Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 3 June – Wednesday, 5 June 2024

Virtual Meeting

Name of Registrant:	**Ian Brown**
NMC PIN	17C0093E
Part(s) of the register:	RNMH: Mental health nurse, level 1 (18 February 2018)
Relevant Location:	Norfolk
Type of case:	Misconduct
Panel members:	Nicola Dale (Chair, lay member) Vanessa Bailey (Registrant member) Joanna Bower (Lay member)
Legal Assessor:	Jayne Salt
Hearings Coordinator:	Rim Zambour
Facts proved:	Charges 1, 2, 3a, 3b, 3c, 4
Facts not proved:	Charge 5
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel had sight of the Notice of Meeting which had been sent to Mr Brown's registered email address by secure email on 24 April 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates (that this meeting was to be heard on or after 29 May 2024) and the fact that this meeting was to be heard virtually.

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

Details of charge

That you a registered nurse;

1) On 24 August 2019 took several residents from Foxhall House unto the grounds to clean your car.

2) On 9 September 2021 did not secure Foxhall house, by using the airlock system, resulting in a Resident A absconding from the unit.

3) On 6 October 2019 did not follow the safety plan for resident B when their family was visiting;
    a) By allowing Resident B to leave Foxhall House without authorised leave approval.
    b) By allowing Resident B's family through the 'airlock' system.
    c) By letting Resident B's family into a restricted area.

4) Between 25-30 October 2019 failed to record and or report to senior management that Resident C disclosed confidential information to you about a staff member.

5) On more than one occasion did not record Section 17 leave.

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

Background

Mr Brown was referred to the NMC on 3 November 2020 by the Norfolk and Suffolk NHS Foundation Trust ('the Trust') where he was working as a staff nurse at Foxhall House (FH), a low secure forensic service based in Ipswich.

Mr Brown was first entered onto the NMC register in February 2018. He commenced working at FH on 5 February 2019.

Mr Brown's first post in the Trust was with the Suffolk Rehabilitation and Recovery Service ('SRRS'). During his time with the SRRS, concerns were raised about his practice. These included unprofessional behaviour towards colleagues and patients. This culminated in a Trust investigation, and he was issued with a final written warning for 12 months on 4 January 2019. In addition, he was redeployed to FH, and he was required to undertake a development plan for a period of six months, focusing on values and behaviours.

All the residents in FH are sectioned under the Mental Health Act. The security system in place requires any leave for residents must have qualifying approval; some residents require approval from the Home Office for community or ground leave. Residents are not permitted to leave the ground without agreed Section 17 leave and any requests for leave are discussed with the whole team.

It is alleged that on 9 September 2019, Mr Brown failed to follow the safety guidance and standards linked to the security of FH. While working in the secure garden at

FH, Mr Brown allegedly opened a secure gate allowing access to the outside area, which resulted in Resident A absconding through the open gate.

It is alleged that on 24 August 2019, Mr Brown took four residents, one of whom did not have authorised Section 17 leave, out to wash his car. A support worker stated that they were surprised by this as it was not common practice, and they could not recall any other staff member doing this.

On 6 October 2019, Resident B had a family visit. Resident B had no Section 17 leave so the visit was to be facilitated solely in the '*family room'*. As Resident B's allocated nurse, Mr Brown was the chaperone for this visit. It is alleged that Mr Brown was asked to be '*extra vigilant*' as it was a high-risk visit. Several members of staff reported seeing Mr Brown outside the main building.

Mr Brown submitted his resignation letter on 16 October 2019.

It is also alleged that on 30 October 2019, Resident C shared with Mr Brown that they had highly confidential information about a member of staff, which potentially put both Resident C and the member of staff at risk of harm. Mr Brown did not record this incident or escalate it to senior management.

Following an Investigation Review meeting held on 19 October 2020, in Mr Brown's absence, the decision was made that, had Mr Brown remained employed by the Trust, he would have been dismissed on the grounds of gross misconduct.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the written representations made by the NMC and your email dated 23 November 2020.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This

means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Lead Nurse employed by the Trust.
- Witness 2: Lead Nurse employed by the Trust.
- Witness 3: Clinical Team Lead employed by the Trust.
- Witness 4: Lead Nurse employed by the Trust at the time.

In considering the written statements of the witnesses the panel noted that witnesses had referred to residents by their initials however the panel found no difficulty in deducing which were references to Residents A, B and C.

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

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

Charge 1

> "That you, a registered nurse;
>
> 1) On 24 August 2019 took several residents from Foxhall House unto the grounds to clean your car."

This charge is found proved.

In reaching this decision, the panel took into account the witness statements, your own statement and exhibit evidence from Colleague 1.

The panel had sight of the Notes of Investigation Interview with Colleague 1 dated 6 February 2020 in which Colleague 1 was asked what they observed in relation to this incident. Colleague 1 stated that:

> *'I was on the late shift, in handover there was nothing to report that he [Mr Brown] was taking the patients out to wash his car, it wasn't discussed. [Mr Brown] said it was therapy.'*

When asked if the patient had leave, Colleague 1 stated, *'[Mr Brown] took 4 patients out, 1-2 patients had leave but the others didn't and he was on his own with them.'*

The panel noted that this account is corroborated by the indirect evidence of Witness 3 in their contemporaneous file note dated 24 August 2019 which states:

> *'On 24th August 2019 I was working the early shift and was handing over to Ian Brown for the late shift. He came into the handover room and while I was handing over said that he had a job for the patients that afternoon and would be having them wash his car.'*

The panel also had sight of Mr Brown's responses in the Trust's Disciplinary 7 Day Allegation Response form. In response to this allegation he wrote that the service user '*had leave and I believe it's more constructive to wash a car than sit outside smoking.'*

In light of all the evidence, the panel determined that this charge is found proved on the balance of probabilities as it is corroborated as well as being accepted by Mr Brown.

Charge 2

> "That you, a registered nurse;
>
> 2) On 9 September 2021 did not secure Foxhall house, by using the airlock system, resulting in a Resident A absconding from the unit."

This charge is found proved.

In reaching this decision, the panel took into account the Trust interview notes with Witness 2 in which they state the following:

> *'IB was in the garden there had been a quality review and there was excess wood and bits had been found between the external fence and the perimeter. IB went out with a patient to clear the area and had left the external gate open without telling anybody. A patient went into the garden and absconded, luckily we managed to get him back.'*

The panel also had sight of Witness 2's statement in which they state that:

> *'I had asked Ian to clear some wood from the OT garden area*
>
> *…*
>
> *My expectation when Ian was clearing the garden area was for Ian to use the 'airlock system and also to ensure the access doors to the OT garden were locked, therefore reducing any risk of any resident absconding.'*

The panel also had sight of Mr Brown's responses in the Trust's Disciplinary 7 Day Allegation Response form. In response to this allegation he wrote that he was *'trying to follow the brief of tidying up and unfortunately mistakes happen.'*

The panel determined that in light of the evidence before it, this charge is found proved on the balance of probabilities.

Charge 3

“That you, a registered nurse;

3) On 6 October 2019 did not follow the safety plan for resident B when their family was visiting;

a) By allowing Resident B to leave Foxhall House without authorised leave approval.
b) By allowing Resident B’s family through the ‘airlock’ system.
c) By letting Resident B’s family into a restricted area.”

This charge is found proved in its entirety.

The panel considered all three sub-charges together as it considered similar evidence for each.

In relation to charge 3a, the panel considered the following interview notes with Witness 3:

‘[Witness 1]: Are you aware of the incident on 6/10/19 when IB escorted [Resident B] with [family]?

[Witness 3]: It had been communicated if [family] visited there was a high risk of drugs and the visit would need to be care planned…

IB took them to the family room in reception and then took them out the front. I watched on CCTV but they went out of sight. The buzzer was pressed and IB asked to go through and he took [Resident B] and [family] through to the OT kitchen and garden. I couldn’t believe was he was doing and wanted to discuss it with [Witness 2] in person. Before I managed to do that, there was an email to say that there were drugs on the ward. I emailed [Witness 2] to let [them] know what had happened.’

The panel also considered Witness 3’s statement:

‘On [6] October 2019 [Resident B] had [their] family visit I was on shift. When [Resident B] and [their] family were in the building, I was in the nursing office working on the computer but had visual sight of the security cameras. I watched Ian, [Resident B] and [their] family leave the family room and go outside of the building away from the camera. This is a security breach as [Resident B] did not have approved section 17 leave. After a short while I watched Ian escort [Resident B] and [their] family back into the building, through the ‘airlock’ and I thought Ian was taking them to the visitor’s room, although there would be no need for him to do this. I was surprised to see Ian escort the family into the OT garden. Again this is a serious security breach as well as an increased in risk of harm to staff, other residents and [Resident B]’s family.’

The panel also considered Mr Brown’s response in the Trust’s response form in relation to this allegation where he stated:

‘Yes I did but have also witnessed staff from CSW to Dr’s doing this.’

The panel therefore found charge 3a proved on the balance of probabilities.

In relation to charge 3b, the panel first had sight of Witness 3’s statement in which they say:

‘I watched Ian escort [Resident B] and [their] family back into the building, through the ‘airlock’ and I thought Ian was taking them to the visitor’s room, although there would be no need for him to do this. I was surprised to see Ian escort the family into the OT garden. Again this is a serious security breach as well as an increased in risk of harm to staff, other residents and [Resident B’s] family.’

This account is supported by Witness 3's contemporaneous file note dated 6 October 2019 in which they record the same version of events.

The panel also considered Mr Brown's response in the Trust's form as mentioned above in relation to charge 3a in which he appears to accept that he did allow Resident B's family through the airlock system.

The panel found charge 3b proved on the balance of probabilities.

In relation to charge 3c, the panel first considered the email sent on 6 October 2019 from Witness 3 to Colleague 2 stating the following:

> *'Yesterday [Resident B] had a visit from [their] [family] which was escorted by Ian Brown. Ian rook them out on leave during the visit and when I looked out there on the camera I couldn't actually see them. He then brought [Resident B] [and their family] on to the ward, through the OT kitchen and into the garden to go and show them the rabbit/R&R…'*

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

> *'During my local interview with [Colleague 2] Staff Nurse, [they state] that [they] saw Ian, resident [B], and [their] family on a bench outside of the main building smoking and laughing together. [Colleague 2] also witnessed Ian lead [Resident B] and [their] family into the OT garden.*
>
> *…*
>
> *After being in the outside area Ian then escorted resident [B] and [their] family back into the building, through the 'airlock' and took them all into the OT garden. To access the OT garden, they would all have to go through the 'airlock' system into the resident area which is a prohibited area for visitors.'*

The panel considered all of the evidence before it and determined that charge 3c is also proved on the balance of probabilities.

Charge 4

> "That you, a registered nurse;
>
> 4) Between 25-30 October 2019 failed to record and or report to senior management that Resident C disclosed confidential information to you about a staff member."

This charge is found proved.

In reaching this decision, the panel first considered that the duty to report in relation to this charge is found in Witness 1's statement where they state:

> *'On Wednesday 30 October 2019 resident [C] shared with Ian that [they] had highly confidential information about a staff member … which could put [them] and [Resident C] at risk of harm. Ian failed to report this information to the nurse in charge or ward manager and failed to record this event in the resident's Lorenzo record.'*

The panel considered Witness 4's evidence. Witness 4 stated that Mr Brown informed them that he had recorded this incident '*in the huddle book. It was recorded that [Resident C] had raised a staff concern but IB hadn't recorded it in the notes, hadn't completed a datix or safeguarding concern.'*

The panel also had sight of Mr Brown's response to this allegation in the Trust's response form. He wrote:

> *'This feels a direct response to my raising concerns a few days earlier. Also [Resident C] informed me on the Wednesday afternoon when [they were] told on the Saturday. [They] spoke with many staff in that time and none datix this issue because the management want to blame this on me to get rid of the person who was causing the trouble…'*

The panel also had regard to the following meeting notes with Mr Brown dated 1 November 2019:

> *'[Witness 4]: Did you report this to anyone?*
>
> *[Mr Brown]: I didn't, I thought it was common knowledge*
>
> *…*
>
> *[Witness 4]: Did you think you had a duty to report this and escalate?*
>
> *[Mr Brown]: No other staff more senior than me knew about it.*
>
> *…*
>
> *[Witness 4]: What happened this morning in the Safety Huddle?*
>
> *[Mr Brown]: Not a huddle. [Resident C] tried to raise it, couldn't remember what [they] said. I tried to shut [them] down. I wrote it in the book.*
>
> *[Witness 4]: What did you write?*
>
> *[Mr Brown]: I wrote [they] raised staff concerns. I didn't raise with anyone else.*
>
> *[Witness 4]: Datix?*
>
> *[Mr Brown]: No, but it's not just me [they are] saying it to. [They] had planned meetings.'*

The panel determined that based on the evidence before it, and on the balance of probabilities, Mr Brown had a duty to but did not record or report to senior management that Resident C had disclosed confidential information about a staff member. Therefore, it found this charge proved on the balance of probabilities.

Charge 5

"That you, a registered nurse;

5) On more than one occasion did not record Section 17 leave."

This charge is found NOT proved.

The panel determined that the NMC had not discharged its burden of proof in relation to this charge. The wording of this charge lacks detail and does not make clear which resident is being referred to or on which dates, and in any event, there is no evidence before the panel which indicates that Mr Brown failed to record the leave.

The panel therefore determined there is insufficient evidence in support of this charge and found it not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mr Brown'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 Brown's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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.'*

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.

In a written submission the NMC invited the panel to take the view that the facts found proved amount to misconduct.

The NMC identified the specific, relevant standards where Mr Brown's actions amounted to misconduct which were sections 4.2, 10.1, 19.1, 20.1, 20.2 and 20.3 of the Code.

The NMC also provided the following written submissions:

> *'We consider the misconduct serious because Mr Brown's actions amount to a number of serious breaches, falling far below the standards expected in the circumstances, which would be found deplorable by a fellow nursing professional. Not only did he fail to ensure the safety of very vulnerable patients, against the clear standing instructions of the Trust's relational security policy, failed to record and or report to senior management that Resident C disclosed confidential information about a staff member and on more than one occasion did not record Section 17 leave. Accordingly, it is submitted that his actions must amount to misconduct.'*

The NMC invited the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain

proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The NMC referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC provided the following written submissions on impairment:

> '*It is the submission of the NMC that [1,2,3] [of the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin))] can be answered in the affirmative in this case.*
>
> *Nurses exercise a level of authority and influence over patients. The evidence suggests that Mr Brown placed patients at unwarranted risk of harm by failing to secure Foxhall house, by using the airlock system, resulting in a Resident A absconding from the unit; on 6 October 2019 Mr Brown did not follow the safety plan for resident B when their family was visiting; allowing Resident B to leave Foxhall House without authorised leave approval; allowing Resident B's family into a restricted area; on more than one occasion did not record Section 17 leave. Overall, Mr Brown failed to ensure the safety of patients, against the clear standing instructions of the Trust's relational security policy.*
>
> *In the local investigation witness statement [Witness 1] confirms that the expectation would be for Mr Brown to have used the 'airlock' system when accessing the outside areas.*
>
> *…*
>
> *Mr Brown confirmed he spoke to resident [C] about the highly confidential information about staff member … on 30th October 2019 but did not share this information with staff and did not record it in the patient notes. By failing to report confidential information, Mr Brown failed to safeguard service users and staff.*

…

Mr Brown showed a lack of risk awareness and repeatedly breached trust protocols.

Although it could be said that there was no actual patient harm in this case, there was a risk of harm being caused. Mr Brown took advantage of vulnerable resident/s by arranging them to wash his car. Witness [1] "It is my opinion this could be an abuse of power by Ian. It is unsafe for Ian as he may have had personal items or photographs in his car, details with his address on. I recall looking at the resident notes and there is nothing to suggest this was an activity the resident enjoyed or liked doing. As a registered nurse we need to care for those we always look after and act professionally. I don't believe Ian acted professionally or in the best interests of the residents. Furthermore, this is a security risk." Mr Brown's conduct has fallen far below the standards expected of a registered nurse undertaking care and treatment of patients with mental health conditions.

Mr Brown's conduct breached fundamental tenets of the profession, such as, professionalism and trust, failing to preserve safety of patients by failing to secure Foxhall house. Mr Brown's actions overall brought the profession into disrepute, it being conduct that fell significantly short of the standards expected for a registered nurse.

…

We consider the registrant has displayed no insight. We take this view because Mr Brown has not denied the allegations and has made no response to the charges. During an internal investigation Mr Brown accepted making a mistake by leaving a fence unsecure which led to a patient absconding. He accepts taking service users from the building to wash his car and escorting a patient outside of the building during a family visit, when this was prohibited.

Mr Brown has not provided any formal responses to the concerns or charges and has not provided any reflective statements that could evidence insight in the seriousness of his errors. Moreover, Mr Brown has failed to provide any evidence of remediation, either through training as he failed to attend the disciplinary hearing at FH, and we are unaware of his current employment status.

We consider there is a continuing risk to the public due to the registrant's lack of full insight, failure to undertake relevant training and having not had the opportunity to demonstrate strengthened practice through work.

…

We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behavior. The registrant's conduct engages the public interest because Mr Brown conduct is repetitive behaviour placing vulnerable patients at risk over a period of time. A member of the public would be concerned to hear if Mr Brown had been found not to be impaired. The public expect nurses to perform these duties safely and professionally, and as such, the absence of a finding of impairment in this case risks undermining public confidence in the profession.'

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

Decision and reasons on misconduct

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

The panel was of the view that Mr Brown's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Brown's actions amounted to numerous breaches of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively

8 Work cooperatively
To achieve this, you must:
8.2 maintain effective communication with colleagues
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with … integrity at all times…
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
20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mr Brown's actions amounted to numerous breaches of the Code which individually and cumulatively amount to serious misconduct involving numerous vulnerable residents and potentially members of the public which occurred over a period of time. The panel determined that this is conduct that showed a flagrant disregard to the Code and would be considered deplorable by fellow nurses as well as an ordinary informed member of the public.

The panel found that Mr Brown's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the

need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

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 finds that vulnerable residents, visitors to FH, members of the public and colleagues were put at risk of physical and emotional harm as a result of Mr Brown's misconduct. Mr Brown's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel found that limbs a, b and c of the *Grant* test are engaged.

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

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

The panel determined that the conduct in this case is not easily remediable due to the wide-ranging nature of the concerns and found that Mr Brown's conduct stemmed from deep-seated attitudinal issues in that he showed no regard for correct procedures and breached them in the knowledge that this could put others at risk. Further, his conduct occurred whilst subject to a final written warning and development plan following previous behavioural issues.

Mr Brown failed to attend a disciplinary hearing at FH and has not engaged with the NMC investigation. The panel has not had sight of any evidence of remediation, remorse, insight or strengthening of practice. In his brief written responses to the local investigation, the panel noted that whilst Mr Brown accepted elements of the alleged conduct, he sought to minimise and excuse it. The panel determined that this evidences deep-seated attitudinal issues.

The panel determined that this conduct is highly likely to be repeated. These charges were raised while Mr Brown was redeployed for previous behavioural allegations of misconduct. Therefore, the panel determined that if Mr Brown continues to practise unrestricted there remains a high likelihood of this conduct being repeated.

The panel decided that a finding of impairment is necessary on the grounds of public protection. It determined that there is a high risk of repetition of the conduct in this case. Vulnerable residents have been put at risk as well as members of the public where high risk residents were left unsecured by Mr Brown and could have caused potential harm to others.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and

maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

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

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

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

Representations on sanction

The panel bore in mind the following written submissions provided by the NMC:

> *'The NMC considers that the appropriate starting point with regards to Sanction is proportionate is that of a Strike Off Order.*
>
> *The aggravating features in this case include:*
>
> - *Mr Brown already had previous concerns raised by the trust, these included unprofessional behaviour towards colleagues and patients. This culminated in a Trust investigation, and he was issued with a final written warning for 12 months on 4 January 2019. In addition, he was*

redeployed to FH, and he was required to undertake a development plan for a period of six months, focusing on values and behaviours.

- *Had previous disciplinary matters at Norfolk and Suffolk trust NS/35 For breaching trust values.*
- *Variety of misconduct matters.*
- *Puting patients and staff in danger by not recording incidents.*
- *Vulnerable mental health patients*
- *Breaching security protocols.*
- *Repetitive behaviour over a period of time*
- *Lack of insight into failings*

Starting with the least restrictive sanction:
Taking no action: The concerns are too serious for this type of sanction (SAN3a) to be imposed. There remains ongoing risk to the safety of patients as Mr Brown's conduct undermines public trust and the need to promote standards and conduct within the profession. Mr Brown has not demonstrated insight as to the risks involved, as such there remains an ongoing risk that the concerns could be repeated.

Caution Order: This sanction would be insufficient to deal with the seriousness of the case and is inadequate to deal with public protection and maintaining standards and confidence within the profession (SAN 3b).

Conditions of Practice: There are no conditions that would work to remediate the problems. Mr Brown did not adhere to policies and procedures that he is aware of and did not conduct risk assessments in dangerous situations. The concerns are too serious for this type of sanction to be imposed.

Suspension Order: The NMC guidance says that a suspension order is not appropriate where the misconduct concerned is incompatible with the continued registration. There is clear evidence of potential harm for the patients, as one absconded and he allowed other patient's out without the appropriate leave and colleagues. Mr Brown also failed to act in respect of a persons right to privacy and confidentiality. This sanction may only be

appropriate where there is a single isolated incident and where this is no evidence of a deep seated and/or harmful attitudinal issue.

Strike Off: Mr Brown's actions have raised fundamental concerns surrounding his professionalism and trustworthiness and are incompatible with continued registration. A striking off order is the only sanction which will be sufficient to protect patients and members of the public. Public confidence could not be maintained if Mr Brown were not removed from the registrant and a striking off order required to declare and maintain proper professional standards.'

Decision and reasons on sanction

Having found Mr Brown'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 found the following aggravating features:

- Mr Brown already had previous concerns raised by the trust, these included unprofessional behaviour towards colleagues and patients. This culminated in a Trust investigation, where he was issued with a final written warning for 12 months on 4 January 2019. In addition, he was redeployed to FH, and he was required to undertake a development plan for a period of six months, focusing on values and behaviours. The final written warning was still live whilst these charges occurred.
- Multiple breaches of the Code.
- Vulnerable residents and members of the public placed at risk.
- Lack of insight in responses to the local investigation.
- Refused to engage with the local disciplinary process.
- Pattern of misconduct over time.

- Deep seated attitudinal behaviour.
- Breaching security protocols in a secure unit.

The panel determined that there are no mitigating features in this case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Brown'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 Brown's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

The panel also considered that Mr Brown was redeployed to this post following previous concerns, yet he flagrantly carried on with disregard to the Code, local protocols and the safety of residents and the public. Further, the deep-seated attitudinal issues identified are not remediable through conditions of practice.

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 panel noted that this was repeated misconduct, there is evidence of harmful deep-seated attitudinal problems and whilst there is no evidence of repetition since these incidents, Mr Brown was, at the time, subject to a final written warning for previous behavioural issues and has shown no insight into his failings.

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 breaches of the fundamental tenets of the profession evidenced by Mr Brown's actions is fundamentally incompatible with Mr Brown remaining on the register and that a suspension order would only afford short term protection to patients and the public whilst he is suspended.

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 determined that these questions can all be answered in the affirmative. Mr Brown'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 Brown's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

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

Representations on interim order

The panel took account of the following written representations made by the NMC:

> *'The striking off order will not take effect for some 28 days and unless an interim order is put in place, Mr Brown would be at liberty to practise as a nurse without restriction. Mr Brown would also be entitled to lodge an appeal during the 28-day period and if no interim were put in place, Mr Brown would be at liberty to practise without restriction until the conclusion of the appeal. We consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.'*

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the appeal period in order to protect the public and meet the public interest considerations in this case.

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

That concludes this determination.