Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 29 April 2024 – 3 May 2024
Tuesday 7 May 2024 – Wednesday 8 May 2024

Virtual Hearing

Name of Registrant:	**Sarah Omolara Phillips**
NMC PIN	16H0231E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – (16 September 2016)
Relevant Location:	Ealing
Type of case:	Misconduct
Panel members:	Wayne Miller (Chair, Lay member) Carol Porteous (Registrant member) Bill Matthews (Lay member)
Legal Assessor:	Jayne Salt
Hearings Coordinator:	Charis Benefo (29 April 2024) Rim Zambour (30 April 2024 – 8 May 2024)
Nursing and Midwifery Council:	Represented by Alex Mullen, Case Presenter
Miss Phillips:	Present and unrepresented
Facts proved by admission:	Charges 1c, 1g, 2a and 5b
Facts proved:	Charges 1b, 1e, 1f, 2b, 2c, 3, 4a, 5a, 6a, 6b, 7 and 8
Facts not proved:	Charges 1a, 1d, 4b
Fitness to practise:	Impaired
Sanction:	**Striking-off order**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on application to amend the charge

At the outset of the hearing, the panel heard an application made by Mr Mullen, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of the stem of charge 1.

The proposed amendment was to correct a typographical error in the year of the alleged incident. It was submitted by Mr Mullen that the proposed amendment would more accurately reflect the evidence.

> "That you, whilst working as a registered mental health nurse in relation to Patient A:
>
> 1) On or around 2 September ~~2021~~ **2022**:"

You indicated that you had no issue with the proposed amendment to the stem of charge 1.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application for hearing to be held partly in private

Mr Mullen made a request that this case be held partly in private [PRIVATE]. The application was made pursuant to Rule 19.

You indicated that you supported the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to hold in private the parts of this hearing that involve reference to [PRIVATE] as and when such issues are raised, in order to protect your privacy. It was satisfied that this course was justified and that the need to protect your privacy outweighed any prejudice to the general principle of public hearings.

Details of charge [as amended]

That you, whilst working as a registered mental health nurse in relation to Patient A:

1) On or around 2 September 2022:

    a) Said to her “you are triple my size” or words to that effect; **[NOT PROVED]**
    b) Called her “fat” or words to that effect; **[PROVED]**
    c) Called her a “bitch” or words to that effect; **[PROVED BY ADMISSION]**
    d) Called her a “side coat” or words to that effect; **[NOT PROVED]**
    e) Threw a wet tissue at her; **[PROVED]**
    f) Threw a medication pot at her; **[PROVED]**
    g) Pushed her on one or more occasions **[PROVED BY ADMISSION]**

2) On 2 September 2022 at approximately 19:34 completed an incident report (‘IR1’) where you:

    a) Recorded incorrectly that you “gently pushed” Patient A; **[PROVED BY ADMISSION]**
    b) Did not record that you pushed Patient A a second time; **[PROVED]**

c) Did not record that you threw one or more items at Patient A **[PROVED]**

3) Your actions as specified in any or all of charges 2a) – 2c) were dishonest in that you attempted to downplay the seriousness of the incident **[PROVED]**

4) On or around 2 September 2022, knowing that Colleague A was going to submit an IR1 which was not going to mention that you pushed Patient A, you:

a) Let the IR1 be submitted; **[PROVED]**
b) Failed to draw the true facts to the attention of a senior colleague **[NOT PROVED]**

5) Your actions as specified at charge 4 were dishonest in that:

a) You knew that what was going to be recorded on the IR1 was not a true account of what had happened; **[PROVED]**
b) You were aware that anyone reading the IR1 would be misled as to the events which had occurred **[PROVED BY ADMISSION]**

6) On 2 September 2022 at approximately 21:32, completed a RiO report on the electronic patient records system and you failed to accurately record what happened in that you: **[PROVED IN ITS ENTIRETY]**

a) Did not record that you had pushed Patient A;
b) Did not record that you had thrown one or more items at Patient A

7) Your actions as specified in any or all of charges 6a) – 6b) were dishonest in that you attempted to downplay the seriousness of the incident **[PROVED]**

8) By failing to accurately record what had happened, your actions as specified in any or all of charges 2 – 7 contributed to the inappropriate seclusion of Patient A for a period of 4 days **[PROVED]**

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

Background

You first entered onto the NMC's register on 16 September 2016.

You were referred to the NMC on 21 March 2023 in relation to incidents that are said to have taken place whilst you were working as a mental health staff nurse employed by West London Mental Health NHS Trust (the Trust) on Parkland Ward, part of the Women's Enhanced Medium Secure Services (WEMSS). At the time of the allegations, you were working at St Bernard's Hospital (the Hospital) on the Orchard Unit (the Unit). The Unit is a women's medium or sometimes enhanced medium secure services unit providing care for women who have mental illnesses or personality disorders.

Mr Mullen split the allegations into four blocks.

<u>Incident with Patient A on 2 September 2022</u>

The first block relates to the allegation that on the afternoon of 2 September 2022, whilst in an interview room, you were assisting Patient A in applying deep heat cream to her legs. In the course of assisting Patient A with applying that cream, you made comments to Patient A which give rise to charges 1a and 1b.

Then, during the evening of 2 September 2022 (captured on Close Circuit Television (CCTV)), in the medications room/the medications hatch, the door was left half open and Patient A attended the room in order to obtain and take medication that was prescribed to them. There appeared to be an issue at the medications hatch possibly surrounding the type of cup that the medication was given in and whether it was suitable. Patient A then allegedly asked for a different cup, leading to a conversation which then led to a minor altercation.

A colleague arrived at the medications hatch and started assisting with handing out the medication to Patient A. You sought to leave the medication room, in spite of the colleague who had arrived suggesting that you stay. It is at this time that the alleged comments in charges 1c and 1d were made towards Patient A.

You allegedly threw what appeared to be a wet tissue in the direction of where Patient A was standing. It missed the patient and stuck to the wall behind where they were standing. You allegedly then threw a medication pot towards Patient A.

The door of the hatch was then fully opened and you and Patient A were standing opposite one another in the doorway of the medications room. You moved to leave the area and in doing so, initially pushed Patient A out of the way of the door in order to leave. You began to walk away but stopped and turned to push Patient A a second time. There was then a very short physical altercation between you, in which Patient A pulled your wig off, and then the altercation concluded.

Incident Report Form (IR1)

The second block relates to your IR1 on the electronic reporting system. The report that was made at 19:34 on 2 September 2022 made no mention of any items being thrown, no mention of the second push of Patient A, and in fact the push is described as being '*gentle'*.

It is alleged that this was an attempt by you to downplay the seriousness of what happened between yourself and Patient A.

Colleague A's IR1

The third block relates to Colleague A's IR1. This report was made at about 00:40 into the following morning of 3 September 2022. There was no mention of pushing in the report, or

the throwing of any items. The allegation is that you appeared to be aware of Colleague A's intention to report the incident in that particular way and did not seek to alert Colleague A or any other colleague to the fact that the report could be misleading.

RiO Report

The fourth block relates to the RiO report, which is another electronic reporting system. It is alleged that this report was created by you, there was no mention of any pushing or throwing of items at Patient A, and that being an attempt by you to downplay the seriousness of the incident.

It is alleged that as a result of the incident, and the way in which it was ultimately reported, Patient A was secluded for a period of four days on the basis that she had assaulted you and pulled off your wig. The allegation was that as a result of the misreporting of the incident, Patient A's seclusion was founded on a false basis; and as a result the seclusion was inappropriate and not warranted had the incident been reported correctly.

Decision and reasons on admissibility of Appendix 11

Prior to its deliberations on the facts, the panel decided to consider the admissibility of the Safeguarding Adult Concern report. This is a record of a telephone conversation which contains details of allegations against you made by Patient A to the Independent Mental Health Advocate (IMHA) when you were not present. The panel considered that Rule 31 provides that, so long as it is '*fair and relevant'* a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel first applied the relevant principles in *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). It determined that in relation to charge 1:

1. The nature and extent of the challenge is that it is wholly disputed.
2. This charge would be considered serious.
3. There is good reason for the non-attendance of Patient A.

4. The NMC have made reasonable efforts to secure the attendance of Patient A.

The panel also considered that to admit this report into evidence would be unfair to you and would put you at a disadvantage as the evidence cannot be tested or challenged.

The panel therefore decided that Appendix 11 is not admissible.

Decision and reasons on admissibility of Mr 1's hearsay evidence

The panel also considered the admissibility of the evidence of Mr 1. This included a written but unsigned statement, as well as written notes from his interview.

The panel first considered the evidence by applying the relevant principles of *Thorneycroft*:

1. This is now the sole and decisive evidence in relation to parts of charge 1.
2. The allegations are wholly challenged.
3. There is no evidence to suggest that Mr 1 had reason to fabricate his allegations.
4. The charge is serious.
5. There is a good reason for the non-attendance of Mr 1 as a result of his health.
6. The NMC has taken reasonable steps to secure the attendance of Mr 1.

The panel considered that notwithstanding the Trust statement and meeting notes being undated and unsigned, and whilst they cannot be tested, the documents are relevant. Mr 1 was present at the time the alleged comments were made by you. You have also admitted in a telephone call to Witness 1 that Mr 1 was present at the time of the incident.

The panel decided to admit these documents into evidence. It will determine what weight it places on them in relation to the charges at the facts stage.

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you made admissions to charges 1c, 1g, 2a and 5b.

The panel therefore found charges 1c, 1g, 2a and 5b proved, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Mullen on behalf of the NMC and by you. The panel viewed the CCTV evidence, noting that it did not have audio.

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:

- Witness 1: Clinical Nurse Manager at the Trust at the time of the allegations;
- Witness 2: Team Leader on a different ward in the Unit at the time of the allegations; and
- Witness 3: Clinical Team Leader on the Ward at the time of the allegations.

The panel also heard evidence from you under oath.

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

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

Charge 1a

'That you, whilst working as a registered mental health nurse in relation to Patient A:

1) *On or around 2 September 2022:*
    a) *Said to her "you are triple my size" or words to that effect;'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the statement and notes taken by Mr 1 who was there at the time in which he states the following:

> *'In the first incident, Patient A asked [you] to give her deep heat and [you] asked why [you] should give it. Patient A said because I cannot bend and [you] responded, 'that's because your [sic] triple my size'.'*

However, the panel attached little weight to this evidence as it could not be tested.

The panel also considered your own evidence in relation to this charge. It determined that you have provided a consistent account of your denial which has been tested throughout the hearing. The panel therefore preferred your evidence in relation to this charge and found it not proved.

Charge 1b

'That you, whilst working as a registered mental health nurse in relation to Patient A:

1) On or around 2 September 2022:

b) Called her "fat" or words to that effect'

This charge is found proved.

In reaching this decision, the panel took into account Mr 1's report as well as your own evidence.

During cross-examination Mr Mullen asked you whether you remember suggesting that Patient A go to the gym to make things better. You replied saying:

> *"Yeah, I did suggest that she could call the gym instructor and they could talk to her…and I was about to say we can also refer you to the physiotherapist…not about losing weight but also about maintaining daily activity that could help her. I was about to say you can also be referred to the physio so I wasn't focusing on her weight at all Sir. I was focusing on her wellbeing"*

Mr Mullen also asked you whether you spoke to Patient A about her size of clothing. You said:

> *"I did not say that and as a professional it's not right for me to say that because it will seem like I'm bullying her or I'm discriminating."*

The panel also had regard to the written note of the telephone conversation on 14 September 2022 as part of your employer's fact-finding exercise. In relation to the incident, you said in the telephone call that:

> *'…I suggested she can go to the gym, I was joking around, Patient A said what about you, I said you cannot compare us, she said she is size 26.'*

The panel did not have direct evidence that you specifically used the word '*fat'* in relation to Patient A. However, it noted that the charge also includes '*words to that effect'*. The panel determined that there is sufficient evidence to indicate that you did use words to the effect of being about Patient A's weight and that it is reasonable for the patient to have construed your comments as being about her weight.

The panel therefore determined that this charge is found proved on the balance of probabilities.

Charge 1d

'That you, whilst working as a registered mental health nurse in relation to Patient A:

1) On or around 2 September 2022:

d) Called her a "side coat" or words to that effect'

This charge is found NOT proved.

In reaching this decision, the panel took into account your evidence. As it had decided not to admit Appendix 11, there was therefore no other admissible evidence in support of this charge.

The panel determined that you have been consistent in your account that you do not know what this term means and is not something that you would ever use.

The panel therefore found that the NMC has not discharged its burden of proof in relation to this charge and found it not proved.

Charge 1e

'That you, whilst working as a registered mental health nurse in relation to Patient A:

1) On or around 2 September 2022:

e) *Threw a wet tissue at her'*

This charge is found proved.

In reaching this decision, the panel took into account the viewed CCTV footage of the incident at 00:11:00 seconds, witness statements, interview notes and your own account.

In the CCTV footage it is clear that there is a wet tissue thrown in the direction of Patient A, which passes over Patient A's head and hits the opposite wall.

The panel also had sight of Witness 1's written statement in which they state the following:

> *'The footage shows the registrant throwing a wet tissue and a medication pot at a service user.'*

The panel took account of the interview notes dated 26 October 2022 in which you stated:

> *'It seems like I threw a tissue but I didn't throw a tissue at her, I was trying to tell [Mr 1] to call [Mr 2] and the tissue was in my hand at the time, that one was a mistake, it fell accidentally from my hand as I didn't intend to do that, I was intending to ask [Mr 1] to call [Mr 2].'*

In your oral evidence you said that you "*talk with [your] hands and didn't mean to throw it"* and that you "*threw it at a member of staff to get their attention"*. The panel found your version of events to be inconsistent and did not accept it.

The panel therefore determined that given the substantial evidence in support of this charge, on the balance of probabilities, it is found proved.

Charge 1f

‘That you, whilst working as a registered mental health nurse in relation to Patient A:

1) On or around 2 September 2022:

f) Threw a medication pot at her’

This charge is found proved.

In reaching this decision, the panel took into account the viewed CCTV footage at 00:39:00 seconds, Witness 1’s statement and your oral evidence.

The panel also had sight of Witness 1’s statement in which they state:

> *‘The footage shows the registrant throwing a wet tissue and a medication pot at a service user.’*

Your account is that you tried to pass the pot to the patient but could not see her and thought her arm was stretched out. The pot then fell and Mr 2 can be seen picking up what appears to be medication from the floor.

The panel determined that it is more likely than not that you did throw the pot at the patient, or in her direction. From the CCTV footage, it appears to be an underarm throw and not with force. The panel did not accept your version of events having had regard to all of the evidence in support of this charge.

The panel therefore found this charge proved on the balance of probabilities.

Charge 2b

‘That you, whilst working as a registered mental health nurse in relation to Patient A:

2) On 2 September 2022 at approximately 19:34 completed an incident report (‘IR1’) where you:

b) Did not record that you pushed Patient A a second time’

This charge is found proved.

In reaching this decision, the panel noted your admission of charge 2a. It determined that through this admission, you accept that you completed the incident report. It is also clear from the CCTV footage that you did push Patient A a second time which is not mentioned in the incident report.

The panel took into account your explanation that you did not remember the second push when interviewed, and that you were not focused on how many times you had pushed Patient A. Rather, you were in a difficult mental state due to the trauma of the incident.

However, the panel must focus on the facts in the evidence available as they relate to the charge, and it is clear that you did push Patient A a second time and did not record this in the IR1. Therefore, the panel found this charge proved on the balance of probabilities.

Charge 2c

'That you, whilst working as a registered mental health nurse in relation to Patient A:

2) On 2 September 2022 at approximately 19:34 completed an incident report ('IR1') where you:

c) Did not record that you threw one or more items at Patient A'

This charge is found proved.

In reaching this decision, the panel took into account the same evidence as in the above charge, and took account of its finding in charges 1e and 1f that you threw a wet tissue and medication pot at Patient A. The CCTV evidence proves that the incident occurred where you threw items at the patient. The panel also had sight of the IR1 which did not make any mention of the throwing of any items.

The panel had regard for your explanation that the trauma of the incident impacted on your ability to recall specific events whilst completing the IR1. The panel accepted that this must have been a stressful situation for you.

However, given the evidence before it, the panel determined that this charge is proved.

Charge 3

'That you, whilst working as a registered mental health nurse in relation to Patient A:

3) Your actions as specified in any or all of charges 2a) – 2c) were dishonest in that you attempted to downplay the seriousness of the incident'

This charge is found proved in its entirety.

The panel first determined that the dishonesty in this charge pertains to the omissions in which you recorded the event, approximately ninety minutes after the incident occurred. The panel was of the view that this was a reasonable amount of time to calm down and start your recollection of what happened. You incorrectly recorded that you '***gently***' pushed Patient A and omitted the second push as well as the throwing of items.

In reaching this decision, the panel considered the test set out in *Ivey v Genting Casinos UK Ltd (Crockfords Club)* [2017] UKSC 67. The panel first considered the actual state of your knowledge or belief as to the facts. The panel took into account your oral evidence in which you stated that you were extremely upset after the incident and you kept asking yourself why you pushed the patient. [PRIVATE]. Your explanation was therefore [PRIVATE] and that you forgot to include the details in the IR1. However, the panel was of the view that your belief as to the facts was that you knew that you had incorrectly recorded the incident.

The panel also determined that your conduct was dishonest by the standards of an ordinary and decent member of the public. Further that you have a duty of candour to be honest, open and truthful.

The panel therefore determined that on the balance of probabilities, this charge is proved.

Charge 4a

'That you, whilst working as a registered mental health nurse in relation to Patient A:

4) On or around 2 September 2022, knowing that Colleague A was going to submit an IR1 which was not going to mention that you pushed Patient A, you:

a) Let the IR1 be submitted'

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence, Colleague A's IR1 and your own evidence.

The panel had sight of Witness 1's statement in which they say the following:

> *'[Colleague A] completed the second incident report. She stated during the investigation that it was the information that was handed to her by the registrant. Therefore, she only documented what she had told her as she had not witnessed the incident herself.'*

The panel also considered Colleague A's oral evidence in which she informed the panel that she told you she would do the IR1 so that the incident could be reported to the police but would '*take out the push part as you are not supposed to push'*.

You also confirmed during your cross-examination that this discussion with Colleague A took place and that she informed you that she would not include the push.

The panel was of the view that you therefore knew the nature of the IR1 that Colleague A was going to submit, and you had time to reflect on this but still allowed the incorrect report to be submitted.

The panel therefore found this charge proved on the balance of probabilities.

Charge 4b

'That you, whilst working as a registered mental health nurse in relation to Patient A:

4) On or around 2 September 2022, knowing that Colleague A was going to submit an IR1 which was not going to mention that you pushed Patient A, you:

b) Failed to draw the true facts to the attention of a senior colleague'

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Colleague A, as well as the evidence considered in charge 4a.

The panel determined that it follows on from charge 4b that you did inform Colleague A, a senior colleague and your supervisor, about pushing the patient. It was not disputed that a discussion took place where you informed Colleague A about the push and she said she would not include it into the IR1 as it was '*wrong to push'*.

Therefore the panel determined that the NMC has not discharged its burden of proving this charge and found it not proved.

Charge 5a

'That you, whilst working as a registered mental health nurse in relation to Patient A:

5) Your actions as specified at charge 4 were dishonest in that:

a) *You knew that what was going to be recorded on the IR1 was not a true account of what had happened'*

This charge is found proved.

The panel noted that it had only found charge 4a proved and therefore only considered that charge in relation to 5a.

In reaching this decision, the panel first considered the *Ivey* test. It determined that at the time, it was clear that you knew the IR1 was going to be submitted without the push being mentioned as Colleague A had told you so. You were therefore complicit by not positively acting to ask Colleague A not to submit an incorrect report. The contents of this discussion are not disputed.

The panel also considered that an ordinary and decent member of the public would find this conduct to be dishonest in that you knew that what was going to be recorded was not a true account of what happened. Further, as a nurse, that you have a duty of candour to be honest, open and truthful.

The panel therefore found this charge proved on the balance of probabilities.

Charges 6a and 6b

'That you, whilst working as a registered mental health nurse in relation to Patient A:

6) *On 2 September 2022 at approximately 21:32, completed a RiO report on the electronic patient records system and you failed to accurately record what happened in that you:*
   a) *Did not record that you had pushed Patient A*
   b) *Did not record that you had thrown one or more items at Patient A'*

This charge is found proved in its entirety.

The panel considered these sub-charges together due to the same evidence being used for both.

In reaching this decision, the panel first took into account the RiO entry dated 2 September 2022 at 21:32. It is set out as follows:

> *'Originator: PHILLIPS, Sarah*
> *2 September 2022 21:32*
>
> *[Nursing - Ward Nurse]*
> *Detail*
> *Update*
> *PM SHIFT*
> *Incident reference number 248553*
>
> *At 1755hours, Patient A was in front of clinical room getting ready for her medication. Medications was given to her but she became argumentative because of paper cups. She then squeezes the paper cup with water inside and spilt the water. Patient A then stood in front of the door in a threatening way saying "I will attack you" and prevented staff from getting out of the medication room. Patient A continued being abusive calling staff "fat soul; who is the fat soul now." As staff tried coming out of the room, trying to get away from the situation, Patient A continued to be hostile and aggressive in manner and pulled staff's hair and attempted to punch staff [You]*
>
> *Team attended, duty doctor and Unit Coordinator were present. Patient A was secluded at 19:10hours. CAD: TAA-58460-22-0101-IR'*

You denied writing this RiO entry and were unable to explain how an entry could be made in your name without your knowledge. The panel also heard evidence from Witness 1 that

there is a username and logon process for the system that is unique to each user and passwords are automatically changed on a regular basis. When questioned by the panel, you stated that you had not given your RiO login details to anyone else.

It is clear from the RiO entry that no mention of your pushing of Patient A is made, nor is there a record of your throwing items at the patient. The RiO entry also states that you were the originator and the panel rejected your account that someone else had created it.

The panel therefore found this charge proved on the balance of probabilities.

Charge 7

'That you, whilst working as a registered mental health nurse in relation to Patient A:

7) Your actions as specified in any or all of charges 6a) – 6b) were dishonest in that you attempted to downplay the seriousness of the incident'

This charge is found proved.

In reaching this decision, the panel took account of the *Ivey* test. It considered that by the time you created the RiO entry, you knew that you were not being completely honest about the facts of the incident. It determined that you had been selective in what was omitted, only including certain details which portrayed the patient as the aggressor. The panel determined that, on the balance of probabilities, it was more likely than not that your intention was to downplay the seriousness of the incident.

The panel also determined that an ordinary member of the public would consider your conduct in charges 6a and 6b to be dishonest.

The panel therefore found this charge proved.

Charge 8

'That you, whilst working as a registered mental health nurse in relation to Patient A:

8) By failing to accurately record what had happened, your actions as specified in any or all of charges 2 – 7 contributed to the inappropriate seclusion of Patient A for a period of 4 days'

This charge is found proved.

In reaching this decision, the panel first considered the statement of Witness 1 which states the following:

> *'Following the incident, the service user did not report any injuries. They were however secluded for 4 days after the incident. The rationale at that time was because the service user had assaulted the registrant and pulled out her wig. It was a joint decision from the registrant, the unit coordinator and another staff nurse to seclude them. Following the viewing of the CCTV footage, it appeared that the seclusion was not appropriate.'*

Contrary to this, is the evidence of Witness 2 who stated that it was '*my decision, I made but I told Sarah about the seclusion'*. Witness 2 stated in their oral evidence that if they knew that you had pushed Patient A, they would not have secluded her as they thought it was a staff assault.

The panel determined that your incorrect recording of the incident, and failure to subsequently correct that, did contribute to the initial and continued seclusion of Patient A. The panel noted that there appeared to be a host of systemic issues in this case which were factors in the ongoing seclusion, but that your failure to report the incident correctly was the root cause of the seclusion in the first place.

The panel determined that as your incorrect recording did contribute to the inappropriate seclusion of Patient A, this charge is found proved on the balance of probabilities.

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 your 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 ability to practise kindly, safely and professionally.

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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Mr Mullen 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.

Mr Mullen identified the specific, relevant standards where your actions amounted to misconduct. He submitted that the falling short in this case is broad and concerns various parts of the Code including sections 11, 10, 10.3, 14, 17, 19, 20 and 20.5.

Mr Mullen submitted that this is a case in which there had been real harm to Patient A who was a vulnerable patient. He stated that the harm caused not only includes being pushed and the use of unacceptable language, but also the harm and distress that Patient A would have suffered by being inappropriately secluded for such a long period of time.

Mr Mullen also submitted that there is a risk of further harm. These fallings short are serious as various particulars of dishonesty have been found proved and any case involving dishonesty is a serious one.

Mr Mullen stated that this is a case in which the duty of candour applies in the need for you to be open and honest. He submitted that there is a need to uphold not only public confidence in the profession but also standards within the profession itself. Mr Mullen submitted that as a result of these broad failings which fall short of the standards set out in the Code, those failings being serious, the ground of misconduct is made out.

You submitted that the panel having found facts proved does not in itself make your fitness to practise impaired. You implored the panel to consider your misconduct in light of all the relevant factors. You stated that these include your unblemished previous record and whether your conduct was easily remediable.

You stated that since you qualified as a registered mental health nurse in 2016 you have never been accused of similar allegations or had any disciplinary investigations against you until 2 September 2022. You told the panel that this incident was an isolated case in the context of your entire nursing career.

You submitted that given all the circumstances that led to the allegation, coupled with the fact that the NMC has not provided evidence of a pattern of behaviour towards your patients before, the facts found proved do constitute misconduct but not impairment.

Submissions on impairment

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

Mr Mullen submitted that Patient A was a vulnerable service user against whom abusive language was used, by your admission calling her a '*bitch'* or words to that effect. The panel also found that you called her '*fat'* or words to that effect. He stated that it was also accepted that violence was used against Patient A by pushing, and that was also plain from the CCTV footage seen.

Mr Mullen submitted that Patient A did suffer real harm from the violence of the pushing, and there was also a risk of suffering greater injury. He stated that there was also more serious harm caused by the extended seclusion that followed the pushing and rude language.

Mr Mullen further submitted that the situation Patient A found herself in, made her further vulnerable. He said that in circumstances where you were a registered professional and the highest standards of honesty and integrity were expected, Patient A was less likely to be believed than you.

Mr Mullen asked the panel to consider the *Grant* test and whether you have breached or are liable to breach the fundamental tenets of the nursing profession. He stated that he

has addressed the panel on the breaches of the Code which the NMC say are several and serious.

With regards to the dishonesty element, Mr Mullen submitted that a finding of dishonesty is not only a breach of the Code and a fundamental tenet of the nursing profession, but is also in and of itself evidence of impairment. He stated that there is plainly a failing found proved in relation to dishonesty, mainly the covering up/falsifying of records and misleading and omitting information. He submitted that you failed to raise the inaccuracy of the reports being made and contributed to a culture which suppresses openness.

Mr Mullen reminded the panel of the context in this case, including evidence of your character, training, reflection and some insight. Further, that you have also made admissions to some of the allegations and have sought to apologise at various stages throughout the case. He also reminded the panel of the evidence from Witness 1 in which they stated that the ward was a particularly difficult one.

Mr Mullen invited the panel to consider all of the factors above in determining the risk of repetition.

Mr Mullen submitted that a finding of impairment would be in the public interest to uphold professional standards of conduct, not least in the professions themselves, but also maintaining the public's confidence in registered professionals who they deal with. He stated that a member of the public watching this hearing would be concerned if impairment is not made out. He submitted that a finding of impairment is also required to mark the seriousness of the conduct in question.

You first informed the panel that you are unable to demonstrate your work record after the incident due to first being placed on an interim conditions of practice order, followed by a suspension order since 19 October 2023. You stated that you have continued to look for jobs as a healthcare assistant (HCA) since then without any success.

You reminded the panel that the purpose of this hearing is not to punish you as a practitioner for your past misdoings, but to protect the public against the acts and omissions of those who are not fit to practise. You submitted that the public interest would include the safe return to practice of an experienced nurse like yourself.

You stated that you have reflected and demonstrated insight into your conduct through the reflective statement you provided. You said that you realised the impact of your actions towards Patient A, your nursing profession, colleagues, the Trust and the wider public. Further, that you have learnt a valuable lesson from the incidents and the consequences that followed.

You told the panel that you qualified as a mental health nurse in August 2016 and worked at the Trust from then until you left in November 2022. You said that throughout this period you had remained a safe practitioner in the Trust until the incident happened. Since leaving the Trust you have continued to strengthen your practice by engaging in various training to further enhance your knowledge and develop your practice. You asked the panel to consider your unblemished record as a nurse prior to the incident.

You stated that you have cooperated fully with both the Trust and the NMC during the proceedings. You said you have also shown initiative by undertaking Safeguarding Adults Training Level One and breakaway techniques to develop further awareness about safeguarding matters and to further strengthen your practice.

You stated that dishonesty is serious and that it means you have undermined the public confidence and trust in the profession as you would have completely departed from the standards expected of a registered nurse. You said you did not offer any justification for your behaviour and take full responsibility for your actions and omissions. You also accepted that you brought the profession into disrepute and breached the fundamental tenets of the nursing profession. You said that this had never happened before 2 September 2022 and would not happen again.

You said that you have acknowledged what went wrong and have also been able to demonstrate to the panel that you learnt from the incident. You apologised to the panel and to Patient A.

You referred the panel to your testimonials and references from various colleagues and asked the panel to add weight to these references in its deliberations.

You submitted that in view of all the issues you have raised, your fitness to practise is not currently impaired and you do not currently pose a risk to patients or the public given the remedial steps you have taken so far.

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your 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*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *To achieve this, you must:*

10.3 *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

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

To achieve this, you must:

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

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

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

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 *take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

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*

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*

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

20.6 *stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers.'*

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

The panel considered misconduct in each of the charges found proved.

Charges 1b and 1c

The panel considered these charges together as they both concerned the verbal abuse of Patient A. The panel determined that by using inappropriate language towards a vulnerable patient, your actions fell below the standards expected of a registered nurse.

The panel therefore determined that your actions at charges 1b and 1c amounted to misconduct.

Charges 1e and 1f

These charges were considered together as they related to the physical acts of throwing items at Patient A.

The panel determined that your actions at these charges did amount to misconduct for the same reasons as those in charges 1b and 1c.

Charge 1g

The panel determined that the public would be shocked to hear that a nurse had twice pushed a vulnerable patient.

The panel therefore found your actions at charge 1g amounted to misconduct.

Charge 2

The panel determined that a member of the public would be disappointed to learn that you did not fully and accurately record the incident. The panel considered that one of the fundamentals of nursing practice includes record-keeping and the duty to record accurately.

The panel therefore found that your actions at charge 2 amounted to misconduct.

Charge 3

This charge relates to dishonesty and the duty of candour to be open and honest as a registered nurse. The panel considered that you had the opportunity to accurately record on the IR1 but that you chose not to and allowed the reader to believe that Patient A was at fault. The panel was of the view that a fellow registrant would find your conduct deplorable.

The panel determined that the misconduct in this charge is serious as you breached your position of trust as a nurse.

Charge 4a

The panel acknowledged that this charge also related to the actions of Colleague A who was senior to you. However, the panel determined that you, as a registered nurse

yourself, did not take sufficient action to prevent Colleague A from submitting the incorrect record knowing that it was incorrect.

The panel therefore found that your actions at charge 4a amounted to misconduct.

Charges 5a and 5b

These charges relate to dishonesty and the duty of candour, specifically the expectation to be open and honest.

The panel considered that you had the opportunity to raise the issue of the incorrect record, but that you made a conscious decision not to and that you were therefore complicit in the submission of the inaccurate record. In doing so, your intent was that others reading the record would have a sanitised version of events.

The panel determined that your actions amounted to misconduct.

Charges 6a and 6b

The panel considered that it is fundamentally expected of registrants to accurately record the care of patients. However, the panel has seen examples where it is clear that you made deliberate attempts to downplay the extent of the incident. The panel was therefore of the view that your actions in these charges do amount to misconduct.

Charge 7

This charge relates to dishonesty and the duty of candour, specifically the expectation to be open and honest.

The panel considered that you downplayed the seriousness of the incident and denied putting anything into the RiO system. It was of the view that a member of the public or a

fellow professional would be appalled at your actions and would expect you to uphold the rights of patients.

The panel therefore found that your actions in this charge amount to misconduct.

Charge 8

The panel considered that you were aware Patient A was going to be secluded, and that the basis for this was that Witness 2 believed you had been assaulted by the patient. At the time Witness 2 had not viewed the CCTV footage. Knowing the basis for this decision, you allowed Patient A to be secluded and did nothing about it, which put them at risk of further harm.

The panel was of the view that your conduct across the whole of the charges found proved fell far short of the standards expected of a registered nurse, Patient A was vulnerable and your conduct towards them was unacceptable. It considered that a member of the public and other professionals would be shocked and appalled to learn that a registered nurse had conducted themselves in this manner. You were in a position of trust as a registered nurse and your actions breached the fundamental tenets of the nursing profession.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*

"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"
If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

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 that Patient A was put at risk and was caused physical and emotional harm as a result of your misconduct. Your misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. The panel found that all four limbs of the *Grant* test are engaged.

The panel then went on to consider the following elements set out in *Cohen v GMC* [2008] EWHC 581 (Admin):

- Whether the conduct that led to the charge(s) is easily remediable.
- Whether it has been remedied.
- Whether it is highly unlikely to be repeated.

The panel first determined that the charges found proved relating to dishonesty and the duty of candour are more difficult to remediate, although they are still remediable.

The panel then went on to consider whether the conduct has been remedied. The panel acknowledged that you have engaged well throughout the proceedings and thought about

your conduct. You have also reflected on the situation which shows some insight around the charges you had previously admitted to. You have also provided training certificates, which would have benefitted with a further reflection commenting on what you learnt from the training. You provided the panel with references and testimonials which speak to your good character, some of which are from other registrants.

The panel was of the view that you have engaged well with the process, have informed yourself well and have presented yourself in a good light throughout the hearing. You have not demonstrated evidence of any deep-seated attitudinal issues and this was an isolated incident. You have also apologised on a number of occasions and stated that this will not happen again. However, the panel was not satisfied that you had demonstrated sufficient insight into your actions.

In relation to the final element of *Cohen*, the panel considered that it did not have sufficient evidence to demonstrate that you had remediated your conduct as you have not yet had an opportunity to do so and as a result, there remains a chance of repetition.

The panel also took account of the contextual factors in this case. [PRIVATE]. The panel also took account of the working environment and culture, as well as the ward being difficult to work on.

The panel determined that a finding of impairment is necessary to protect the public. It has seen evidence of actual harm as a result of your conduct, and there remains an unwarranted risk of harm until you are able to demonstrate your safe practice and developed insight.

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 concluded that public confidence in the profession would be undermined due to the seriousness of the misconduct if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your 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 you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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

Submissions on sanction

Mr Mullen informed the panel that in the Notice of Hearing, dated 28 March 2024, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired.

Mr Mullen submitted that this is a case in which violence was used towards a vulnerable patient which makes it particularly serious. He submitted that the aggravating and mitigating factors in this case are as follows.

Aggravating factors:

- Incident concerning a vulnerable patient.
- Incident of violence and abuse towards a patient.

- Real harm was caused to a patient, not only physically but due to the extended seclusion which put them at risk of further harm.
- Serious concerns which are difficult to put right.
- Concerns regarding dishonesty and breach of the professional duty of candour fundamentally expected of a registered nurse.
- Conduct found proved which amounts to a significant and wide-ranging departure from the standards set out in the Code.

Mitigating factors:

- Broader circumstances and contextual factors of the ward being particularly difficult.
- [PRIVATE].
- Not conduct which is wide-spread, it is limited conduct which occurred during the course of that particular shift.
- A degree of insight shown and some admissions to facts in the charges.
- The level of apology has been clear throughout the course of this hearing and in written documents provided to the panel.

Mr Mullen took the panel through the sanctions available to it, starting with the least restrictive. He first asked the panel to consider that no further action would not be appropriate in this case as your conduct was responsible for undermining the public's trust in the professions and professional standards amongst registrants. He submitted that this is a serious case, and not the sort of rare case mentioned in the guidance where this sanction is appropriate.

Mr Mullen then moved on to the caution order. He stated that this is reserved for cases at the lower end of the spectrum of seriousness, and submitted that this is not that sort of case. He submitted that a caution order would not be sufficient to protect the public given the risk of ongoing harm identified by the panel.

In relation to a conditions of practice order, Mr Mullen submitted that in order to impose effective conditions they must be capable of being monitored and assessed, as well as

being able to protect patients during the period that they are enforced. He submitted that in a case of dishonesty such as this one, it is difficult to formulate conditions that would effectively meet the aims of protecting the public and upholding the proper standards. He stated that this sanction would also undermine public and professional confidence in registered nurses.

With regards to a suspension order, Mr Mullen asked the panel to consider the factors that call into question whether a registrant can remain on the register. He submitted that this is a case in which those factors are engaged, namely due to your breach of the professional duty of candour and a degree of cover up after the incident. He stated that although this was an isolated incident, your conduct fell short of the expected standards in a broad way as it not only included violence and abusive language towards a service user, but dishonesty. Mr Mullen reminded the panel of its decision on impairment in which it found that there remained a risk of repetition in this case given the insufficient evidence of your remediation. He submitted that for these reasons, a suspension order would not be appropriate.

Mr Mullen reminded the panel that a striking-off order is the most serious sanction and likely to be appropriate when a registrant is fundamentally incompatible with remaining on the register. He submitted that there remains a risk of repetition in this case, and that public confidence would be seriously undermined by the imposition of any other sanction. Further, that a member of the public would be extremely concerned that a registered nurse used violence towards a vulnerable patient and then was dishonest about what had happened which led to further harm to that patient.

Mr Mullen submitted that, sadly, this is a case in which the proved conduct is fundamentally incompatible with continued registration and therefore the only proportionate sanction is one of a strike off.

The panel also bore in mind your submissions. You reminded the panel of the principle of proportionality when a panel is deciding on an appropriate sanction. You drew the panel's attention to the recommendation of the SG that:

> *'…any interference with the nurse or midwife's ability to practise must be no more than necessary to satisfy the public interest, which includes the protection of the public. It must strike a fair balance between the rights of the nurse or midwife and the public interest.'* [The panel noted that you had quoted previous but similar guidance from 2017 which had been superseded by guidance issued in February 2024.]

You submitted that a member of the public would benefit from the skills, experience and knowledge of a registrant such as yourself. You stated that you are very passionate about your job and genuinely regret the incident. Further, that nursing has become your life since you qualified as a registered nurse.

You asked the panel to consider your demonstration of insight through your reflective statement, as well as the remedial steps you have taken to address your failings. You also reminded the panel of your early admissions to charges 1c, 1g, 2a and 5b and your subsequent acceptance of the panel's findings on the remaining charges found proved. You said that you have taken full responsibility for your actions and have demonstrated your determination to continue to reflect and learn from your misconduct in order to become a safe registered nurse.

You acknowledged the panel's finding that it did not have sufficient evidence to demonstrate remediations, and that as a result there remains a risk of repetition. However, you implored the panel to give you a platform where you can remediate your failings rather than striking you off the register.

You submitted that you observed good principles by keeping up to date with areas of practice and demonstrated remedial steps through various training you have undertaken.

You reflected and completed a reflection statement as well as doing Prevention and Management of Violence and Aggression (PMVA), breakaway and Safeguarding Adult training.

[PRIVATE]. You submitted that your conduct on that shift was completely out of character and that you have demonstrated a level of insight on how to deal with similar situations in the future so that you do not place patients at risk of harm again.

You submitted that the following mitigating factors apply in this case:

- Full engagement with NMC proceedings and no previous regulatory concerns relating to care delivery.
- No pattern of similar misconduct.
- No evidence of further risk to patients or members of the public.
- Good, positive testimonials from colleagues.

You said the aggravating factor that you will look into more includes avoiding putting patients at risk of potential harm in the future.

You informed the panel of the effect that the current interim suspension order has had. You stated that you have not been able to obtain work as a support worker or HCA despite frequent job-hunting and determination to remain in the care setting in order to start addressing your failings.

[PRIVATE].

Decision and reasons on sanction

Having found your 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:

- Incident involving a vulnerable patient, including a physical altercation between yourself and the patient.
- Real harm was caused, and there was a further risk of harm.
- Serious concerns which are difficult to put right.
- Concerns relating to the duty of candour and dishonesty.
- Abuse of a position of trust.

The panel also took into account the following mitigating features:

- Difficult ward with patients who have complex needs.
- [PRIVATE].
- One-off incident.
- Conduct in the hearing has been exemplary.
- Some actions carried out were with the support of a supervisor.
- Early admissions of some of the facts.
- Written and verbal apologies.
- Previous good character.

The panel first considered the seriousness of the dishonesty in relation to the guidance 'Considering sanctions for serious cases' SAN-2 which states the following:

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

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
- *…*
- *vulnerable victims*
- *…*
- *direct risk to people receiving care'*

The panel also considered that, according to the guidance, dishonesty can be less serious if any of the following apply:

- *'one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *incidents outside professional practice'*

The panel determined that this was a one-off incident, however it was not spontaneous conduct as you did have sufficient time to think about your actions before and after submitting the report and allowing the RiO to be submitted by Colleague A. Further, there was an element of personal gain in your actions as you sought to avoid getting into trouble. Finally, this incident did occur within your professional practice.

The panel next considered the effect of your interim suspension order on your ability to remediate your practice. Whilst the panel acknowledged the challenges you have faced in obtaining employment, it was of the view that a suspension order in itself does not normally prevent a registrant from obtaining employment as an HCA where you may have been able to demonstrate some remediation.

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 your 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 your 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 your 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 involving dishonesty which is difficult to monitor and assess. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

The 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 your actions is fundamentally incompatible with you remaining on the register.

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?*

In relation to the first question, the panel determined that the concerns do raise fundamental questions about your professionalism, especially in relation to your oral and physical conduct with Patient A, as well as your dishonesty.

With regards to the second question, the panel determined that confidence in nurses and midwives could not be maintained due to the nature of your conduct. Patient A was secluded longer than necessary in circumstances which you could have put right but chose not to.

In relation to the final question, the panel noted that it had considered all of the lesser restrictive sanctions above and determined that none would be appropriate to protect patients and the public, nor would they mark the seriousness of the misconduct in this case.

Your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were

serious and to allow you 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 your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, 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 you 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 your own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Mullen. He submitted that an interim order is sought to cover the 28-day appeal period for which the sanction would not take effect if an appeal were lodged.

Mr Mullen invited the panel to impose an interim suspension order for a period of 18 months, to expire on the expiry of the appeal period if lodged. He submitted that an interim order is necessary on the grounds of public protection as this is a case in which there is a serious risk of future harm, marked by the severity of the sanction imposed. Further, that this is a case in which real harm has been suffered by a vulnerable patient.

Mr Mullen further submitted that a member of the public or a fellow registrant would be shocked and troubled if you were permitted to return to practice unrestricted during any appeal period. He therefore submitted that an interim order is also otherwise in the public interest.

The panel heard submissions from you but these related to you inviting it to impose a caution order.

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 to cover the appeal period in order to protect the public and meet the public interest considerations in this case.

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

That concludes this determination.