged 5 to 8 was such as could foreseeably cause direct or indirect resident harm.

The panel also took into account the following mitigating features:

- In respect of charges 5 to 8, Mr Wright may have been under stress at the time due to personal circumstances
- No regulatory concerns since Mr Wright registered and qualified as a nurse in 2012.
- Accepted at an early stages the facts relating to charges 5 to 8.

The panel had sight of a brief letter dated 11 January 2023 but did not consider this to be a letter of reference.

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 Wright'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 Wright'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 Wright's registration would be a sufficient and appropriate response. The misconduct identified in this case involved clinical concerns and dishonesty and lack of candour; whist the clinical concerns have the potential to be addressed through conditions of practice, both the seriousness of the case and the finding of dishonesty pose significant issues for conditions of practice, bearing in mind the registrant has provided extremely limited insight, shown no remediation or demonstrated how these concerns can or have been addressed since they first occurred in 2016.

The panel also considered that an element of attitudinal concerns and not just clinical errors is present. 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. Furthermore, the panel concluded that the placing of conditions on Mr Wright's registration would not adequately address the seriousness of this case and would not protect the public or the public interest.

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;*

The incidents which led to the charges are not all directly related clinical charges. However, the panel noted more than one NMC referral over a period of several years. There are a number of common threads including poor and non-existent record keeping, failure to follow policies and processes and poor communication. In addition, the panel found dishonesty and lack of candour in relation to charges 1 to 4.

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 Wright's actions is fundamentally incompatible with Mr Wright remaining on the register. The panel determined that a member of the public will have a serious concern about Mr Wright continuing as a registered nurse due to the concerns raised against him and the lack of insight into his failings.

The panel have no evidence to suggest that Mr Wright has taken steps to strengthen his practice, especially since some of the concerns raised against him relate to his clinical practice which can be remediated. The panel noted that Mr Wright has had ample opportunities since the first referral to make improvements or developments within his career and evidence this to the NMC but has failed to do so.

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?*

With a finding of dishonesty, it is important to note that a registered nurse should work with honesty, integrity and trustworthiness. Mr Wright had multiple opportunities to address these concerns both at the time of the incidents and up until this point in time either directly or through counsel. The panels view is that there had been evidence of a deliberate misuse of power by Mr Wright impacting on vulnerable residents, care staff dependant on Mr Wright and Resident A's family.

Mr Wright'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 Wright'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 effect of Mr Wright'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 on the grounds of both public protection and public interest.

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. Again, the panel noted the lack of any substantive engagement by Mr Wright with these proceedings which involved very serious charges.

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 Wright's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Dr Joshi. He submitted that an interim suspension order is appropriate to cover the appeal period, on the grounds of public protection and public interest. Dr Joshi also submitted that the duration of the order is for the professional judgement of the panel to determine.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public 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 substantive striking off order 28 days after Mr Wright is sent the decision of this hearing in writing.

This will be confirmed to Mr Wright in writing.

That concludes this determination.