# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Wednesday, 24 July – Tuesday, 6 August 2024**
**Friday, 9 August 2024**
**Monday, 9 December – Tuesday, 17 December 2024**

Virtual Hearing

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| **Name of Registrant:** | **Thomas George Lyon** |
| **NMC PIN** | 10I1681S |
| **Part(s) of the register:** | Registered Nurse – Mental Health Nursing RNMH – (30 December 2013) |
| **Relevant Location:** | Aberdeen |
| **Type of case:** | Misconduct |
| **Panel members:** | Richard Weydert-Jacquard (Chair, Registrant member)<br>Kamaljit Sandhu (Lay member)<br>Joanna Bower (Lay member) |
| **Legal Assessor:** | Sean Hammond |
| **Hearings Coordinator:** | Nicola Nicolaou |
| **Nursing and Midwifery Council:** | Represented by Rosie Welsh, Case Presenter (24 July – 9 August 2024)<br>Represented by Alex Radley, Case Presenter (9 December – 17 December 2024) |
| **Mr Lyon:** | Present and represented by Simon Holborn, from NMC Watch (24 and 25 July 2024, 5 and 6 August 2024, 9 August 2024, 9 December 2024)<br>Not present and represented by Simon Holborn, from NMC Watch (26 July – 2 August 2024, 10 - 16 December 2024)<br>Not present and not represented at the hearing (17 December 2024) |
| **Facts proved by way of admission:** | Charge 1c |

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| **Facts proved:** | Charge 1b, and 1d |
| **Facts not proved:** | Charge 1a |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Striking-off order** |
| **Interim order:** | **Interim suspension order (18 months)** |

**Submissions on application for adjournment**

Prior to the hearing commencing, a preliminary meeting was held between Ms Welsh, on behalf of the Nursing and Midwifery Council (NMC), you, the legal assessor, and the NMC Hearings Coordinator. During the preliminary meeting, you informed parties that you had recently approached the organisation, NMC Watch, to obtain representation for these proceedings and that as of 23 July 2024, they agreed to represent you. However, you then informed parties that your representative, Mr Holborn, will be making an application to adjourn these proceedings as he has not had sufficient time to prepare your case.

Mr Holborn sent an email to the NMC Hearings Coordinator at 10:50 on 24 July 2024 to inform her that he would be available to attend and present his application for adjournment at 09:00 on Thursday, 25 July 2024.

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

After confirming that the hearing would reconvene at 09:00 on 25 July 2024, Ms Welsh made a request that this case be held partly in private on the basis that reference may be made to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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 it would go into private session as and when issues regarding [PRIVATE] are raised in order to protect your privacy.

**Submissions on application for adjournment (continued)**

All parties returned at 09:00 on Thursday, 25 July 2024 when Mr Holborn presented his application for these proceedings to be adjourned. Mr Holborn submitted that you initially thought you would be able to represent yourself in these proceedings, however, [PRIVATE], you sought representation from NMC Watch. Mr Holborn informed the panel that he was only appointed as your representative on 24 July 2024.

Mr Holborn submitted that the matters in this case are serious and complicated, involving multiple witnesses. He further submitted that this case has a long history, with the alleged incident occurring in 2018. Mr Holborn submitted that you are currently subject to an interim conditions of practice order, having previously been subject to an interim suspension order. He submitted, however, that you are not currently working in a clinical capacity, therefore there is a level of protection to the public.

Mr Holborn submitted that it is your position that some documentary evidence, including the CCTV footage of the alleged incident, is missing from the hearing papers. He submitted that your case was subject to a criminal investigation, and that you were found not guilty, but that there were documents from those proceedings that may be relevant to this case.

Mr Holborn submitted that he would require more time to adequately prepare your defence. He submitted that there is no real prejudice to the witnesses' memories as they provided their evidence in the form of a written statement and signed it to declare that it is true to their knowledge. Mr Holborn submitted that it would not be fair to you to continue with these proceedings without representation. He submitted that you want to engage and cooperate fully with these proceedings.

Mr Holborn submitted that an adjournment is necessary to ensure you receive a fair hearing, and to allow him adequate time to prepare your case.

Following questions from the panel, Mr Holborn submitted that he is unavailable to attend this hearing on 29, 30, and 31 July 2024 due to another proceeding. He

submitted that he would require at least one day to prepare your case, however, given the context of potentially missing documents, he may require more time.

[PRIVATE]

Ms Welsh submitted that the NMC opposed the adjournment application. She submitted that both you and Mr Holborn have not set out a clear course for how long the hearing may need to be adjourned for. She further submitted that it is not known what preparation time may be required for Mr Holborn, and that the entirety of the remaining days of the hearing may not be feasible.

Ms Welsh informed the panel that these proceedings were previously adjourned in February 2024, to allow the NMC to enquire into the availability of the CCTV footage. She submitted that a further adjournment would cause further inconvenience to the NMC and to the witnesses who had previously been warned to attend earlier this year and warned again for this hearing.

Ms Welsh reminded the panel that the alleged incidents occurred in 2018, and the potential effects of a delay may impact witness evidence. She submitted that it is crucial that witnesses are able to attend and give their evidence as soon as possible given that the previous delay has already caused great inconvenience to witness attendance.

[PRIVATE]

Regarding the CCTV footage, Ms Welsh submitted that at the adjourned hearing in February 2024, the NMC were asked by the panel to make further attempts to confirm with the Procurator Fiscal and Police Scotland regarding the availability of the CCTV footage. She submitted that the NMC received information that the footage was *"most-likely destroyed"*, and therefore not available for these proceedings.

Ms Welsh submitted that you had been invited to inform the NMC of what documentation you wished to provide for this hearing. She further submitted that you

were informed by Police Scotland that you would be able to use the documentation from the criminal proceedings for your NMC case, and that the NMC says this is available. Ms Welsh submitted that you have had months to engage representation. She submitted that there is public interest in efficiently disposing of this case as soon as possible. Ms Welsh submitted that it is not in the public interest to adjourn these proceedings further.

Ms Welsh submitted that it is the NMC's position that you would still be able to have a fair hearing if the panel is able to salvage the remaining days of this hearing and hear witness evidence as soon as possible.

Following questions from the panel, Ms Welsh submitted that she would need to take instructions to get a full chronology of this case, but to her understanding, the NMC case was delayed due to the outcome of the criminal proceedings which concluded on 1 December 2022, and that the NMC had to then prepare its case following the outcome of the criminal proceedings.

The legal assessor also posed some questions to Ms Welsh for clarity. He asked if the NMC are in possession of the full criminal bundle of evidence. Ms Welsh responded that the police handed over all of the documents that they had, but that some of the documents (detection of incident paperwork, hand over sheet, and data accident reporting form) were missing. Ms Welsh also clarified that the hearing in February 2024 was adjourned by volition of the panel for enquiries to be made if the CCTV footage was available. She submitted that no application for adjournment was made by you or the NMC at that time.

The panel accepted the advice of the legal assessor.

**Decision and reasons on application for adjournment**

The panel took into account the submissions from both Mr Holborn and Ms Welsh. It considered whether there was any injustice to either party, were it to agree an adjournment.

The panel determined that a prolonged adjournment would be unjust to the NMC and not in the public interest, given the near six-year timescale since the concerns arose. The panel considered that there has already been one adjournment this year, and that witnesses have already been inconvenienced both in February, and recently in the course of this hearing.

The panel determined that it would not be fair to you to impose a further long adjournment as this matter has been going on, without resolution, for a significant period of time.

The panel determined that the inconvenience to witnesses in this situation is material. It considered that given the absence of CCTV footage of the events in question, the witnesses' memory is paramount and should not be subject to further delay and risk of deterioration. Consequently, the panel determined that it would be unjust to both you and the NMC if a prolonged adjournment was granted.

The panel determined that there was strong public interest in not delaying the case further, given the near six-year timeline and previous adjournment.

The panel considered that fairness to you needed to be balanced against the public interest. It therefore determined that a short adjournment would enable Mr Holborn time to prepare your case and gather necessary evidence for the facts stage, and therefore preserve fairness to you.

In light of the above, the panel refused Mr Holborn's application to adjourn the case generally. However, the panel determined that it would be fair to both parties, and in the public interest to adjourn the hearing until 1 August 2024, thus enabling progress to be made and evidence to be heard during the remainder of the allocated hearing dates.

Following the panel's decision for a brief adjournment, Mr Holborn raised the indication by the NMC that the CCTV footage has been lost. He submitted that the police would have followed a process in which the CCTV data was reduced to raw data and so there would be a record of the footage. He submitted that the CCTV

footage is important and would assist the panel, and that an attempt should be made to obtain the raw data file that the police would have had.

Ms Welsh submitted that the NMC made reasonable efforts to obtain information regarding the CCTV footage and were informed that it was *“most-likely destroyed”.* She submitted that the CCTV footage may have been available to you at the time of the criminal proceedings, via your legal representative in those proceedings. However, the NMC have not investigated this further and this may be something Mr Holborn wishes to investigate.

The panel noted that the previous hearing in February was adjourned for enquiries to be made regarding the CCTV footage. The panel heard from Ms Welsh that all efforts were made to enquire about the footage. It determined that if he wishes, Mr Holborn can utilise the brief adjournment from 25 July 2024 – 1 August 2024 to investigate this matter.

**Decision and reasons on application for hearsay application to be held in private**

Prior to making the hearsay application, Ms Welsh made a request that this application be held in private on the basis that reference will be made to [PRIVATE]. The application was made pursuant to Rule 19 of the ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

Mr Holborn indicated that he 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.

Having heard that there will be reference to [PRIVATE], the panel determined to hear the hearsay application in private in order to protect Witness 4’s privacy.

**Decision and reasons on application to admit the written statement of Witness 4 as hearsay evidence**

The panel heard an application made by Ms Welsh under Rule 31 to allow the written statement of Witness 4 into evidence. Ms Welsh provided a background to the case and referred the panel to the Hearsay Bundle within the hearing papers. She explained that the NMC contacted Witness 4 via telephone on 9 April 2024, when Witness 4 explained that [PRIVATE] but would be able to attend the hearing as it was virtual. On 4 June 2024, the NMC asked Witness 4 to confirm what dates she would be available to attend. Witness 4 wrote to the NMC to confirm possible dates. On 13 June 2024, the NMC wrote back to Witness 4 to confirm that she would be unavailable from 26 – 30 July, and whether it was possible for her to attend and give evidence on 24 or 25 July. Witness 4 confirmed that she would be able to attend either day. Witness 4 was served with notice of the hearing on 15 June 2024. She then contacted the NMC on 16 June 2024 and informed them that she had let them know previously what dates she would be unavailable, that she had already planned a holiday around the dates the hearing was due to start and would not be able to participate or attend the hearing.

The NMC informed you on 17 July 2024 that Witness 4 would no longer be participating in the hearing, and that the NMC would be applying for her evidence to be admitted as hearsay.

Ms Welsh relied on the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). She submitted that the panel should take into account the considerations set out at paragraph 56 of the judgment in *Thorneycroft*:

1) *whether the statement was the sole or decisive evidence in support of the charge;*

Ms Welsh submitted that Witness 4's evidence is not sole or decisive evidence in support of the charge. She submitted that the NMC have additional witnesses who exhibit contemporaneous documentation from the time of the incident relating to Resident A, as well as documentation and statements regarding the CCTV footage.

Ms Welsh further submitted that the witnesses have provided sworn statements regarding the allegation, and that they are attending the hearing to provide live evidence and will be open to cross examination.

2) *the nature and extent of the challenges to the contents of the statement;*

Ms Welsh submitted that although Witness 4 will not be available, the panel is able to scrutinise and test her evidence against other NMC witnesses and contemporaneous documentation. She submitted that you have engaged a representative and will be able to address the panel on Witness 4's evidence and test it against other evidence available.

3) *whether there was any suggestion that the witness had reason to fabricate their allegations;*

Ms Welsh submitted that there is no information to suggest that Witness 4 fabricated her evidence. She submitted that Witness 4 provided a signed and dated statement to the NMC indicating that it is a true and accurate record of her account. Furthermore, that Witness 4 exhibited a signed declaration of truth statement she made to the police at the time of their investigation.

4) *the seriousness of the allegations, taking into account the impact that adverse findings might have on the Registrant's career;*

Ms Welsh submitted that the charge relates to a serious concern, if it went on to be proven. She submitted that it may be considered to demonstrate physical abuse towards a vulnerable patient, with excessive and inappropriate force and would need to be addressed with regulatory intervention.

5) *whether there was a good reason for the non-attendance of the witness;*

Ms Welsh submitted that Witness 4 informed the NMC that she is unavailable and explained her reasons for this. The NMC decided that Witness 4 provided a good reason for her non-attendance.

6) *whether the NMC had taken reasonable steps to secure the attendance;*

Ms Welsh submitted that the NMC took reasonable steps to secure the attendance of Witness 4. It was intended that Witness 4 would attend the hearing, but the NMC decided that it would not be appropriate to issue Witness 4 a witness summons in these circumstances.

7) *the fact that the registrant did not have prior notice that the witness statement was to be read.*

Ms Welsh submitted that you were provided with a copy of Witness 4's witness statement and exhibit. She submitted that you were notified on 17 July 2024 that Witness 4 would not be attending the hearing and that the NMC intended to apply for her evidence to be admitted as hearsay.

Ms Welsh submitted that the evidence provided by Witness 4 is relevant and fair, and that the panel would be justified to admit it into evidence.

Mr Holborn submitted that you received the notice of Witness 4's non-attendance, and her witness statement. He submitted that you have seen reasonable steps taken by the NMC to secure Witness 4's attendance.

Mr Holborn submitted that the contents of some of the evidence contains what appears to be opinion and joint evidence in conjunction with others. He submitted that you deserve the right to question that evidence accordingly.

Mr Holborn submitted that you question whether there are any other witnesses that were available who could give similar, or same evidence as a live witness, but you assume that the NMC have taken that into account.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far 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 considered the application in regard to Witness 4's written statement. The panel noted that Witness 4's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by her.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 4 to that of a written statement. In making its decision, the panel had regard to the NMC guidance on hearsay evidence, DMA-6, and the case of *Thorneycroft*. The panel considered the seven factors of *Thorneycroft* in turn:

1) *whether the statement was the sole or decisive evidence in support of the charge;*

The panel determined that Witness 4's evidence is not sole or decisive due to the other direct witnesses. It determined that Witness 4's evidence can be tested against other witnesses and the contemporaneous documentation.

2) *the nature and extent of the challenges to the contents of the statement;*

The panel determined that there may be a challenge to some aspects of Witness 4's evidence.

3) *whether there was any suggestion that the witness had reason to fabricate their allegations;*

The panel determined that there is no evidence before it to suggest Witness 4 has fabricated her evidence. It took into account that both the NMC witness statement, and the exhibited statement to Police Scotland are signed and dated.

4) *the seriousness of the allegations, taking into account the impact that adverse findings might have on the Registrant's career;*

The panel determined that the charge is serious and alleges potential physical abuse of a vulnerable patient.

5) *whether there was a good reason for the non-attendance of the witness;*

The panel determined that Witness 4 has provided a very compelling reason for her non-attendance. It took into account [PRIVATE] and noted that she has engaged with the NMC by providing her witness statement for the hearing and exhibiting her police statement.

6) *whether the NMC had taken reasonable steps to secure the attendance;*

The panel determined that the NMC has taken all reasonable steps to secure the attendance of Witness 4, but given [PRIVATE], a witness summons would be disproportionate and not appropriate to seek to compel her attendance.

7) *the fact that the registrant did not have prior notice that the witness statement was to be read.*

The panel determined that you have had knowledge of the contents of Witness 4's witness statement since the criminal investigation in 2022. The panel took into account that you were provided with a copy of Witness 4's witness statement on 17 July 2024, when you were notified of her non-attendance and the NMC's intention to apply her evidence as hearsay. The panel also noted Mr Holborn's submission that you were provided sufficient notice.

Having regard to the above, the panel applied the test for the admissibility of the disputed hearsay evidence set out in Rule 31.

In terms of the relevance of Witness 4's evidence, the panel noted that Witness 4 was the direct witness at the time of the incident, and that her evidence relates to

Charge 1c), and 1d). The panel was therefore satisfied that the evidence was relevant to the disputed charges.

When considering fairness, the panel was mindful that it must conduct a careful balancing exercise taking into account its findings in relation to each of the factors listed in the case of *Thorneycroft*, the panel determined that it would be fair to admit Witness 4's witness statement as hearsay evidence. In reaching this decision, the panel also took into account the nature and form of Witness 4's evidence which includes her signed witness statement, and her exhibited police statement. The panel noted that both statements consist of signed declarations of truth.

In these circumstances, the panel came to the view that the evidence was relevant and that it would be fair to admit it as hearsay evidence.

Having decided to admit Witness 4's witness statement as hearsay evidence, the panel will determine what weight to attach to it in due course.

**Background**

The NMC received a self-referral from you on 12 November 2018, followed by a second referral from the Centre Director for Dee View Court ('the Unit') on 20 November 2018 with the following regulatory concern:

1. Failings in patient care – inappropriate use of restraint techniques

The regulatory concern related to an alleged unauthorised restraint that took place on 31 October 2018 at the Unit in relation to Resident A.

**Details of charge**

That you, a registered nurse:

1. On 31 October 2018:

a. Restrained resident A against the wall.
b. Threw resident A to the floor.
c. Restrained resident A by holding him on the floor.
d. Lifted resident A off the floor and hit him back down again.

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

**Decision and reasons on application to admit the hearsay evidence of Ms 6**

It was agreed between Ms Welsh and Mr Holborn that the hearsay evidence of Ms 6, contained in Ms 6's written statement dated 1 November 2018, minutes of an investigation meeting between Witness 3 and Ms 6, and a statement from Resident A, recorded by Ms 6, was relevant to the charges and that it would be fair to admit it pursuant to Rule 31.

The panel noted that both parties were in agreement to admit this evidence as hearsay. Having read the evidence, the panel came to the view that the evidence was relevant and that it would be fair to admit it as hearsay evidence.

Having decided to admit Ms 6's written statement, minutes of the investigation meeting, and Resident A's statement recorded by Ms 6 as hearsay evidence, the panel will determine what weight to attach to it in due course.

**Submissions on interposing Witness 5's evidence**

An additional day, Friday, 9 August 2024, was added to this hearing with the intention that the panel would finish hearing evidence from the NMC witnesses, you, and your witness, and to deliberate and hand down on facts before this hearing goes part heard. On 6 August 2024, the panel heard from you that you would not be available to attend to continue your evidence until 15:30.

As a result of this, the panel considered the possibility of utilising the remaining time for this hearing and invited submissions from both parties regarding interposing Witness 5's evidence before concluding your evidence.

Ms Welsh submitted that it is the NMC's position that this is a matter for the panel. She submitted that this is an unusual circumstance but it is important that this case concludes. Ms Welsh submitted that there could be further inconvenience to Witness 5 if the panel decided to interpose her evidence as there is already a possibility that she may have to be called back if any further questions arise after hearing your evidence in full. Ms Welsh further submitted that the panel have already made accommodations for you in terms of the timetabling of this hearing, and that it is a choice for you to attend at 12:00 on Friday, 9 August 2024.

Mr Holborn submitted that you are content to interpose Witness 5 and hear her evidence at 12:00 on Friday, 9 August 2024. He submitted that the potential for Witness 5 to be recalled is minimal. Mr Holborn submitted that it is sensible and fair to hear Witness 5 at 12:00 and then continue with your evidence from 15:30 when you will be available.

The panel accepted the advice of the legal assessor.

The panel determined that even if it were to interpose Witness 5's evidence, there may not be enough time to finish hearing all of the factual witness evidence for this case, and to reach a determination on the facts before this part of the hearing concludes on 9 August 2024. The panel therefore determined that it would conclude your evidence at 15:30 on Friday, 9 August so that once the hearing resumes on the next listed dates, it would only have to hear evidence from Witness 5 before it could deliberate on the facts.

**Information regarding late evidence provided during your evidence**

During the process of you giving evidence, Mr Holborn produced a letter from the Unit regarding Resident A potentially being physically aggressive towards male members of staff.

Both Mr Holborn and Ms Welsh agreed that the letter will be entered as evidence, and that you will be able to be questioned on it when you return to continue cross-examination. It is noted that you have seen the document before and had asked your representative to produce it earlier.

Witness 5 (the author of the letter) will later formally produce this as an exhibit during her evidence.

The NMC has expressed its concern about potential unfairness, including the document arriving after the NMC closed their case, and not being put to witnesses, and how suddenly the document has arrived from Mr Holborn after a warning from the panel not to discuss the evidence while you were under affirmation.

The parties have agreed that this document raises issue that could have been properly put to other witnesses earlier in the case.

The parties have agreed that after hearing evidence from you and Witness 5, the NMC would be within their right to make an application to the panel, should they wish to recall witnesses. The NMC do not propose to make such an application at this stage but reserve the ability to do so.

**Decision and reasons on admitting the hearsay evidence of Witness 5**

On Monday 9 December 2024, Mr Holborn informed the panel that he was under the impression that the NMC would warn Witness 5 for these resuming dates, and therefore, he did not make contact with her to arrange dates or times for her to attend. He informed the panel that you no longer wish to call Witness 5 but would still like her letter dated 9 November 2018 to be admitted as hearsay evidence.

Mr Holborn submitted that this letter is dated and signed and should be admitted into evidence as it provides information regarding Resident A that was not previously put before the panel.

Mr Radley, on behalf of the NMC, submitted that the NMC do not object to the document being admitted into evidence. He informed the panel that he is aware of previous concerns regarding recalling NMC witnesses to challenge them on this new document, but that the NMC do not consider this necessary in these circumstances.

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

The panel took into account that neither party has opposed to Witness 5's letter being admitted into evidence. It determined that the letter is contemporaneous and is signed by Witness 5, and that it is relevant to the facts of this case. The panel determined that it would be unfair to you to not admit Witness 5's letter into evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence Witness 5's letter but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

**Decision and reasons on facts**

During his closing submissions on the facts of this case, Mr Holborn informed the panel that you admit to charge 1c.

The panel therefore finds charge 1c proved by way of your admission.

In reaching its decisions on the disputed facts, namely charges 1a, 1b, and 1d, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Welsh and Mr Radley on behalf of the NMC and by Mr Holborn.

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: Staff Nurse at the Unit at the time of the incident

- Witness 2: Staff Nurse at the Unit at the time of the incident

- Witness 3: Head of Care at the Unit at the time of the incident

The panel also heard evidence from you under affirmation.

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 Mr Holborn.

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

**Charge 1a**

That you, a registered nurse:

1. On 31 October 2018:

a. Restrained resident A against the wall.

**This charge is found not proved.**

In reaching this decision, the panel took into account Witness 1's contemporaneous note dated 31 October 2018 which stated:

'[…] *I couldn't see what happened next, but saw Tom restraining Resident A against the wall of corridor and Resident A fighting against the restraint* […]'

This is corroborated by minutes of an investigation meeting that took place between Witness 1 and Witness 3 on 1 November 2018. The minutes stated:

'[…] [Witness 3] *asks how TL* (you) *restrained Resident A*. [Witness 1] *states that TL pushed Resident A against the wall* […]'

The panel took into account that Witness 1 also mentioned in her oral evidence that *"Resident A was being restrained by Mr Lyon against the wall".*

The panel was aware that you vehemently denied restraining Resident A against the wall. Under panel questioning, you reiterated that neither you nor Resident A were near a wall when the physical altercation started.

The panel balanced your oral evidence against Witness 1's evidence in which she recalled that you had restrained Resident A against the wall. Furthermore, the panel was mindful that no other witnesses had made reference to you restraining Resident A against the wall, including Witness 3 who had gone through the CCTV footage in detail.

As such, the panel determined that on the balance of probabilities, it is unlikely that you restrained Resident A against the wall on 31 October 2018. The panel therefore did not find this charge proved.

**Charge 1b**

That you, a registered nurse:

1. On 31 October 2018:

b. Threw resident A to the floor.

**This charge is found proved.**

In reaching this decision, the panel took into account your oral evidence when you said that you grabbed Resident A's biceps and *"put my left leg behind his leg."* The panel noted that you then went on to mention *"I've grabbed onto him and pulled him down with me.* […] *it didn't look good. It didn't look professional at all, which I admit to".*

The panel took into account the context surrounding this incident, which was provided by you in oral evidence. You mentioned that you were *"absolutely terrified"* as Resident A *"was a much larger man".* You told the panel that [PRIVATE] and that you *"had become so fearful".* You also told the panel that you were not *"fully in control"* of the situation.

The panel also took into account Witness 1's contemporaneous note dated 31 October 2018 which stated:

> '[…] *This escilated* [sic] *in seconds to Resident A being on the floor restrained by Tom.'*

This is corroborated by the minutes of the investigation meeting which took place between Witness 3 and Ms 6 on 2 November 2018 which stated:

> '[…] *TL pushed Resident A against the wall, then before she knew it they were wrestling on the floor and TL was on top of Resident A'*

This is further supported by Witness 1's oral evidence when she said *"It all happened really, really quickly. I'm not even really sure how to describe it other than within seconds, Resident A was being restrained by Mr Lyon against the wall. And then, within seconds, restrained him again onto the floor."*

The panel took into account Witness 3's witness statement which stated:

> *'Thomas swiped him from beneath his legs and threw him to the floor. He grabbed him by* [sic] *jumper and spun him around as he swiped his legs from*

*him. I’ve been a mental health nurse for years and those moves are not taught at any point.’*

This is corroborated by Witness 3’s written statement to the police dated 21 October 2019 which stated:

‘[…] *I saw Thomas grabbing a hold of Resident A’s jumper by the sleeve, spun him round so that Resident A was standing in front of him and then he tried to restrain him from behind, they kind of tusselled* [sic] *and then Thomas pinned Resident A onto the floor.’*

This is further supported by Witness 3’s oral evidence when she said *“Thomas had then spun Resident A round so that Resident A’s back was to Thomas’s front. He swiped his legs and then he landed on the ground.”*

The panel applied the ordinary meaning of “threw” in these circumstances, in that you attempted to bring Resident A to the floor suddenly and with force. The panel determined that all of the witnesses called on by the NMC were credible and reliable, and that they were consistent across their witness statements, contemporaneous documents, police statements, and oral evidence.

Therefore, the panel determined on the balance of probabilities that it is likely that you threw Resident A to the floor on 31 October 2018. The panel therefore found this charge proved.

**Charge 1c**

That you, a registered nurse:

1. On 31 October 2018:

c. Restrained resident A by holding him on the floor.

**This charge is found proved.**

In reaching this decision, the panel took into account Mr Holborn's submission that you admitted to this charge. It also determined that the evidence provided by all of the witnesses in respect of this charge was consistent in that you did restrain Resident A by holding him on the floor on 31 October 2018.

The panel therefore found this charge proved by way of your admission.

**Charge 1d**

That you, a registered nurse:

1. On 31 October 2018:

d. Lifted resident A off the floor and hit him back down again.

**This charge is found proved.**

In reaching this decision, the panel took into account your oral evidence when you said that Resident A was sitting up after *"having thrown me off of him"* and that you *"managed to get up and get on him again".* You mentioned that you had to *"use more force to get him down"*

The panel took into account Witness 4's written statement to the police dated 20 October 2019 which stated:

> '[…] *I also remember Thomas banging Resident A's head off the ground. It was all just such a shock.'*

This is corroborated by Witness 3's written statement to the police dated 21 October 2019 which stated:

> '[…] *Resident A's head hit the ground too* […]*'*

This is further corroborated by Witness 3's oral evidence when she said that you lifted Resident A's *"entire chest off the ground, and head"* and *"slammed his head down".*

The panel took into account the minutes of the investigation meeting which took place between Witness 3 and Ms 6 on 2 November 2018 which stated:

> '[Ms 6] *states that Resident A's head hot* [sic] *the ground.'*

This is corroborated by Witness 1's oral evidence when she confirmed that she recalled watching the CCTV footage and saw Resident A's head *"being hit off the ground quite severely by Mr Lyon".*

The panel determined that there is contemporaneous evidence to suggest that it is more likely than not that on 31 October 2018, you lifted Resident A off the floor and hit him back down again. Therefore, the panel found this charge proved.

Mr Lyon did not attend the virtual hearing on Thursday 12 December 2024, when submissions regarding misconduct and impairment were made.

**Fitness to practise**

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Lyon'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, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Lyon'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 Radley 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 Radley identified the specific, relevant standards where Mr Lyon's actions amounted to misconduct. He submitted that Mr Lyon's actions are failings that directly relate to the care and management of a vulnerable mental health patient.

Mr Radley submitted that Mr Lyon's actions are not simply breaches of a local disciplinary policy or minor concerns, but that they are matters that are fundamental to nursing practice. Further, he submitted that Mr Lyon's behaviour relates to his role as a registered professional and the clear impact on his area of practice, which affected patient care and appeared to lack compassion.

Mr Radley submitted that the public's trust and confidence in the nursing profession and the NMC as the regulator would not be upheld should the panel determine that Mr Lyon's actions do not amount to misconduct.

Mr Holborn submitted that Mr Lyon did not intend to cause harm to anybody, and that he found himself in a difficult and frightening situation that he had not encountered before.

Mr Holborn submitted that Mr Lyon did his best to manage the situation under the circumstances he was in and that he had a genuine concern for the safety of not only Resident A, but that of the other residents and members of staff.

Mr Holborn submitted that Mr Lyon acknowledges that, upon reflection, his actions in relation to charge 1c could have been handled differently. He submitted that Mr Lyon has taken proactive steps to address these concerns and that he does not intend to return to nursing practice.

Mr Holborn submitted that Mr Lyon's actions do not amount to misconduct.

**Submissions on impairment**

Mr Radley 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. He made reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Radley submitted that Mr Lyon breached multiple components of the NMC Code, and as such, has breached a fundamental tenet of the nursing profession, and that his fitness to practise is currently impaired.

Mr Radley submitted that the consequences of Mr Lyon's conduct put patients at risk of harm and could have seriously injured Resident A. He submitted that Mr Lyon has provided some insight into his failings, and that he has engaged with the NMC regarding these proceedings, but that he has not demonstrated that he is currently able to practise kindly, safely and professionally.

Mr Radley submitted that a finding of impairment is required to mark the unacceptability of Mr Lyon's behaviour, emphasise the importance of the fundamental tenet breached, and to reaffirm proper standards of behaviour.

Mr Holborn informed the panel that Mr Lyon did not wish to give oral evidence at this stage of the hearing, but that he had provided Mr Holborn with instructions in relation to misconduct and impairment so that he could provide the panel with Mr Lyon's written submissions. These were admitted into evidence (Exhibit 12) for the panel to consider.

This document focused on several key areas. Firstly, that Mr Lyon *'acknowledges the seriousness of the concerns but maintains his innocence on a number of specific charges* […]*'*. Secondly, that at the criminal trial, Mr Lyon represented himself and raised the issue of self-defence, and was found not guilty. Thirdly, that the panel was wrong to rely upon the evidence of the NMC's witnesses because *'Witnesses relied upon in the NMC proceedings were deemed unreliable in the criminal proceedings. This undermines the credibility of the allegations.'* Fourthly, *'The absence of CCTV evidence deprives the panel of an objective record of events and limits the ability to confirm certain allegations.'* Mr Lyon does not accept that his fitness to practise is currently impaired.

Mr Holborn submitted that Mr Lyon had represented himself for the past six years throughout criminal proceedings, and the start of the NMC investigation, and as a result, he has *"fought alone"* and has *"moved along a lone road"* in defending himself. Furthermore, that Mr Lyon remains in the mindset that he was acting in self-defence.

Mr Holborn referred the panel to a number of positive testimonials provided on behalf of Mr Lyon which speak to his good character. He submitted that these testimonials were given with full knowledge of the charges against Mr Lyon.

Mr Holborn submitted that Mr Lyon did not fully accept that what he did was correct at the time of the incident, and moving forward, it would not happen again. He submitted that Mr Lyon does not intend to return to nursing practice, but if he were

to, he would practise kindly, safely and professionally. Further, Mr Holborn submitted that this was a single incident in an otherwise unblemished career.

Mr Holborn submitted that Mr Lyon has demonstrated insight into his previous failings, and that he has continued to engage with the NMC regarding these proceedings. He submitted that Mr Lyon's reflections have been true and honest and that his intentions were also honest in that he wanted to ensure the safety of all patients and staff.

Mr Holborn submitted that Mr Lyon may have been impaired at the time of the incident, but that his fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

**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 Lyon's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Lyon's actions amounted to breaches 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*
*1.5 respect and uphold people's human rights*

***2 Listen to people and respond to their preferences and concerns***
*To achieve this, you must:*
*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***

*To achieve this, you must:*

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

*3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*

***8 Work cooperatively***

*To achieve this, you must:*

*8.2 maintain effective communication with colleagues*

*8.6 share information to identify and reduce risk*

***13 Recognise and work within the limits of your competence***

*To achieve this, you must:*

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

***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*

***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*

*17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people*

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

*To achieve this, you must:*

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

*19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)*

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

*Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive.* […]

***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*

*20.3 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, the panel took into account that Mr Lyon had only recently received training in de-escalation, and that he did not apply his training when dealing with this situation. The panel also took into account that Resident A was vulnerable, and that this was a known fact amongst staff. The panel determined that Mr Lyon took unilateral action, in that he did not attempt to involve other members of staff by raising an alarm and instead, attempted to handle the situation by himself.

The panel considered the seriousness of the conduct in the manner (prone position) and length of time (15 – 20 minutes) of the restraint of Resident A, which was considered deplorable by fellow practitioners. Witness 3, who witnessed the CCTV footage, believed that *"risk of death was definitely there from the restraint"*. Indeed, Mr Lyon accepted that the *'restraint was such that the patient could have been injured during the incident.'* In the context of a no-restraint policy, this was an abuse of power against a vulnerable resident. Consequently, the panel concluded that Mr Lyon's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

The panel next went on to decide if as a result of the misconduct, Mr Lyon'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 February 2024, 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 to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must 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)* […]'

The panel determined that Resident A was put at risk of harm as a result of Mr Lyon's misconduct. Mr Lyon's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was of the view that Mr Lyon took unilateral actions without informing or involving other members of staff and by engaging in and escalating a physical altercation with a vulnerable resident, who was, at the time walking away from him.

The panel determined that despite six years passing since the incident occurred, there were concerns that Mr Lyon's view was that whilst he could have done things differently, there was an element of justification for his actions. The panel took into account Mr Lyon's reflective piece dated 7 December 2024 which stated:

> *'I honestly believe that some of my nursing colleagues from backgrounds such as forensic nursing would have acted in the same way I did.'*

The panel considered the context of the situation in that Mr Lyon expressed [PRIVATE], but that he did not acknowledge the impact that his actions had on the other residents and members of staff. It considered that though Mr Lyon has defended himself in the criminal proceedings, and was acquitted, the standard of proof is different in these proceedings. Furthermore, Mr Lyon still seeks to place blame on others, rather than take accountability for his actions. The panel had regard to Mr Lyon's reflective piece which stated:

*‘If you have a patient with full capacity of mind who leaves the unit they reside in under their own volition, visits local stores making purchases with their own money but engages in behaviour of an aggressive, violent and predatory nature you, as a nurse manger have a duty to inform your nursing colleagues about these behaviours in the most effective and immediate way possible. I honestly believe that is through the handover sheet, which is and should always be an essential signpost to staff new to a care facility.’*

The panel was of the view that Mr Lyon had not taken the opportunity to reflect sufficiently, even in the abstract, upon why actions set out in the charges found proved, involving a vulnerable resident, would be considered deplorable by fellow practitioners. Furthermore, the panel did not have any evidence before it to demonstrate Mr Lyon had expressed any remorse for his actions. Specifically, no apology to Resident A or his family, or acknowledgement that his unilateral actions, and sustained use of force, had caused his colleagues to feel frightened.

The panel considered that Mr Lyon acknowledged in his reflective piece that members of the public would be shocked at the situation, and that he expressed that he wants to put things right, but that he has not demonstrated why or how he would do so.

The panel had regard to the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) when determining whether Mr Lyon’s actions were remediable. The panel was of the view that the misconduct in this case, though capable of being addressed, would be very difficult. The panel determined that though the misconduct in this case involved a single incident, given the length of time that has passed, and the absence of remorse, insight (even in reflection in the abstract), and Mr Lyon continuing to seek to blame others, that this indicated that he had a deep-seated attitudinal problem.

The panel was of the view that remediating this attitudinal issue, would likely involve demonstration of remorse, thorough reflections evidencing well-developed insight into the impact of Mr Lyon’s actions on Resident A, other residents, his colleagues, and the wider confidence in the nursing profession. Furthermore, remediation could

be assisted by attendance on courses on de-escalation techniques, working collaboratively, and managing conflict, alongside reflections on what Mr Lyon had learned on these courses.

Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Lyon has taken steps to strengthen his practice. The panel determined that Mr Lyon has not demonstrated any strengthening of his practice. It took into account that Mr Lyon has not worked as a registered nurse since the incident occurred in 2018. It noted his reflective piece in which he said that the facts found proved would not happen again, but that he has not demonstrated how.

In light of Mr Lyon's limited insight, the panel is of the view that it could not be confident that he was highly unlikely to repeat his misconduct, if faced with a similar situation. Given there is a risk of repetition, the panel concluded that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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.

Mr Lyon, in his reflective piece, acknowledges that *'any member of the public viewing this incident would be shocked. To restrain a patient in the way that I did wasn't in any way representative of nursing.'* The panel also heard evidence that Mr Lyon's colleagues were *"frightened"* and felt unable to intervene as this was something they *"had never seen before."* Therefore, 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 Lyon's fitness to practise impaired on the grounds of public interest.

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

**Decision and reasons on proceeding in the absence of Mr Lyon**

[PRIVATE]

The hearing resumed on Tuesday 17 December 2024 when the panel then considered whether it should proceed in the absence of Mr Lyon. It had regard to Rule 21 and heard the submissions of Mr Holborn who submitted that it would be appropriate for him to withdraw from these proceedings as he is no longer being instructed by Mr Lyon.

Mr Holborn withdrew from the hearing.

Mr Radley noted Mr Lyon's indication [PRIVATE] that he no longer wishes to engage with the NMC. He submitted that the NMC has a duty to protect the public and that an adjournment would be unnecessary in these circumstances. Mr Radley invited the panel to proceed in Mr Lyon's absence.

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 Lyon. In reaching this decision, the panel considered Mr Holborn's withdrawal from the proceedings, the submissions of Mr Radley, 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:

- No application for an adjournment has been made by Mr Lyon;

- Mr Lyon informed [PRIVATE] that he no longer wishes to engage with the NMC and has therefore voluntarily absented himself;
- There is no reason to suppose that adjourning would secure his attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

The panel considered the disadvantage to Mr Lyon in proceeding in his absence. However, the panel has received written submissions regarding misconduct and impairment, a reflective piece, and testimonials from Mr Lyon, as well as hearing oral evidence from him at the fact-finding stage. The panel considered that it would not be in Mr Lyon's best interests to adjourn this hearing as it has been six years since the incident occurred, and Mr Lyon previously told the panel that he wishes for this matter to be concluded as soon as possible. The panel determined that it is also in the public interest to proceed with the hearing in Mr Lyon's absence given that there have already been a number of adjournments to this hearing. The panel considered it unlikely that Mr Lyon would attend or engage with the process if a further adjournment was granted. Therefore, the limited disadvantage is the consequence of Mr Lyon's decisions to absent himself from the hearing.

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

**Sanction**

The panel has considered this case carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Lyon off the register. The effect of this order is that the NMC register will show that Mr Lyon 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 Radley informed the panel that in the original Notice of Hearing, dated 15 May 2024, the NMC had advised Mr Lyon that it would seek the imposition of a striking off order if it found Mr Lyon's fitness to practise currently impaired.

Mr Radley submitted that considering all of the sanctions available to the panel, in ascending order of seriousness, a striking-off order is the only appropriate sanction to reflect the seriousness of this case.

The panel accepted the advice of the legal assessor.

**Decision and reasons on sanction**

Having found Mr Lyon's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Abuse of a position of trust
- Lack of sufficient insight into failings
- Misconduct which put a vulnerable patient at risk of serious harm
- No evidence of apology, remorse, or strengthened practice

The panel also took into account the following mitigating features:

- Testimonials on behalf of Mr Lyon dated between 2018 and 2022, however the panel attached little weight to these as the majority of the testimonials spoke of Mr Lyon as a student, and not as a registered nurse.
- A single incident of misconduct

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 not protect the public, nor would it be 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 Lyon'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 Lyon's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would not protect the public, nor would it be in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Lyon's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges and the panel's finding of a deep-seated attitudinal concern. The panel determined that it cannot be assured that Mr Lyon would comply with any conditions were they to be imposed. The panel also determined that given the ongoing risk identified, patients may still be put at risk of harm even if conditions were imposed. Furthermore, the panel concluded that the placing of conditions on Mr Lyon's 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 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 Lyon's actions is fundamentally incompatible with Mr Lyon remaining on the register.

The panel considered Mr Lyon's limited insight and lack of remorse, as well as its findings of a deep-seated attitudinal concern and Mr Lyon's recent disclosure that he no longer wishes to engage with the NMC and determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

The panel were not satisfied that Mr Lyon has demonstrated significant insight so as not to repeat the behaviour that was found proved in this case. The panel noted that Mr Lyon has not practised as a registered nurse for six years, nor has he demonstrated any evidence of keeping his skills up to date. The panel also took into account Mr Lyon's reflective piece in which he said, *'it is not my intention to return to nursing'.* Therefore, the panel determined that a period of suspension would serve no useful purpose in this case.

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

The panel determined that in escalating a physical altercation with a vulnerable resident, who Mr Lyon restrained on the floor for approximately 20 minutes without clinical justification in a clinical setting that did not permit restraining techniques, as well as six years passing with no evidence from Mr Lyon to demonstrate remorse or sufficient insight, that this raises fundamental concerns around Mr Lyon's professionalism.

In considering seriousness, the panel determined that Mr Lyon's conduct was so serious so as to amount to an abuse of trust, and inappropriate use of force and behaviour causing serious risk of harm to a vulnerable patient. The panel considered the NMC guidance FTP-3 on *'how we determine seriousness'*, which states that:

> *'some behaviours are particularly serious as they suggest there may be a risk to people receiving care; examples include:*
>
> - *conduct or poor practice which indicates a dangerous attitude to the safety of people receiving care,* […]*'*

The panel further considered the guidance which states:

*‘Protecting people from harm, abuse and neglect goes to the heart of what nurses, midwives and nursing associates do. Failure to do so, or intentionally causing a person harm, will always be treated very seriously due to the high risk of harm to those receiving care, if the behaviour is not put right.’*

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 Lyon’s actions in bringing the profession into disrepute by adversely affecting the public’s view of how a registered nurse should conduct themself, 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. The panel determined that a member of the public, who was fully informed of all the facts and evidence in this case, would be deeply concerned if Mr Lyon was permitted to remain on the register.

This will be confirmed to Mr Lyon 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 Lyon’s own interests until the striking-off sanction takes effect.

**Submissions on interim order**

The panel took account of the submissions made by Mr Radley. He invited the panel to impose an interim suspension order for a period of 18 months to allow time for any

possible appeal. Mr Radley submitted that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest.

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

**Decision and reasons on interim order**

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow time for any possible appeal

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

That concludes this determination.