Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 1 July 2024 – Friday 5 July 2024
Monday 2 December 2024 – Wednesday 4 December 2024

Virtual Hearing

Name of Registrant:	**David Victor Kenneth Graham**	
NMC PIN	78B0113N	
Part(s) of the register:	Registered Nurse Sub part 1 RN3: Mental health nurse, level 1 (25 May 1991) Registered Nurse Sub part 2 RN7: General nurse, level 2 (9 April 1980)	
Relevant Location:	Isle of Man	
Type of case:	Misconduct	
Panel members:	Rachel Forster Jane Jones Sabrina Sheikh	(Chair, lay member) (Registrant member) (Lay member)
Legal Assessor:	William Hoskins	
Hearings Coordinator:	Maya Khan (1 July 2024 – 5 July 2024) Catherine Blake (2 December 2024 – 4 December 2024)	
Nursing and Midwifery Council:	Represented by Grace Khaile, Case Presenter (1 July 2024 – 5 July 2024), and Stephen Page, Case Presenter (2 December 2024 – 4 December 2024)	
Mr Graham:	Not present and not represented at the hearing	
Facts proved:	Charges 1c, 1d, 2a, 2b, 2c, 2d and 3	

Facts not proved:	Charges 1a and 1b
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 Graham was not in attendance and that the Notice of Hearing letter had been sent to Mr Graham's registered email address by secure email on 30 May 2024.

Ms Khaile, on behalf of the Nursing and Midwifery Council (NMC), referred the panel to the contact email address held by the NMC and which was evidenced by a screenshot in the service bundle. Ms Khaile also referred the panel to the witness statement in the service bundle which confirmed that the Notice of Hearing had been sent to Mr Graham's email address on 30 May 2024.

Ms Khaile submitted that the Notice of Hearing had been served in good time and the NMC had complied with the requirements of Rules 11 and 34 of 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 allegations, 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 Graham's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In light of all of the information available, the panel was satisfied that Mr Graham had been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Graham

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

Ms Khaile referred the panel to the Proceeding In Absence (PIA) bundle including the NMC's attempts to contact Mr Graham, an email from Mr Graham's former representative and Mr Graham's responses to the NMC. The PIA bundle included the following:

- An email dated 2 January 2024 to the NMC from Mr Graham's former representative at 'Unite the Union' stating that they are no longer representing him.
- An email dated 8 January 2024 from Mr Graham to the NMC stating that he is no longer a nurse, he has decided to retire and the NMC bundle has *'already disposed of and he has little time or intention to consider this further'* [sic].
- An email dated 8 May 2024 from Mr Graham stating that he would be in the Philippines during the substantive hearing and would be unavailable for any communications and advised the panel to enjoy the meeting in his absence.

It was Ms Khaile's submission that the NMC has made reasonable efforts to contact Mr Graham and that he has voluntarily absented himself.

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

- The NMC has made reasonable efforts to contact Mr Graham.
- Mr Graham is aware of today's hearing and has informed the NMC that he does not wish to engage with the proceedings.
- No application for an adjournment has been made.

- It is highly unlikely that an adjournment would secure Mr Graham's attendance.
- There are three witnesses who are due to give live evidence in this case; not proceeding may inconvenience the witnesses and their employer(s).
- The charges relate to events that occurred in 2019 and therefore there is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Graham by proceeding in his absence. The evidence upon which the NMC relies has been sent to him but he will not have the opportunity to challenge the evidence relied upon by the NMC nor will he be able to give evidence on his own behalf. However, the panel considered that it can make allowance for the fact that the NMC's evidence will not be tested by cross-examination by exploring through its own questioning any inconsistencies in the evidence which it identifies.

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

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

Ms Khaile made a request that parts of this case be held in private on the basis that proper exploration of Mr Graham's case may involve reference to his and witnesses' [PRIVATE]. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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.

Having heard that there may be reference to Mr Graham's and witnesses' [PRIVATE], the panel determined to hold those parts of the hearing in private.

Decision and reasons on the hearsay application to admit paragraphs 40-46 in Ms 1's witness statement

The panel heard an application made by Ms Khaile under Rule 31 to allow paragraphs 40-46 of Ms 1's written statement into evidence which is hearsay evidence. She submitted that this evidence goes to charge 3 and it is not *"sole and decisive".* Ms Khaile told the panel that the NMC has taken steps to try to secure the attendance of Patient A's relatives. The NMC was told by the hospital that following the death of Patient A, his records were no longer available at the hospital where he was treated and therefore contact details for his relatives could not be provided to the NMC.

The panel accepted the advice of the legal assessor with regards to admitting hearsay evidence. The advice was that the panel was entitled admit hearsay evidence under Rule 31 of the NMC (Fitness to Practise) Rules subject only to the requirements of relevance and fairness. The panel was referred to the principles within the authority of *Thorneycroft v The Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). If the evidence was admitted, the panel would need to consider carefully the weight to be attached to that evidence.

The panel gave the application consideration and accepted that the matters being considered in relation to Mr Graham's practice are serious. The panel considered whether Mr Graham would be disadvantaged by the NMC's position to admit paragraphs 40-46 of Ms 1's witness statement into evidence.

The panel considered that the evidence was clearly relevant.

The panel considered that as Mr Graham had been provided with a copy of Ms 1's witness statement and, as the panel had already determined that Mr Graham had chosen to voluntarily absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. The panel noted that Ms 1's evidence was not sole and decisive in respect of charge 3. The panel considered that there has been no suggestion or indication that Ms 1 has fabricated her evidence and it had been made in the course of her professional role. It also considered that within Mr Graham's responses to the NMC,

he refers to the same incidents contained in paragraphs 40-46 in Ms 1's witness statement and the factual evidence is not contentious.

The panel considered that there was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that there was a good reason for non-attendance by Patient A's relatives. It considered that the NMC had made enquiries to secure the attendance of Patient A's relatives however there was no means of contacting them. It also considered there to be concerns surrounding the appropriateness of contacting relatives about this case given that Patient A had died.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence paragraphs 40-46 of Ms 1's witness statement but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Details of charge

That you, a registered nurse:

1) On 24 June 2019 in relation to Patient A, whilst awaiting admission to the Glen Suite, used inappropriate methods of handling and/or restraint in that you:

> a) Grabbed him by his left arm and moved him towards and into the lift.
>
> b) Grabbed him by both wrists and pulled him out of the lift.
>
> c) Pushed him into a seated position on a chair.
>
> d) When he tried to get up, pushed him back down onto the chair causing him to make a sound.

2) On 24 June 2019 in relation to Patient A, whilst awaiting admission to the Glen Suite failed to document:

a) Behaviours during the transfer.

b) How they were managed.

c) Details of any restraint used.

d) A handover of information to staff at Manannan Court.

3) Between 25 June 2019 and 23 June 2020, during an on-going investigation into your conduct on 24 June 2019 and following the death of Patient A, you telephoned the widow of Patient A and arranged to meet her in a café in the presence of your wife and child, in breach of your professional boundaries.

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

Amendments of Charge 2

During the course of the panel's deliberations, the panel decided that it would be appropriate to amend charge 2 by deleting the words "whilst awaiting" and inserting the words "Patient A's transfer and".

The amended charge:

2) On 24 June 2019 in relation to Patient A***'s transfer and*** admission to the Glen Suite failed to document:

a) Behaviours during the transfer.

b) How they were managed.

c) Details of any restraint used.

d) A handover of information to staff at Manannan Court.

The panel had regard to Rule 28 of the Fitness to Practice Rules 2004 and considered that this amendment could be made without injustice to any parties. The mischief aimed at in this charge was the alleged failure to document at any time the amount set out at sub paragraphs a b c and d.

The panel received no objection from Ms Khaile in relation to the proposed amendment.

Background

Mr Graham first entered the NMC Register on 9 April 1980 as a Registered Nurse – General (Level 2). On 25 May 1991, a further entry was added as a Registered Nurse – Mental Health.

Mr Graham was referred to the NMC on 15 July 2020 by Ms 1, Dementia Care and Support Service Manager with overall responsibility for Manannan Court Acute Services.

At the time of the incident which led to the referral, Mr Graham was employed as a Band 6 nurse within the Dementia Care and Support Service (DCSS), based at Thie Menagh Unit (the Unit). The Unit is an Elderly Mentally Infirm Unit which supports patients with dementia who display challenging behaviours. Mr Graham had been employed there since May 2013.

Patient A [PRIVATE] could be physically aggressive towards staff and other residents. Patient A's notes reported that in the days preceding the events referred to in this allegation, he had displayed challenging behaviour such as biting, spitting and kicking, being verbally abusive, hitting out and being aggressive. He was described as being unpredictable, needing several members of staff on occasion to restrain him. There were also notes of Patient A losing balance when walking as well as having ongoing cardiac problems. On 22 June 2019, Patient A was assessed by Ms 3 Approved Social Worker (ASW) employed by Manx Care and Senior Practitioner of the Adults Safeguarding Team. Following that assessment, Patient A was detained under section 2 of the Mental Health Act 1983. As a result of the assessment, Patient A was due to be moved from the Unit to Manannan Court (the Hospital), an acute mental health inpatient hospital and was waiting

for a bed to become available. On 23 June 2019 the Rio notes show that ASW Ms 3, the doctor and a member of staff met and discussed Patient A. The notes show that they discussed the fact that Patient A had episodes of extreme aggression and presented a risk to other residents, to himself and to staff. It is also noted that the Dementia Capable Care Techniques which staff were trained in *"may not be adequate to meet the level of challenges presented."*

On 24 June 2019, a bed became available on a ward (Glen Suite) at the Hospital and Patient A was to be conveyed there in the afternoon.

On 24 June 2019, Mr Graham had returned from two weeks of annual leave and was on an early shift. He attended the Unit for a handover meeting from 10:30am to 11:00am with Ms 1 to discuss transferring Patient A to the Hospital. The panel heard evidence that Ms 3, the ASW, had the overall responsibility for arranging conveyance. Patient A was transported from the Unit to the Hospital by car rather than the usual ambulance. Mr Graham was accompanied by a senior support worker who was heavily pregnant at the time and a student nurse when conveying Patient A from the Unit to the Hospital. Ms 3 met Mr Graham and Patient A and accompanying staff at Glen suite.

Mr Graham arrived at the Hospital in the reception area with Patient A, Patient A's wife and accompanying staff members. They waited for around 20 minutes in the foyer before Patient A could be admitted to the Glen Suite. Whilst in the reception area, Mr Graham and Patient A's wife waited in the foyer area sitting at a table, walked around the reception area and eventually took the lift to the upper floor where Patient A was seated on a chair prior to being admitted to Glen Suite.

The day after the incident, on 25 June 2019, staff raised concerns about Mr Graham's interventions during the transfer. As a result, Ms 1 reviewed the CCTV from the Hospital. This appeared to her to show that Mr Graham had used excessive force and unapproved restraint techniques on Patient A. Ms 1 suspended Mr Graham later that afternoon on 25 June 2019 and his employers commenced an internal disciplinary investigation.

A safeguarding meeting took place on 25 July 2019 and an initial planning meeting on 28 June 2019 with the police. Having viewed the CCTV, the police carried out an investigation but took no further action as the threshold for criminal proceedings was not met.

Mr Graham submitted his resignation on 17 March 2020. The Hospital's disciplinary hearing was held on 27 May 2020, following which Mr Graham was dismissed from his post for gross misconduct from 1 June 2020.

On 23 June 2020, Ms 1 received a telephone call from Patient A's daughter. She told Ms 1 that Mr Graham had contacted Patient A's wife (by this time his widow) and asked to meet her for a coffee.

The meeting did not take place because Patient A's daughter advised her mother not to attend. Mr Graham contacted Patient A's wife by telephone several times. Ms 1 advised the family to contact the police which they did and the police advised Mr Graham not to contact Patient A's wife again.

The first allegation arises out of Mr Graham's alleged mishandling of Patient A in his transfer from the reception area of the Hospital to Glen Suite. Allegation 2 arises out of Mr Graham's alleged failure to document the transfer and handover and Allegation 3 arises out of alleged breach of professional boundaries in contacting Patient A's wife by telephone after the incident and arranging a meeting with her.

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 Ms Khaile.

The panel had sight of the following documents, Band 6 job description, CCTV footage, DHSC Mandatory Training Policy of DHSC staff, Mr Graham's training records, Mr Graham's attendance records, DHSC Environmental risk assessment, DSCC Behaviours that challenge the service protocol, 'Guidance of managing violence and aggression in the

community or outpatient setting', Conveyance of patients' policy, the risk assessment for Patient A, Patient A's Rio records, notes and statements from the investigation, disciplinary hearing and safeguarding meetings, the Datix report and various emails between the Hospital and Mr Graham.

The panel also received a response bundle from Mr Graham containing reflections, testimonials, handwritten handover notes and notes of meetings.

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

- Ms 1: Dementia Care and Support Service Manager with overall responsibility for Manannan Court Acute Services

- Ms 2: Learning and Development Manager at Isle of Man Government

- Ms 3: Senior Practitioner of the Adults Safeguarding Team employed by Manx Care

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

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 noted the following:

- The two members of staff, the senior support worker and the student nurse who accompanied Mr Graham and Patient A from the Unit to the Hospital as part of Patient A's transfer and who were direct witnesses of some of the matters forming

part of charge 1 were not called by the NMC nor was any statement from them produced for the panel.

- The senior support worker and the student nurse were not interviewed as part of the Hospital's internal investigation.
- The panel noted that a statement from the senior support worker, had been provided for the Hospital's investigation and that it had been referred to in the investigation notes as being largely supportive of Mr Graham. However, the panel did not have sight of this local statement.
- The nurse in charge of Glen Suite who was a direct witness to some of the events in charge 1 was also not called to give evidence by the NMC and no statement from him was produced for the panel.
- A body map of Patient A was requested in the aftermath of the events alleged in charge 1 but no body map was produced to the panel and it was uncertain whether such a document had ever been produced.

The panel accepted the advice of the legal assessor, who advised that the word 'grabbed' as it appeared in charges 1a and 1b should be given its normal English meaning. The legal assessor also reminded the panel of the guidance contained in *Dutta v GMC* [2020] EWHC 1974 (Admin) in relation to assessing evidence and resolving factual disputes.

The panel considered the witness and documentary evidence provided by the NMC and the responses and reflections provided by Mr Graham.

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

In reaching its decision with regards to charge 1, the panel took into account Mr Graham's mandatory training record and DHSC Mandatory Training Policy of DHSC Staff.

The panel noted that Mr Graham's training was overdue by two years according to the policy; he had last done Dementia Capable Care Training in June 2016 and his manual handling training was last completed in February 2016. The panel acknowledged that Mr Graham had been off sick for a large part of 2018, however it noted from the policy and

from Ms 1’s evidence that it was his responsibility as a registered nurse to ensure that his training is kept up to date.

The panel also noted Mr Graham’s attendance record and that he had been on annual leave for two weeks prior to the 24 June 2019.

The panel did not have any clear evidence about when Patient A was admitted to the Unit nor when Mr Graham met him for the first time.

The panel noted that ASW Ms 3, who was responsible for arranging the conveyance of Patient A, was on a training course on the day of the transfer in a building opposite to the Hospital. She was dealing with issues concerning the conveyance of Patient A in her breaks on the training course. She said that she could not receive phone calls but was available by email.

Charge 1

That you, a registered nurse:

1) On 24 June 2019 in relation to Patient A, whilst awaiting admission to the Glen Suite, used inappropriate methods of handling and/or restraint in that you:

a) Grabbed him by his left arm and moved him towards and into the lift.

This charge is found NOT proved.

In reaching its decision, the panel took into account the oral and written evidence from Ms 1 and Ms 2 and the CCTV footage.

The panel first considered the meaning of the word ‘grabbed’. The panel considered that this word carried the connotation of ‘to take hold of with a sudden movement and with some element of being firm or rough’. The panel also took into account that in the context of the charge the word ‘grabbed’ carried some negative connotation as implying a sudden use of force as a method of handling and/or restraint.

Ms 2, in her oral evidence, used a technical description of the word ‘grabbed’ from the context of manual handling courses and Dementia Capable Care training. She explained that in that context the term ‘grabbed’ meant a type of grip which involved placing the thumb on top of the wrist and four fingers underneath the wrist. When asked by the panel, Ms 2 accepted that a lay person could define the word ‘grabbed’ as ‘using your hand to hold someone firmly’ and ‘to take hold of something with a closed grip’.

The CCTV footage was shown to Ms 2 during her oral evidence. Ms 2 said that Mr Graham was using an incorrect technique, and his actions were not best practice.

Ms 1 recalled from her previous viewing of the CCTV footage that Mr Graham was using an *‘arm-link method’* to move Patient A towards and into the lift and did not consider his actions to be ‘grabbing’ Patient A.

The panel saw the CCTV footage and determined that Mr Graham did not ‘grab’ Patient A. The panel did not see Mr Graham use improper force to restrain Patient A nor was there any sudden movement. There was no sense of Patient A being pulled or dragged. The panel noted from the clinical records that Patient A could be unsteady on his feet and also noted from the CCTV footage that Patient A was accompanied by his wife on one side and Mr Graham on the other as they moved towards the lift.

The panel accepted Ms 1’s oral evidence as it was consistent with the CCTV footage it had viewed. On this basis, the panel concluded that Mr Graham had not ‘grabbed’ Patient A by his left arm in the sense alleged by charge 1a. No other specific criticism was made of the way in which Mr Graham had moved Patient A towards the lift.

Having regard to the evidence, the panel concluded that charge 1a was found not proved.

Charge 1b

> *That you, a registered nurse:*
>
> *1) On 24 June 2019 in relation to Patient A, whilst awaiting admission to the Glen Suite, used inappropriate methods of handling and/or restraint in that you:*

b) Grabbed him by both wrists and pulled him out of the lift

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and written evidence from Ms 2 and the CCTV footage.

The panel considered that during Ms 2's oral evidence whilst watching the CCTV footage, she said that Mr Graham did not use the recommended technique to manually handle Patient A. Ms 2 said that Mr Graham would have been expected to stand behind Patient A and guide him, alternatively he could have moved Patient A from one member of staff to another in an ideal situation. She also said that Mr Graham should not have been alone in the lift with Patient A.

The panel had regard to the normal meaning of the word 'grabbed'. The panel considered the CCTV footage and determined that Mr Graham did not 'grab' Patient A. The panel did not consider Mr Graham to have 'pulled' Patient A out of the lift but rather held both of Patient A's wrists in an attempt to steer and/or guide Patient A in the right direction and noted that Patient A did not appear to be agitated. Patient A's wife was present as Mr Graham helped Patient A to leave the lift and guided him towards the chair.

The panel considered Mr Graham's written reflections in his response bundle. Mr Graham stated:

> *'We went to the lift and went inside. Only finding myself alone in the lift with [Patient A], during the 5 or 6 second journey he attempted to both kick and punch me and this has to be contained for my safety and protective reasons by holding his wrists and when exiting lift maintained this position until we reached the small settee and [Patient A] was sat down on this as clearly there was less risk of further assault attempts, and reduce the risks to [Patient A] or others now in attendance.'*

Having regard to the evidence, the panel found Charge 1b not proved.

Charge 1c

That you, a registered nurse:

1) On 24 June 2019 in relation to Patient A, whilst awaiting admission to the Glen Suite, used inappropriate methods of handling and/or restraint in that you:

c) Pushed him into a seated position on a chair.

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence from Ms 1, Ms 2, Ms 3 and the CCTV footage.

Ms 3 (a direct witness) and Ms 2 both said that Mr Graham did not follow the correct handling method when he pushed Patient A onto the chair. Ms 2 said that Mr Graham should not have stood in front of Patient A and pushed him into position. The panel watched the CCTV footage and could clearly see that Mr Graham pushed Patient A into a seated position onto the chair.

The panel considered this charge proved based on the CCTV footage it had seen and the evidence of Ms 2.

Having regard to the evidence, the panel found Charge 1c proved.

Charge 1d

That you, a registered nurse:

1) On 24 June 2019 in relation to Patient A, whilst awaiting admission to the Glen Suite, used inappropriate methods of handling and/or restraint in that you:

a. When he tried to get up, pushed him back down onto the chair causing him to make a sound.

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence from Ms 1, Ms 2, Ms 3 and the CCTV footage.

The panel considered the CCTV footage and the document titled *'Guidance of managing violence and aggression in the community or outpatient setting'* which outlined that nurses would be expected to adopt a non-threatening posture and to recognise the importance of a patient's personal space. The panel could see from the CCTV footage that Mr Graham was standing over Patient A who was seated on the chair. At this point, the panel noted that Mr Graham appeared to be managing Patient A by himself albeit there were other responsible staff in the immediate vicinity. Patient A tried to stand up and Mr Graham forcefully pushed Patient A by his shoulders back onto the chair. Mr Graham was bent over Patient A restraining him by holding both his arms down. The panel saw that Mr Graham was standing very close to Patient A with his face in very close proximity to Patient A's. In paragraph 20, Ms 3 said in her statement that she had concerns about the force used by Mr Graham and was concerned about the way he had put Patient A in the chair, resulting in Patient A making a groan type sound.

Ms 3 in her oral evidence said that she heard Patient A make a sound and described it as *"aaah"* and a groan. She said that he had not made that sound when he sat down the first time but when he was pushed down a second time, she heard him make the groaning sound. The panel considered Ms 3's evidence to be plausible in the light of the CCTV footage it had seen, and Patient A's history of chest/abdominal pain and recent fall as seen in the Rio notes.

The panel considered Mr Graham's written response in his bundle. Mr Graham stated:

> *'When they were positioned on the settee and during what must be stated was a seriously prolonged transfer/waiting period whilst inside and already at [the Hospital] and after his attempts to bite, hit, punch and kick me, and then being aware that he wanted to again get up from a fairly safe position, I did try to prevent this at first by hand gestures, and then holding his shoulders and wrists to avoid him getting to what I considered to be a more risky position. At this stage he was*

already now getting more agitated and can be seen trying to again kick me, I was situated in front of him and whilst this isn't an ideal position to be in with a cognitively restricted person was however faced with me being the only staff engaged, and both student and pregnant staff unable to help, had NO other option for a number of immediately obvious risk assessment rational computing in my professional thought processes.'

The panel determined that there was clear evidence on the CCTV footage of Mr Graham inappropriately pushing Patient A back down onto the chair. The panel determined that Ms 3's evidence, that Patient A did make a sound when pushed back down, was plausible. Accordingly, the panel found Charge 1d proved.

Charge 2

That you, a registered nurse:

2) On 24 June 2019 in relation to Patient A's transfer and admission to the Glen Suite failed to document:

a) Behaviours during the transfer.

b) How they were managed.

c) Details of any restraint used.

d) A handover of information to staff at Manannan Court.

These charges are found proved.

The panel first considered whether Mr Graham had a duty to document the matters listed in 2a, 2b, 2c and 2d. The panel considered the document titled *'Dementia care & support services that challenge the service protocol'* which stated:

'All staff have a responsibility to ensure:

- *…*
- *Any changes in behaviour are clearly documented on Rio.* [Rio being the electronic recording system used by staff members]
- *That any discussions with other professionals is clearly documented and communicated to others.*
- *…*

The panel took the view that Mr Graham had a duty to document the matters on Rio listed in 2a, 2b, 2c and 2d and comply with the protocol. Such a duty also arises from Mr Graham's responsibilities as a registered nurse.

The panel found one entry on Rio on 24 June 2019 by Mr Graham which was at 11:44 prior to Patient A being transferred to the Glen Suite. There were no other entries made by Mr Graham on 24 June 2019. The panel requested to see the Rio entries dated 25 June 2024 in fairness to Mr Graham as his shift had ended by the time Patient A's conveyance had been completed. The panel considered that there was a possibility that he may have made a retrospective entry when coming onto shift the following day prior to being suspended in the afternoon. Ms 1 provided the panel with the Rio entries dated 25 June 2024. The panel found there to be no entries by Mr Graham on 25 June 2019.

The panel considered Mr Graham's written responses. He stated:

> *'…due to my not being able to enter the IT system dictated the notes briefly what had occurred to the nurse in charge [Colleague A] I left the unit at 15:30 ish as I had another family appointment I was running late for…'*
>
> *'Copy of the RIO entry by the [nurse in charge Colleague A] in [the Unit] following the transfer dictated by myself outside my shift time as me being unable to access RIO myself…'*
>
> *'…unable to access the IT system (locked out) but I was reassured and saw this entry had been made with my direction by the nurse in charge of the shift [Colleague A]'.*

The panel considered Mr Graham's handwritten notes detailing what happened from his perspective on 24 June 2019. The provenance of the handwritten notes was not clear to the panel. These handwritten notes were shown to Ms 1 during her oral evidence, and she said that she had not seen these handwritten notes before. The panel took the view that Mr Graham's handwritten notes did not discharge his responsibility to document the matters alleged in charge 2.

The panel considered Mr Graham's explanation about why he was unable to access the Rio system on 24 June 2019. He said that his password had expired whilst he was on leave the previous week and he therefore had been locked out of the Rio system. However, the panel noted a Rio entry from Mr Graham dated 24 June 2019 at 11:44 and therefore did not find his explanation plausible.

The panel noted that Mr Graham stated that he had dictated his version of the events to the nurse in charge on the Unit and asked them to update the Rio system as he was unable to access it. The panel noted entries by the nurse in charge at 15:23 19:46 on the Rio system on 24 June 2019 however neither of those entries documented details about Patient A's behaviours during the transfer, how Patient A was managed, details of any restraint used or details about the handover of information to staff at the Hospital nor did they refer to the notes having been dictated by Mr Graham.

Having regard to the evidence, the panel concluded that on 24 June 2019 in relation to Patient A's transfer and admission to the Glen Suite Mr Graham failed to document Patient A's behaviours during the transfer, how Patient A was managed, details of any restraint used or details about the handover of information to staff at the Hospital.

Accordingly, the panel found Charge 2a, 2b, 2c and 2d proved.

Charge 3

That you a registered nurse:

3) Between 25 June 2019 and 23 June 2020, during an on-going investigation into your conduct on 24 June 2019 and following the death of Patient A, you telephoned the widow of Patient A and arranged to meet her in a café in the presence of your wife and child, in breach of your professional boundaries.

This charge is found proved.

In reaching this decision, the panel took into account the written responses from Mr Graham and the witness statement from Ms 1.

The panel considered paragraphs 40 – 46 by Ms 1 in her witness statement which stated:

'On 23 June 2020, I was contacted by the Patient's daughter who informed me that the Registrant had contacted her mother (the Patient's wife). I do not know how the Registrant obtained a contact number for the Patient's wife. The Registrant had been suspended since 25 June 2019 and therefore did not have access to the records following his suspension. I am aware that a telephone number for the Patient's wife is listed in the local phone book.

It was reported to me that the Registrant had said that he was carrying out a research project regarding elderly people with dementia including her husband. The Registrant asked the Patient's wife if he could meet her for a coffee. The Registrant did not give his name but he gave a contact phone number to the Patient's wife.

The Patient's wife reported this to her daughter. She said that the person was an Irish gentleman who wanted to meet at an M&S café. The Patient's daughter found this suspicious and so contacted me to report it. I checked the number that the Registrant had given to the Patient's wife. The number matched with the number that I had for the Registrant's wife, who was also working within the DCSS at the time.

The Patient's wife did not go and meet the Registrant at the café. However, the Patient's daughter reported that the Registrant continued to call the Patient's wife

several times in order to arrange a meeting. The Patient's wife was recently widowed as Patient A had passed away. She lived alone and I was informed by her daughter that she became increasingly concerned and was worried that the Registrant may turn up at her house.

The Patient's daughter contacted the Police who then contacted me for background information…

They spoke to the Registrant regarding his contact with the Patient's wife and that she should stop contacting her.

It was completely inappropriate of the Registrant to contact the Patient's wife…

…The Registrant only knew Patient A for a short period of time and was involved in an investigation relating to an adult protection matter involving the Patient. There was no appropriate reason for him to contact the Patient's wife and his actions were against the conduct expected of a registered nurse.'

The panel then went on to consider Mr Graham's written responses. He accepts that the actions in charge 3 occurred and confirms the fact that telephone calls happened and a meeting with Patient A's wife was set up although Mr Graham gives different reasons from those given by Ms 1 as to why this had happened. Mr Graham stated:

'Through my personal experiences I felt it would be all right to give her a call and express my condolences to her and the family.

When I phoned her I gave what I thought was a clear explanation of who I was and explained I had known Patient A only for that very short time when he was Thie Meanagh and went to Manannan Court

I gave her my condolences verbally and asked if she minded me making contact with her, which she reassured and advised she appreciated my contact and thanked me for passing my sympathies on.

I asked if she was alright and she expressed her sadness Patient A was gone and I asked if she wanted to meet up and have a chat anytime to talk through how she was feeling

She asked me again who I was and I explained I had worked a long time with residents with dementia… [PRIVATE].

She agreed and she suggested she was free most days…we both agreed to meet the following day.

I went to the M&S café the following day with my wife and very young daughter which would have been a talking point for Patient A's wife and also an opportunity to bring a little cheer to her life…

We waited about 35 minutes and when she didn't arrive we were both a little concerned she had an accident or was ill so decided to call her.

She answered the phone and I again advised my name and said we were at the M&S café the place she had suggested already thinking maybe she had forgotten. She advised she wasn't feeling well and was apologetic she hadn't called me to explain she didn't feel well enough to go out but explained couldn't find my phone number I had given her.

I advised it wasn't a problem and hoped she would feel better soon and we could meet up another time which she agreed…'

'…Two days later I received a call from someone advising they were the police and advised I had made contact with Patient A's wife and I confirmed this

The gentleman advised due to the situation this was not appropriate? And I should make no further contact! Which I immediately agreed.

I was very shocked at this call and very sad to realise there had been an issue as this was the first suggestion there was any issue.'

The panel agreed with Ms 1 that there was no legitimate reason for Mr Graham to telephone and meet with Patient A's widow and noted that this had caused her considerable distress, at a time when she had recently been bereaved. The panel also noted that Mr Graham had been suspended from his employment at the Hospital a year prior to this event and was dismissed on 1 June 2020 some weeks prior to making contact with Patient A's widow.

Having regard to the evidence, the panel concluded that Mr Graham had breached professional boundaries by telephoning the widow of Patient A and arranging to meet her in a café in the presence of his wife and child.

Accordingly, the panel found Charge 3 proved.

Decision and reasons on service of Notice of Hearing of resuming dates

The hearing went part-heard on 5 July 2024. Upon resuming the hearing on 2 December 2024, the panel was informed that Mr Graham was not in attendance and that the Notice of Hearing letter had been sent to Mr Graham's registered email address by secure email on 2 October 2024.

Mr Page, on behalf of the NMC, submitted that the Notice of Hearing of the resuming hearing had been served in good time and the NMC had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided the time and dates of the resuming hearing, and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Graham's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In light of all of the information available, the panel was satisfied that Mr Graham had been served with the Notice of Hearing for the resuming hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Graham

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

Mr Page submitted that the NMC has made reasonable efforts to contact Mr Graham and that he has voluntarily absented himself. Mr Page informed the panel that Mr Graham continues to not engage with NMC proceedings.

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 retired to consider whether to proceed in the absence of Mr Graham. It considered the submissions of Mr Page and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- The NMC has made reasonable efforts to contact Mr Graham.
- Mr Graham is aware of today's hearing.
- Mr Graham did not attend the original dates of this hearing, and sent correspondence to say that he did not intend to engage with the proceedings.
- Mr Graham continues to not engage with NMC proceedings.
- No application for an adjournment has been made by Mr Graham.
- It is highly unlikely that an adjournment would secure Mr Graham's attendance at a future date.

- The charges relate to events that occurred in 2019 and therefore there is a strong public interest in the expeditious disposal of the case.
- The hearing has already gone part-heard and there is strong public interest in the hearing not being delayed any further.

The panel decided in the light of this that it was fair to proceed in the absence of Mr Graham.

Fitness to practise

Having previously 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 Graham's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, recognised that it has a 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 Graham's 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 Page 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 Page identified the specific, relevant standards where he submitted that Mr Graham's actions amounted to misconduct, in particular that the following paragraphs of the Code are relevant: 1.1, 8.1, 8.5, 13, 20.5, and 20.8.

Submissions on impairment

In written submissions, Mr Page addressed 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Page submitted that the first three limbs of the test in *Grant* are engaged in this case. He submitted that Mr Graham's conduct and Code breaches caused harm to members of the public and placed them at unwarranted risk of harm.

Mr Page submitted there is no evidence that Mr Graham has addressed the concerns or strengthened his practice. He submitted that Mr Graham's reflection showed little insight into the impact of his behaviour, and he instead shifted blame to third parties. Mr Page submitted that there is no evidence before the panel of remediation by Mr Graham.

Mr Page submitted that without full insight and reflection into the impact of Mr Graham's conduct on colleagues, the nursing profession and the wider public interest there remains

a risk of repetition. He submitted that there is nothing to suggest that Mr Graham has identified the problems and learnt from them such that the panel can be satisfied that he is capable of safe and effective practice.

Mr Page submitted that a finding of impairment is needed in order to declare and uphold proper standards of conduct.

The panel accepted the advice of the legal assessor.

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

> ***'Prioritise people***
> *You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.*
>
> ***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*
> ***1.3*** *avoid making assumptions and recognise diversity and individual choice*
> ***1.5*** *respect and uphold people's human rights*

2 Listen to people and respond to their preferences and concerns

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

2.6 *recognise when people are anxious or in distress and respond compassionately and politely*

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

3.1 *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*

3.4 *act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*

4. Act in the best interests of people at all times

4.1 *balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*

5. Respect people's right to privacy and confidentiality

5.1 *respect a person's right to privacy in all aspects of their care*

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

6.2 *maintain the knowledge and skills you need for safe and effective practice*

8. Work cooperatively

8.2 *maintain effective communication with colleagues*

8.5 *work with colleagues to preserve the safety of those receiving care*

10. Keep clear and accurate records relevant to your practice

10.1 *complete all 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*

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*

13.4 *take account of your own personal safety as well as the safety of people in your care*

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

16.2 *raise your concerns immediately if you are being asked to practise beyond your role, experience and training*

16.3 *tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can*

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

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

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*

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other health and care professionals and the public.

20. Uphold the reputation of your profession at all times

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

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

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

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

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

However, in relation to charges 1c and 1d, the panel found these charges did amount to misconduct. The panel was of the view that Mr Graham did not follow Hospital policy with regard to the manual handling and restraint of Patient A, and he did not show respect to Patient A when he pushed him back onto the seat against his will both times. Further, Mr Graham caused actual harm, both physical and psychological, to Patient A, and potential psychological harm to Patient A's wife. Colleagues, including a student nurse, all witnessed Mr Graham's treatment of Patient A. The panel determined that this behaviour was very serious because it significantly contravened the Code, and fell far below the standards of professional conduct expected of a registered nurse. The panel found that Mr Graham's behaviour at each charge amounted to misconduct.

In relation to charge 2, the panel found this charge did amount to misconduct. The panel determined that Mr Graham did not record the incidents of 24 June 2019 in Patient A's notes at the end of his shift, nor did he take steps on the following day to ensure that the transfer of Patient A and the related incidents were documented. The panel determined this had the potential to cause harm to Patient A as the handover was not recorded or communicated to the broader team. The panel determined that this omission was serious because it had the potential to impact the care Patient A received subsequently, and potentially cause harm to Patient A. It also contravened the Code, and fell far below the standards of professional conduct expected of a registered nurse. The panel found that Mr Graham's behaviour at this charge amounted to misconduct.

In relation to charge 3, the panel found this charge did amount to misconduct. The panel determined that Mr Graham had breached his professional boundary by contacting the wife of Patient A a year after the event, six months after Patient A had died, and also after Mr Graham had been dismissed from his employment at the Hospital. The panel noted that Mr Graham's conduct caused significant distress to Patient A's wife and daughter, so much so that Patient A's family involved the Police. The Police told Mr Graham not to

contact Patient A's family again. This indicates the level of severity and distress caused by Mr Graham's actions. The panel determined that this behaviour was very serious because it significantly contravened the Code, and fell far below the standards of professional conduct expected of a registered nurse. The panel therefore found that Mr Graham's behaviour at this charge amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct which the panel has found, Mr Graham's 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 and maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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;

d) …’

The panel found that Patient A was put at risk and suffered physical and emotional harm as a result of Mr Graham’s misconduct by being pushed twice into a chair. Mr Graham failed to treat Patient A with dignity and respect, failed to keep accurate records, and breached professional boundaries. The panel also found that Mr Graham’s misconduct

breached the fundamental tenets of the nursing profession, including failure to treat Patient A and his family with kindness and respect. Mr Graham's misconduct was witnessed by Patient A's wife and Mr Graham's colleagues, and resulted in the extended family and the Police becoming involved. The nursing profession's reputation has been brought into disrepute as a result. The panel therefore found that limbs a, b, and c of the test in *Grant* were engaged.

The panel went on to consider the following elements set out in *Cohen:*

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

Mr Graham has not submitted any further reflective statements since the panel handed down its determination on facts. The panel therefore referred to his reflective statements provided prior to the original dates of the hearing.

The panel considered that the misconduct in this case could be remediated if sufficient insight, engagement and reflection was evidenced. Although some of the misconduct in this case involved attitudinal issues, and as such may be more difficult to remedy, the panel determined that it was capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Graham has taken steps to strengthen his practice and put right the failings that occurred as a result of his misconduct.

With regard to his actions at charge 1, the panel took into account Mr Graham's reflection:

> *'Systems failures were a major part to play and evidenced [sic] but appear not considered as any part of investigation or disciplinary…*
>
> *…*

'There was no risk assessments for this patient and I should have insisted these were documented.

I should have insisted at reception staff should be there to welcome and receive the patient as planned (as in reality the transfer was already completed)

I should have insisted with reception to be given an alarm which is policy I believe and could have been discretely activated when the patient first showed signs of agitation.'

The panel acknowledged there may have been some system and resource failures in how Patient A was transferred from one care setting to another. An appropriate mode of transport was not readily available and Mr Graham was assisted in the transport of Patient A by a pregnant healthcare assistant and a student nurse. The situation which he faced was not therefore ideal. Mr Graham acknowledged that he should have escalated these issues prior to the transfer of Patient A. Further, there was an unfortunate delay prior to Patient A's admission to the Glen Suite. However, as a nurse of 40 years' experience, of which 30 years were as a mental health nurse, the panel found that Mr Graham would have been aware that he had a responsibility, despite any system failures he may have encountered, to ensure that Hospital policy was adhered to, that the correct standard of care was provided at all times, and that appropriate manual handling and restraint techniques were used with Patient A.

The panel noted Mr Graham's reflective statement and his comments that he could benefit from additional training:

'I fully recognise I need further training and build [sic] on techniques to be used in similar situation but to a level that addresses and deals in accordance with detained patients and in an environment were [sic] staff work together and have been trained to that level.

> *…*
>
> *'I have undertaken copious amounts of reflections with both peers and senior previous managers along with suitable qualified persons.*
>
> *I have requested and booked further training appropriate to deal with patients detained under the Mental Health Act and also further guidance from trainers of Health and safety taking full account of duty under common law'*

However, the panel has seen no evidence that Mr Graham has undergone any further training. The panel understands that he has not worked as a registered nurse since these incidents.

With regards to his actions at charge 2, the panel took into account Mr Graham's reflection and his explanation of what happened in relation to record keeping.

The panel noted that Mr Graham said there were issues with him accessing the IT system on 24 June 2019. However, the panel noted that Mr Graham had been able to access the system earlier that day at 11:44. The panel acknowledged that the transfer of Patient A took longer than expected which resulted in Mr Graham having to leave quickly at the end of his shift. He said that this resulted in him having no time to make an entry in Patient A's notes on that day in relation to the incidents with which the panel is concerned:

> *'…due to my not being able to enter the IT system dictated the notes briefly what had occurred to the Nurse in Charge (LF) I left the unit at 15.30 ish as I had another family appointment I was running late for.'*

However, the panel noted that Mr Graham was on duty the following day but made no retrospective entry detailing the transfer of Patient A, the incidents and system failures that had occurred.

In respect of charge 3, the panel also took into account Mr Graham’s reflection in which he provides an explanation for his actions:

> *‘I have attempted to meet with the patients [sic] family and wife following my period of suspension and service to first and foremost offer my sincere condolences and also support the elderly wife learning recently (June 20) the patient had passed away last January from a friend.*
>
> *I truly believed this could have help [sic] both myself and the family and was always lead to believe the patients [sic] wife had never been involved as evidenced during my police interview and have no detail informing anything other than this view in either investigation or disciplinary since, in fact the disciplinary commented I could have requested Patient A’s wife to be a witness.*
>
> *At no time was I ever advised within my contact with Patient A’s wife was it suggested my contact was in any way unwelcome, but was advise [sic] it had been appreciated. I would never repeat such an action as can by [sic] open to being mis interpretation [sic] and may have lead to the confusion or my intent, but may also result in families thinking I’m uncaring.’*

However, the panel has not seen any acknowledgement from Mr Graham about the impact that his behaviour had on Patient A’s wife and daughter, nor has it seen a full understanding by Mr Graham of the distress that his actions caused Patient A’s wife and family.

> *‘I wanted to reflect on this having done this felt I could contact the family member to give my condolences.*
>
> *I have offered support a number of times during my career and on every previous occasion the family expressed their appreciation for my contact and expressed support in sharing their grief.*

…

'[Patient A's wife] asked me again who I was and I explained I had worked a long time with residents with dementia and held an [sic] personal and professional interest in dementia care…

…

'Two days later I received a call from someone advising they were the police and advised I had made contact with Patient A's wife and I confirmed this
The gentleman advised due to the situation this was not appropriate? And I should make no further contact! Which I immediately agreed.
I was very shocked at this call and very sad to realise there had been an issues as this was the first suggestion there was an issue.

…

'I have learned from this situation and can reassure the NMC this will not occur in any future roles I hold either within a nursing role or any others [sic] employment but reassert as I was completely unaware and it was at no time suggested that my contact was unwelcome it's difficult to be aware of an issue exists'

The panel found that Mr Graham's shock at being contacted by the police indicated a lack of understanding as to why contacting Patient A's wife was a breach of professional boundaries. The panel considered that, being a registered nurse with 40 years' experience in clinical practice, Mr Graham ought to have known that his behaviour at charge 3 was a breach of professional boundaries. The panel has not seen any evidence of insight from Mr Graham, nor has he demonstrated that he now understands the ramifications of his breach of professional boundaries.

The panel determined that it has seen insufficient insight in the areas of concern from Mr Graham, in particular how he would behave differently in the future. The panel considered that Mr Graham's reflection focussed on the impact that this referral has had on him, without acknowledging the impact his behaviour had on others The panel considered that Mr Graham has not taken responsibility for the physical and psychological harm caused by his actions in his reflective statements, nor has he accepted that what he did was wrong. The panel has seen very little insight from Mr Graham into why his behaviour at any of the charges amounted to misconduct, and what the impact of his behaviour was on Patient A and his family and Mr Graham's colleagues.

Therefore, the panel was not satisfied that the matters were highly unlikely to be repeated, pursuant to the guidance in *Cohen*. In fact, the panel was concerned about the likely risk of repetition in this case given the limited understanding and insight that Mr Graham has shown, and the absence of strengthening of his practice despite Mr Graham's acceptance that he needed further training. Accordingly, the panel was not satisfied that the misconduct in this case has been addressed.

The panel therefore decided that a finding of impairment is necessary on the ground of public protection.

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

The panel 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 Graham's fitness to practise is impaired on the ground of public interest.

Having regard to all of the above, the panel was satisfied that Mr Graham’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 Graham off the register. The effect of this order is that the NMC register will show that Mr Graham has been struck-off the register.

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

Submissions on sanction

Mr Page, in written submissions, informed the panel that in the original Notice of Hearing, dated 30 May 2024, the NMC had advised Mr Graham that it would seek the imposition of a striking-off order if the panel found his fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mr Graham’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:

- Patient A was vulnerable, [PRIVATE]

- Patient A's wife was vulnerable, being recently widowed, in terms of charge 3
- Conduct which caused Patient A actual harm
- Conduct which potentially put Patient A's wife at risk of psychological harm
- Lack of insight into failings related to the charges found proved
- Despite having over 40 years' experience as a registered nurse, there was no understanding as to why his conduct was inappropriate
- Abuse of a position of trust in Mr Graham's inappropriate treatment of Patient A
- Abuse of a position of trust in that Mr Graham contacted Patient A's widow stating he was a registered nurse from the Hospital, despite having recently been dismissed, when he had no authority to do so
- That charge 3 occurred after the incidents set out in charges 1 and 2 over a year later

The panel also took into account the following mitigating features:

- The context in which charges 1c and 1d occurred was in an environment where there were some systemic failures and possible under resourcing

However, the panel concluded that this was limited mitigation as the circumstances did not alter his overarching responsibility as an experienced nurse to act in accordance with Hospital policies and to ensure that Patient A was treated safely and with dignity and respect.

The panel noted the three positive testimonials from other registered nurses, who had worked with Mr Graham in previous roles and were aware of the charges against him. The panel also noted that Mr Graham had worked for over 40 years as a registered nurse with no regulatory findings.

The panel considered the NMC Guidance (FTP-3b Serious concerns which could result in harm if not put right) and determined that Mr Graham's misconduct constituted significant and wide-ranging breaches, that were not addressed or explained by him, and this

highlighted deep-seated attitudinal concerns. Indeed, Mr Graham's reflective pieces only confirmed to the panel his lack of understanding as to why the breaches found proved had been so serious and constituted misconduct. The panel considered that this increased the seriousness of the concerns.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case, and the fact that the panel had identified there was an ongoing significant risk to the public which requires a restriction to be placed on Mr Graham's practice. 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 Graham'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 Graham's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Graham's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated. The panel considered that, as Mr Graham has continued not to engage with these NMC proceedings, there is no evidence before the panel to suggest that he would respond positively to conditions on his practice nor that he would be willing to undertake further training. The panel also noted that it has seen information from Mr Graham that he has no intention of returning to nursing practice. Further, considering the significant attitudinal concerns identified and very limited insight, the panel was not satisfied that the placing of conditions

on Mr Graham’s registration would adequately address the seriousness of this case and 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:

- *No evidence of harmful deep-seated personality or attitudinal problems; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Graham’s actions is fundamentally incompatible with him remaining on the register, especially in light of his lack of remediation and insight. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel was of the view that the findings in this particular case demonstrate that Mr Graham'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.

The regulatory concerns raise fundamental questions about Mr Graham's professionalism. Mr Graham caused actual physical harm to Patient A in relation to charge 1, psychological harm to Patient A's widow and daughter in relation to charge 3, and breached professional boundaries by contacting Patient A's widow a year after the incident on several occasions with no professional purpose. Furthermore, Mr Graham showed no insight, understanding or reflection as to why his misconduct was inappropriate despite his many years of practice. The panel regarded this as extremely serious.

A fully-informed member of the public would be very concerned about Mr Graham's misconduct as it is a serious departure from the standards expected of an experienced registered nurse.

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

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 Graham'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 and although not intended to be punitive in its effect, may have such consequences.

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.

The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Graham's action is incompatible with Mr Graham remaining on the register.

This will be confirmed to Mr Graham in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Page, who submitted that in light of the striking-off sanction, an interim suspension order for 18 months would be appropriate to allow time for any appeal to be resolved.

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 allow for any appeal to be resolved; not to impose an interim suspension order in this case would be inconsistent with the panel's earlier decision.

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

That concludes this determination.