Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Monday, 20 November 2023 – Friday, 24 November 2023
Monday, 27 November 2023 – Friday, 1 December 2023
Monday 24 June 2024 – Thursday 27 June 2024

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	Darren Gary Hoskins
NMC PIN	94J0060W
Part(s) of the register:	Mental Health Nurse (level 1) – 31 March 1998 Specialist Practitioner: Mental Health Mental Health Nurse – 20 March 2001
Relevant Location:	Somerset
Type of case:	Misconduct
Panel members:	Michelle McBreeze (Chair, Lay member) Jan Bilton (Lay member) Michael Duque (Registrant member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Max Buadi (20 - 24 November 2023, 27 November 2023 – 1 December 2023) Leigham Malcolm (24 – 27 June 2024)
Nursing and Midwifery Council:	Represented by Amy Hazlewood, NMC Case Presenter (20 - 24 November 2023, 27 November 2023 – 1 December 2023) Lucie Danti of counsel (24 – 27 June 2024)
Mr Hoskins:	Present and represented by Ed Wylde, (instructed by Thompsons Solicitors)
Facts admitted:	Charges 1b, 1d, 2 and 3b

No case to answer:	Charges 3a(i) and 4b
Facts proved:	Charges 1a(i), 1a(ii), 1a(iii), 1e, 3a(ii), 3c, 3d, 3f
Facts not proved:	Charges 1c, 1f, 3a(iii), 3e, 4a, 4c, 4d, 5a-e, 6a-f, 7a-c, 8, 9a, 9b(i) and 9b(ii)
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge

That you, a registered nurse

1. On the 25 May 2020 in relation to Patient A:
    a. Used an inappropriate method of restraint in that you:
        i. moved behind Patient A.
        ii. placed your arm around Patient A's upper chest/neck.
        iii. pulled Patient A backwards.
    b. Took Patient A to the floor in an unsafe manner.
    c. Continued to restrain Patient A when it was not clinically justified.
    d. Failed to adopt an arm holding technique.
    e. Put Patient A at unnecessary risk of harm.
    f. Failed to try alternative de-escalation strategies.

2. Recorded an inaccurate account of Patient A's physical restraint on 25 May 2020 on the referral to improve safety (IRIS) system.

3. On 11 March 2020 in relation to Patient D
    a. Used an inappropriate method of restraint in that you:
        i. approached Patient D from behind.
        ii. placed your arm around Patient D's upper chest/neck.
        iii. pulled Patient D backwards to the floor.
    b. Took Patient D to the floor in an unsafe manner.
    c. Put Patient D at unnecessary risk of harm.
    d. Put colleagues at unnecessary risk of a harm.
    e. Failed to ensure that verbal de-escalation techniques were applied prior to any restraint.
    f. Failed to ensure Patient D's care plan was followed.

4. On one or more occasions, without Person A's consent or professional and/or practical reason to touch her:

    a. Touched Person A's thigh.
    b. Picked Person A up from behind and placed her on the weighing scales.
    c. Touched Person A's breasts.
    d. Attempted to kiss Person A.

5. On one or more occasions, said to Person A or in the hearing distance of Person A
    a. Asked colleagues 'how many pints they would need to shag [Person A]', or words to that effect.
    b. Stated 'what do you want, our special relationship to stop?', or words to that effect.
    c. Stated 'do you want me to stop flirting with you?', or words to that effect.
    d. Stated 'come on, it's going to happen at some point', or words to that effect.
    e. Took your top off, and asked Person A to give you a once over, to teach [Person A], or words to that effect.

6. On one or more occasions displayed an attitude that undermined female colleagues by:
    a. Indicating they could not do the job.
    b. Asking if they could handle patient confrontation.
    c. Stating the job was about strength not skills.
    d. Intervening unnecessarily with patients when assistance was not requested.
    e. Choosing male colleagues over female colleagues when assistance was required.
    f. Asking Person A, in a sarcastic tone, if they thought they would be able to handle Patient F, if they kicked off.

7. On one or more occasions acted in a manner that was confrontational in that you:
    a. Brushed patients away with hand gestures.

b. Failed to disengage with Patient E.
c. Antagonised Patient E to escalate the situation.

8. Your actions at charge 4 above were done in pursuit of or to obtain sexual gratification.

9. Your actions at all or any of charges 4, 5, and 6f above harassed Person A

    a. It was unwanted conduct of a sexual nature.
    b. Your actions had the purpose or effect of:
        i. Violating Person A's dignity
        ii. Creating an intimidating hostile, degrading, humiliating or offensive environment for Person A

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

At the outset of the hearing, the panel heard from Mr Wylde, who informed the panel that you had made full admissions to charges 1b, 1d and 3b.

The panel therefore finds charges 1b, 1d and 3b proved in their entirety, by way of your admissions.

Background

You were employed by Wellesley Hospital in Somerset ("the Hospital") from July 2018 until you were dismissed for gross misconduct on 20 January 2021.

Patient A was a 69-year-old patient on the Selworthy Ward, a low-secure rehabilitation ward for patients with mental health diagnoses. Patient A was detained under the Mental

Health Act. While detained at the Hospital, Patient A was diagnosed with terminal lung cancer and was reportedly nearing the end of their life at the time of the incidents.

On 25 May 2020, Patient A allegedly threatened and/or tried to punch staff members during a confrontation. You intervened to restrain Patient A and, in doing so, allegedly used a non-approved form of restraint, which resulted in Patient A being moved to the floor in an unsafe manner. Patient A suffered a broken hip as a result of your restraint. Patient A was taken to a nearby hospital to be treated for his broken hip but sadly passed away on 29 May 2020 of causes unrelated to the incident.

On 26 May 2020, the Hospital suspended you from work pending the outcome of an internal investigation. The Hospital reported the matter to the police on 27 May 2020.

Following the inquest, the Hospital concluded their internal investigation and related disciplinary action. You were dismissed for gross misconduct after finding that you had used an inappropriate form of restraint towards Patient A and that you had failed to provide a full and accurate account of the event when you reported the incident on IRIS (Incident Reporting System) and in Patient A's care notes (Patient Electronic Record) in accordance with the Hospitals reporting protocols.

Having reported the matter to the NMC, the Hospital has since disclosed details of a similar incident.

On or around 11 March 2020, you allegedly restrained Patient D inappropriately, by approaching him from behind and placing your arm around his upper chest/neck. It is further alleged that you took him to the ground in an unsafe manner without first attempting to verbally de-escalate a potential confrontation. The incident was recorded on CCTV.

In a letter dated 18 June 2019, Person A made a number of other allegations against you, including allegedly displaying general “sexist” behaviour, which undermined female colleagues.

Person A further alleged that you were rude to patients, gesturing and acted in a manner that was confrontational.

Person A also alleged that you would make inappropriate comments to or about female staff, such as “How many pints they would need to shag her?”, or words to that effect, when speaking to a male colleague about a female colleague.

Person A also alleged that on one or more occasions you touched her thigh, breasts and attempted to kiss her. Further she also alleged that you picked her up from behind and attempted to place her on weighing scales.

Decision and reasons on application on special measures for Person A

The panel heard an application made by Ms Hazlewood, on behalf of the Nursing and Midwifery Council (“the NMC”), under Rule 23 for Person A to be accompanied by an NMC Witness Liaison Officer whilst she is giving oral evidence.

Ms Hazlewood submitted that Person A is the subject of charges 4 and 5 which pertain to allegations of a sexual nature. Ms Hazlewood referred the panel to Rule 23 (1) (e) which stated:

> *23. (1) In proceedings before the [Fitness to Practise] Committee, the following may be treated as vulnerable witnesses -*
>
> …

(e) any witness, where the allegation against the registrant is of a sexual nature and the witness was the alleged victim; or

Mr Wylde, on your behalf, did not oppose the application.

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

The panel took account of the nature of charges 4 and 5. Further it noted that you did not oppose the application. The panel therefore determined to allow the application for special measures to be provided for Person A.

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

While cross-examining Person A, Mr Wylde made a request that the parts of his cross-examination, that pertain to allegations of a sexual nature, be held in 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 Hazlewood did not oppose 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 the allegations of a sexual nature relating to Person A, the panel determined to hold those parts of the hearing in private.

Submissions on application for no case to answer

At the close of the NMC's case, the panel heard an application made by Mr Wylde, on your behalf, that there is no case to answer in respect of charges 2, 3a(i), 4b, 7b and 7c.

With regards to charge 2, Mr Wylde referred the panel to Witness 1's witness statement. Witness 1 stated that your Identification and Referral to Improve Safety (IRIS) log of the incident was *"broadly accurate"*, the inaccuracies related to the discrepancy between what was recorded and what was observed on the CCTV footage.

Mr Wylde reminded the panel that Witness 1, under cross examination, accepted that your entry on the IRIS log reflected what was seen on the CCTV. He further submitted that in response to panel questions, Witness 1 stated that she would have expected more detail within the IRIS log but accepted that this was something that you could have added later, but that was not possible due to police intervention.

Mr Wylde also submitted that the panel could consider "The Investigation summary and summaries of discussions (Patient A)." However, he submitted that this is hearsay from a doctor who is not present to give evidence and therefore the evidence from this summary is untested.

Mr Wylde submitted that a properly directed panel cannot be satisfied to the required standard that the IRIS log is an inaccurate reflection of what happened and is not lacking in such detail that could be considered inaccurate. He invited the panel to find that you have no case to answer in respect of this charge.

With regards to charge 3a(i), Mr Wylde submitted that, based on the CCTV footage of the incident, you approached Patient D from the front as opposed to from behind as described in the charge.

Mr Wylde invited the panel to find that you have no case to answer in respect of this charge.

With regards to charge 4b, Mr Wylde referred the panel to Person A's witness statement. Person A stated that you picked her up from behind and *"attempted"* to put her on the scales. Mr Wylde submitted that Person A repeated this under cross-examination.

Mr Wylde submitted that there is no evidence that you placed Person A "on the weighing scale", as described in the charge, and invited the panel to find that you have no case to answer in respect of charge 4b.

With regards to charge 7b, Mr Wylde reminded the panel that "failure" as described in the charge, requires there to be evidence of a positive duty, taken from a policy document, training document or care plan and evidence that the duty had been breached.

Mr Wylde submitted that there is no evidence provided of a duty to disengage from Patient E as none of the aforementioned pieces of evidence mentioning "disengagement" or similar words have been provided.

Mr Wylde invited the panel to find that you have no case to answer in respect of this charge.

With regards to charge 7c, Mr Wylde submitted that there is no evidence that any alleged antagonism of Patient E was "to escalate the situation" as described in the charge. He reminded the panel that Person A when questioned replied that you did antagonise Patient E but offered no other evidence.

Mr Wylde invited the panel to find that you have no case to answer in respect of this charge.

Ms Hazlewood opposed the application. With regards to charge 2, she submitted that the IRIS log the panel has before them is inaccurate. She submitted that there is no evidence to demonstrate that the ability to change the IRIS log absolves your responsibility to ensure that the IRIS log is accurate.

Ms Hazlewood referred the panel to the charge 10.2 of the NMC code of professional conduct: standards for conduct, performance and ethics (2004)' (the Code) which stated:

> ***'10 Keep clear and accurate records relevant to your practice***
>
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
>
> *To achieve this, you must:*
>
> *10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.'*

Ms Hazlewood reminded the panel of Witness 1's oral evidence where she stated that your IRIS log was not clear or reflective of the events and should have been more descriptive about what restraint you applied.

Ms Hazlewood also referred the panel to "The Investigation summary and summaries of discussions (Patient A)." which stated that the IRIS report did not reflect the events accurately and is not corroborated by others present in full.

Ms Hazlewood submitted that the panel has evidence before it pertaining to the concerns raised in the charge.

With regards to charge 3a(i), Ms Hazlewood submitted that the CCTV footage demonstrated that Patient D's left shoulder drops to the right and appears to make a turning motion and you come from Patient D's left side of the dropped shoulder. She submitted that it can be inferred that you approached Patient D from behind.

With regards to charge 4b, Ms Hazlewood referred the panel to Person A's evidence. She also reminded the panel that under cross examination, Person A stated that you physically picked her up and tried to place her on the scale. She submitted that Mr Wylde is relying on the discrepancy that Person A changed her position to state that you tried to put her on the scale.

Ms Hazlewood submitted that discrepancies in evidence in a case with a charge of this nature are not unfamiliar and not a reason for it to fall away.

With regards to charge 7b, Ms Hazlewood referred the panel to Person A's witness statement. She referred to Mr Wylde's submissions where he stated that allegations of a "failure" requires evidence. Ms Hazlewood submitted that the panel does have evidence and referred it to Person A's witness statement. She reminded the panel that Person A's oral evidence was consistent with her witness statement stating that you failed to disengage.

Ms Hazlewood submitted that Person A's evidence is consistent and enough to support the charge.

With regards to charge 7c, Ms Hazlewood submitted that Mr Wylde's submissions are a direct contradiction to Person A's evidence. She submitted that Person A described the entire incident with great detail and was consistent in her oral evidence. She submitted that Person A, under cross examination, did not waiver from her account.

Ms Hazlewood submitted that the panel have sufficient evidence to find that you have a case to answer in respect of this charge.

Mr Wylde responded to the submissions of Ms Hazlewood.

With regards to charge 2, Mr Wylde reiterated that when he took Witness 1 through the CCTV, she accepted that your IRIS log matched with what was shown on the CCTV. He submitted that the NMC's evidence is tenuous.

Mr Wylde submitted that the Code is not a matter for the fact stage but rather the misconduct stage. With regards to code 10.2, he submitted that colleagues would have all the information they needed in relation to the incident. He submitted that the IRIS log was accurate as accepted by Witness 1.

With regards to charge 3a(i), Mr Wylde replayed the CCTV footage and submitted that you are in front of Patient D and walked towards him. He referred to Ms Hazlewood's submissions and submitted that coming from Patient D's left side is not coming from behind.

With regards to charge 4b, Mr Wylde submitted that Person A has been consistent with the fact that she was not placed on the scales at any point. He submitted that, under cross examination, she stated you physically picked her up and tried to put her on the scales. He reminded the panel of what the charge says and submitted that it has not been made out.

With regards to charge 7b, Mr Wylde submitted that the NMCs only evidence to support the charge is Person A's account which is an opinion. He submitted that it is a training document, policy or care plan that would provide the duty.

With regards to charge 7c, Mr Wylde submitted that the key point he is addressing is the escalation of the incident.

Decision and reasons on application of no case to answer

The panel heard and accepted the advice of the legal assessor. He referred the panel to the NMC Guidance headed "Evidence" with particular focus on the sub-heading "No case

to answer". He also referred to the test set out in the case of *R v Galbraith (1981) 73 Cr App R 124.* Which stated:

- *If there is no evidence that the crime alleged has been committed by the defendant there is no difficulty. The Judge will of course stop the case.*
- *The difficulty arises where there is some evidence but is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistence with other evidence.*
- *Where the Judge comes to the conclusion that the prosecutor's evidence taken at its highest is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made to stop the case ;*
- *Where, however, the Crown's evidence is such that its strengths or weaknesses depends on the view taken of a witness's reliability or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which a jury could [not would or should] properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury. There will of course, as always in this branch of the law be borderline cases. These can safely be left to the discretion of the Judge.*

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decisions, the panel made an initial assessment of all the evidence that had been presented to it at this stage. It considered the evidence at its highest, taking into account its strength and its weaknesses. The panel was solely considering whether sufficient evidence had been presented, such that a properly directed panel could find the charge proved and therefore whether you had a case to answer.

Charge 2

2. Recorded an inaccurate account of Patient A's physical restraint on 25 May 2020 on the referral to improve safety (IRIS) system.

Witness 1 in her witness statement stated:

> *"…I reviewed the CCTV and the IRIS incident report…The Hospital's security team and I reached the consensus that although the IRIS for the incident was broadly accurate, there were some concerns with the information recorded in the IRIS…The inaccuracies mainly related to the variance between the timeline of the events as recorded in the IRIS from that observed on the CCTV."*

The panel bore in mind that it had viewed the CCTV footage of the incident during Witness 1's oral evidence. Further, Witness 1 in her oral evidence said that the IRIS record was "lacking". It also took account of your IRIS report and particularly noted that next to the heading "Clinical Note" there is a sub-heading which is entitled "How did it finish" in relation to the incident. You have stated:

> *"[Patient A] then moved forward in an aggressive punching out at Bank Healthcare Worker…then moved to take the arms of [Patient A] who was hitting out and ended on the floor in an unplanned intervention."*

The panel bore in mind that for something to be accurate, it has to be exact particularly in respect of its importance to fellow practitioners. Based on the CCTV footage it had seen, it was of the view that the IRIS record falls short of being completely accurate. Therefore, by omission, this appears to be an incomplete record.

Applying the test in *Galbraith*, the panel concluded that based on the evidence of Witness 1 and the CCTV footage, a reasonable panel, properly directed, could find charge 2 proved.

In these circumstances, you have a case to answer in respect of this charge.

Charge 3a(i)

3. On 11 March 2020 in relation to Patient D
    a. Used an inappropriate method of restraint in that you:
        i. approached Patient D from behind.

The panel bore in mind that Ms Hazlewood and Mr Wylde agreed that in order for there to be a case to answer, in respect of this charge, the NMC had to establish that you approached Patient D from behind.

The panel based on the evidence before it, particularly upon viewing the CCTV footage, were not sufficiently satisfied that the approach on Patient D came from behind.

Applying the test in *Galbraith*, the panel concluded that no reasonable panel, properly directed, could find this charge proved.

In these circumstances, a charge based on the direction of your approach in relation to inappropriate methods of restraint could not be made out and you have no case to answer in respect of this charge.

Charge 4b

4. On one or more occasions, without Person A's consent or professional and/or practical reason to touch her:
    b. Picked Person A up from behind and placed her on the weighing scales.

Person A in her witness statement stated:

"[Mr Hoskins] picked me up from behind and attempted to put me on the scales."

The panel bore in mind that Person A in her oral evidence consistently, and on multiple occasions, stated that you picked her up and tried to place her on the scales.

Looking at the evidence in respect of this charge, the panel took account of Person A's evidence, where she stated you had picked her up from behind and attempted to place her on the scales. However, it noted that her evidence was quite clear in that she stated you never placed her on the weighing scale as described in the charge.

Applying the test in *Galbraith*, the panel concluded that no reasonable panel, properly directed, could find this charge proved.

In these circumstances, a charge based on you picking Person A up from behind and placing her on the weighing scales could not be made out and you have no case to answer in respect of this charge.

7. On one or more occasions acted in a manner that was confrontational in that you:
    b. Failed to disengage with Patient E.
    c. Antagonised Patient E to escalate the situation.

Person A, in her witness statement stated:

> *"[Mr Hoskins] told Patient E that they could not bring their speakers into the communal lounge, following which a back and forth conversation took place between Patient E and [Mr Hoskins]…The conversation escalated into an argument…[Mr Hoskins], who was actively participating in the argument, walked away from Patient E and then came back again. I felt as though I was watching the kind of argument I expect to see on the streets, not within a Hospital environment between a patient and nurse…*
>
> *In situations such as the above incident, I would expect [Mr Hoskins] to disengage from any confrontation in order to de-escalate the patient, but [Mr Hoskins] kept*

coming back and antagonising Patient E. I felt that the way in which [Mr Hoskins] dealt with Patient E was unprofessional and that [Mr Hoskins]'s failure to disengage or allow me to take over led to the confrontation escalating."

The panel bore in mind that it only had the evidence of Person A. It also bore in mind that the stem of this charge alleged that you acted in a manner that was confrontational. It particularly noted that Person A described the argument between yourself and Patient E as something she would *"expect to see on the streets, not within a Hospital environment between a patient and nurse".*

In light of the above, the panel was satisfied that there is sufficient evidence to suggest that the incident required you to disengage with Patient E and not antagonise him.

The panel considered that there would be a duty for an experienced nurse not to antagonise patients. Further, it was of the view that there would be an expectation for an experienced nurse to disengage and not actively participate in an argument with a patient.

Applying the test in *Galbraith*, the panel concluded that based on the evidence of Person A, a reasonable panel, properly directed, could find charges 7b and 7c proved.

In these circumstances, you have a case to answer in respect of these charges.

After the panel handed down its decision, Mr Wylde informed the panel that you had accepted charge 2.

The panel therefore finds charge 2 proved in its entirety, by way of your admission.

Decision and reasons on facts

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

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: At the relevant time, Lead Nurse at the Hospital;
- Witness 2: Management of Violence and Aggression Director at Elysium Healthcare;
- Person A: Senior Support Worker at the Hospital;

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

- Witness 3: At the relevant time, a Charge Nurse at the Hospital.
- Witness 4: At the relevant time, a Healthcare Assistant.

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.

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

Charge 1a(i)

That you, a registered nurse

1. On the 25 May 2020 in relation to Patient A:
    a. Used an inappropriate method of restraint in that you:
        i. moved behind Patient A.
        ii. placed your arm around Patient A's upper chest/neck.
        iii. pulled Patient A backwards.

This sub-charge is found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and your evidence.

The panel bore in mind that at the outset of this hearing, you accepted that you had moved behind Patient A during the incident on 25 May 2020. This is also confirmed by the CCTV footage of the same incident which the panel has seen.

The panel also noted that in the CCTV footage of the incident, you placed your arm around Patient A's upper chest and pulled him backwards.

The panel turned to the stem of the charge. It now had to make a determination as to whether your actions as described above were an inappropriate method of restraint.

Witness 2 in his witness statement stated:

> *"When I provide opinions on MVA incidents, I look at whether the response of staff members was both necessary and proportionate to the individual incident*
>
> *In my opinion, the Nurse's conduct in relation to this incident was unnecessary and disproportionate to the given situation. In the given situation, as observed, I would have expected staff members to initially approach in a team formation and to engage in secure standing arm holds, with a staff member securing ether arm and with a view of immobilising the patient's upper limbs, as it appeared that the other member of staff tried to do. As Patient A was not moving fast and did not appear particularly strong I would have thought this to be the best approach based on the previous training provided. Staff would then have been able to initially immobilise the upper limbs and thereafter redirect and walk Patient A to more appropriate and less stimulating area where appropriate de-escalation strategies could be employed. In my opinion there was no need for the Nurse to take Patient A to the floor.*
>
> *In addition to the fact that I consider the Nurse's decision to take Patient A to the floor unnecessary, the way in which it was done was not in line with MVA training, as the Nurse appeared to pull Patient A from their feet backwards, almost throwing them to the floor. A controlled team descent to the floor is an MVA manoeuvre within the core curriculum and the localised training programme."*

The panel also bore in mind that Witness 2 was shown the CCTV footage of the incident during his oral evidence. He confirmed that your actions in relation to this charge were not a Management of Violence and Aggression (MVA) recognised technique of restraint. He

also stated that, in restraining Patient A, you should have gone for his left arm as opposed to the neck or the chest.

The panel bore in mind that while you accepted that you had moved behind Patient A, you denied that it was an inappropriate method of restraint. You stated that your actions within this charge are in the context of you attempting to neutralise Patient A's left arm which he was using in an attempt to strike you and your colleague. You stated that you initially would take the left arm, but made a dynamic clinical assessment to change to Patient A's striking arm.

You also stated that you did not pull Patient A backwards, rather that after Patient A had thrown a punch at you, he had lost his balance and your momentum in trying to restrain him caused the fall.

The panel noted that Patient A was vulnerable due to him being elderly and frail. Additionally, it took account of the fact that you had accepted charges 1b and 1d. The panel was of the view that these actions were inappropriate. With this in mind, the panel was of the view that you used excessive force in restraining Patient A and your actions, as described in this charge, were an inappropriate method of restraint.

The panel therefore finds this sub-charge proved.

Charge 1c

That you, a registered nurse

1. On the 25 May 2020 in relation to Patient A:
    c. Continued to restrain Patient A when it was not clinically justified.

This sub-charge is found not proved.

In reaching this decision, the panel took account of the CCTV footage of the incident, the evidence of Witness 4 and your evidence.

In your oral evidence, you stated that Patient A was still mumbling words aggressively when he was on the ground. You stated that you could not see the struggle in his legs and that Witness 4 had secured his legs.

However, Witness 4 in her oral evidence stated that she ran to assist you and held the bottom of Patient A's legs. She stated that this was not necessary in hindsight as Patient A was not moving his legs aggressively.

Upon viewing the CCTV footage of the incident, the panel can see that you are still restraining Patient A whilst he is on the floor. Further, it also appears that Patient A continues to struggle with his arms while being restrained. The panel bore in mind that you stated in your oral evidence that you were undertaking a dynamic risk assessment. While the panel accept that the CCTV footage does not have sound, it appears that you are talking to Patient A and members of staff. As soon as you have finished talking you assisted Patient A to stand up.

In light of the above, the panel was of the view that the CCTV footage appeared to support your version of events. It considered that the incident continued and as a result, it would have been clinically justified to restrain Patient A while the dynamic risk assessment was ongoing.

The panel reminded itself that it is for the NMC to prove the charge. However, the panel does not have any documentary evidence before it nor any oral evidence from the NMC's witnesses to suggest that it was not clinically justified to continue to restrain Patient A in these circumstances.

The panel therefore finds this sub-charge not proved.

Charge 1e

That you, a registered nurse

1. On the 25 May 2020 in relation to Patient A:
    e. Put Patient A at unnecessary risk of harm.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1.

Witness 1 in her witness statement stated:

> *"The Nurse's restraint of Patient A had the potential to cause harm. Beyond the physical harm which it did cause to Patient A, it could have been psychologically harmful for both the patient and the staff. It could have caused trauma. In addition, it had the potential to cause physical harm to the staff involved in the incident.*
>
> *I started to hear more about Patient A's injury, which was identified as a fracture to their hip…"*

Witness 1 confirmed in oral evidence that Patient A had indeed fractured his hip during the restraint.

The panel considered that when a patient needs restraint, there is inevitably going to be a risk of harm. However, it bore in mind that it had found that you used an inappropriate method of restraint pertaining to Patient A. It also bore in mind that you accepted charges 1b and 1d. In the panel's view, the amount of force used increased the risk of harm to Patient A and subsequently, Patient A suffered a fractured hip.

In light of the above the panel concluded, on the balance of probabilities, that on 25 May 2020 you put Patient A at unnecessary risk of harm.

The panel therefore finds this charge proved.

Charge 1f

That you, a registered nurse

1. On the 25 May 2020 in relation to Patient A:
    f. Failed to try alternative de-escalation strategies.

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 1, the CCTV footage, and your evidence.

Witness 1 in her witness statement stated:

> *"There is a policy for dealing with violence and aggression at the Hospital known as Elysium Safe and Therapeutic Management of Violence and Aggression... Nurses ought to engage with the patient, de-escalate the situation verbally and remove any individuals who may be triggering the agitation, before resorting to MVA. Other methods which could be used prior to physical restraint would include self soothe work, one-to-one support and medication. The application of restraint should be a last resort where, if not used, there is a risk of the patient causing harm to themselves or someone else."*

In your oral evidence, you stated that during the incident you did try alternative de-escalation strategies. You said that you tried to persuade Patient A to go to his bedroom.

The panel took account of the CCTV footage. It noted that before the attempted restraint of Patient A, you appear to make appeasing nonaggressive hand gestures. Further, it can see you pointing to your keys which supports your account that you had tried to persuade Patient A that you would unlock his room so he could go there. The panel also noted even when Patient A is approaching you, it appears that you are still making verbal de-escalation attempts.

The panel also considered that Witness 2, in his oral evidence, accepted that the behaviour of staff members during the incident would indicate that they were also trying to diffuse the situation.

The panel also bore in mind that it in charge 1c, it found that you were undertaking a dynamic risk assessment while restraining Patient A which would have included verbal de-escalation techniques.

While the CCTV footage did not have sound, it noted that it appeared to support your version of events in relation to this charge. It accepted that you were attempting a number of de-escalation strategies and went to restrain Patient A as a last resort.

In light of the above the panel concluded, on the balance of probabilities, that on 25 May 2020 you did try alternative de-escalation strategies.

The panel therefore finds this charge not proved.

Charge 3a(ii)

That you, a registered nurse

3. On 11 March 2020 in relation to Patient D
    a. Used an inappropriate method of restraint in that you:
    ii. placed your arm around Patient D’s upper chest/neck.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and your evidence.

Witness 1 in her witness statement stated:

> *"Based on reviewing the CCTV footage of the incident on 11 March 2020, my understanding of the incident is as follows. Patient D was in the communal area of the ward without their top on, and appears to be asked to put their top on. Patient D then has an aggressive outburst, throwing water at the staff members. At this point Patient D is placed in safe arm holds. Patient D appeared to be very aggressive and overpowering the staff who had them in holds, one of whom was the Nurse. The Nurse looks to lost control of Patient D's left arm and attempts to get it back. In doing so, the Nurse puts their arm around the back of Patient D's head/neck..."*

Witness 2 in his witness statement stated:

> *"The staff members struggle with Patient D for a short period and are unable to secure arm holds and a scuffle breaks out between Patient D and the staff members. Patient D breaks free from the staff holds and the situation moves across the room, the Nurse approached Patient D, moves down towards their side and behind them, puts their arm around Patient D's upper chest…"*

In your oral evidence, you stated that you did not intentionally place your arm around Patient D's chest/neck area. You did state that from looking at the CCTV, your arm brushed his chest area briefly, but this was not intentional.

The panel took account of the CCTV footage. It was of the view that it was quite clear that you had your arm around Patient D's upper chest/neck area.

The panel turned to the stem of the charge. It now had to make a determination as to whether your actions, namely placing your arm around Patient D's upper chest/neck was an inappropriate method of restraint.

The panel took account of Patient D's care plan. Within the section entitled "If I need to be restrained I prefer to be restrained by" it stated:

> *"If Patient D is placing himself and/or others at immediate risk and all above interventions have failed, staff should engage in approved MVA techniques"*

The panel also noted that Witness 2 in his witness statement stated:

> *"…the technique deployed by the Nurse was not in line with the MVA training provided, or included in the core curriculum developed by GSA."*

Witness 2 reiterated this in his oral evidence and confirmed, during questions from the panel, that reasonable force was not used in relation to Patient D.

The panel, having already viewed the CCTV footage for itself, and coming to the conclusion that you placed your arm around Patient D's upper chest/neck, preferred the evidence of Witness 2. It was determined that you used an inappropriate method of restraint on Patient D.

The panel therefore finds this charge proved.

Charge 3a(iii)

That you, a registered nurse

3. On 11 March 2020 in relation to Patient D

a. Used an inappropriate method of restraint in that you:
iii. pulled Patient D backwards to the floor.

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and your evidence.

Witness 1 in her witness statement stated:

> "*The Nurse looks to lost control of Patient D's left arm and attempts to get it back. In doing so, the Nurse puts their arm around the back of Patient D's head/neck, from their front, and the momentum brings them both to the floor, with Patient D descending in the prone position face up."*

Witness 2 in his witness statement stated:

> *"The staff members struggle with Patient for a short period and are unable to secure arm holds and a scuffle breaks out between Patient D and the staff members. Patient D breaks free from the staff holds and the situation moves across the room, the Nurse approached Patient D, moves down towards their side and behind them, puts their arm around Patient D's upper chest/neck and pulls them backwards to the floor…"*

In your oral evidence, you denied pulling Patient D to the floor. You stated that you stumbled during the descent and moved your body across his back so that he did not hit the furniture so you could protect him.

The panel took account of the CCTV footage. It was of the view that you did not pull Patient D backwards to the floor. Rather, you both fell forwards in what appears to be an unplanned descent to the floor.

The panel therefore finds this charge not proved.

Charge 3c

That you, a registered nurse

3. On 11 March 2020 in relation to Patient D
    c. Put Patient D at unnecessary risk of harm.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and your evidence.

The panel bore in mind that in relation to charge 3a(ii) it had found that you used an inappropriate method of restraint in that you placed your arm around the Patient D's upper neck/chest. It was assisted in coming to this conclusion by the CCTV and the evidence of Witness 2 who confirmed that the technique you used was not in line with the MVA training provided.

In light of the above, the panel determined that your attempt to immobilise Patient D put him at an unnecessary risk of harm as it was not in line with the MVA training.

The panel therefore finds this charge proved.

Charge 3d

That you, a registered nurse

3. On 11 March 2020 in relation to Patient D

d. Put colleagues at unnecessary risk of a harm.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and your evidence.

Witness 2 in his witness statement stated:

> *"The Nurse's use of this inappropriate technique. I feel, risked injury to Patient D…and the supporting staff/Nurse who went down with them. If the Nurse used the appropriate technique to move Patient D to the floor, with the assistance of other staff members, the risk of injury would, I feel, be significantly lower, especially with a full staff team including a head person to support and protect the patients head during the descent."*

The panel bore in mind that you stated in your oral evidence that you did not intentionally place your arm around Patient D's chest/neck area. You did state that from looking at the CCTV, your arm brushed his chest area briefly but that this was not intentional.

The panel considered that while you tried to immobilise Patient D you used an inappropriate technique. In doing so, and unintentionally, you have both fallen to the floor.

The panel also noted that Witness 4 in her oral evidence stated that she did not believe you put colleagues at risk during the course of the incident. She stated that she felt you were trying to keep colleagues safe.

However, the panel also bore in mind that in your oral evidence, you stated that a member of staff was headbutted during your restraint of Patient D. The panel saw that this was evident in the CCTV footage. It was of the view that this occurred because the technique used to restrain Patient D failed.

The panel was of the view that due to the nature of the incident and the fact that a colleague was injured, you had put colleagues at unnecessary risk of a harm.

The panel therefore found this sub-charge proved.

Charge 3e

That you, a registered nurse

3. On 11 March 2020 in relation to Patient D
    e. Failed to ensure that verbal de-escalation techniques were applied prior to any restraint.

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Person A, Witness 4 and your evidence.

Person A in her witness statement stated:

> *"When I arrived on Mendip Ward, I found Patient D sat on the sofa with their top off. The Nurse was also present. I recall the Nuse saying "put your top back on" , or words to that effect, to which the patient responded that they were hot. The Nurse then said to Patient D that if they did not put their top back on they would have to move to de-escalation, however, Patient D appeared to mishear this and I believe they thought the Nurse has said seclusion. Even though the Nurse corrected Patient D, explaining that they did not say seclusion, Patient D became agitated…I did not feel that, at that time, Patient D posed any threat to us or their peers, as they were just sat on the sofa, so I offered to speak to them to verbally de-escalate but the Nurse would not let me…*

…As above, Hospital policy I that restraint should be a last resort, so an attempt to verbally de-escalate Patient D should have been made before any staff put hands on them. However, there was no attempt at verbal de-escalation before the Nurse gestured for hands to go on, despite me trying to offer to speak to Patient D. I thought this was the wrong approach."

However, Witness 4 in her witness statement stated:

"On the day of the restraint, I do not recall the reason why he ended up being restrained. My assumption is that he was being aggressive in some way as response was called and [Mr Hoskins] was speaking to him, trying to verbally de escalate him. I was standing behind him when he was being talked to and he was sitting on the sofa in the communal lounge."

The panel took account of your oral evidence. It noted that you explained your approach in attempting to de-escalate the situation. You stated that by leaning against the counter at some distance away from Patient D, you were trying not to invade his space and prevent escalation. You stated that in a potentially hostile situation you want to show that you are in a calm manner and relaxed giving clear instructions. You said that when you moved forward you just wanted to make sure that Patient D could hear your instructions. You said that there was no attempt to antagonise Patient D, you were trying to de-escalate the situation.

You also denied that Person A tried to intervene.

The panel took account of the CCTV footage. While it noted that there was no sound, it is clear that you are talking with Patient D while you are some distance away leaning on the sink with your legs crossed. It was apparent to the panel that you had a relaxed demeanour. The panel was of the view that the CCTV footage supported your version of events.

The panel therefore finds this charge not proved.

Charge 3f

That you, a registered nurse

3. On 11 March 2020 in relation to Patient D
    f. Failed to ensure Patient D's care plan was followed.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and your evidence.

Witness 1 in her witness statement stated:

> *"As shown in Patient D's care plans…Patient D has a lengthy history of violence and aggression and a diagnosis of Schizoaffective Disorder. Patient D can became intrusive when agitated and this could be perceived as an intimidating behaviour. Staff should therefore be mindful of this to prevent assault. Patient D also has an identified MVA care Plan which they were involved in and identifies a least restrictive approach and the utilisation of seated de-escalation in the first instance. If deemed necessary, due to the level of risk, the MVA care plan identifies the utilisation of MVA techniques. These must be within the GSA approved techniques and used for the shortest time possible."*

The panel bore in mind that in your oral evidence, you confirmed that you were aware of Patient D's care plan and the traffic light system. Within the care plan, there is a section which stated:

"Red strategies: Crisis Phases
Patient D: behaviour may deteriorate further and result in

- *Intimidating behaviour towards staff and/or peers*
- *Throwing drinks over individuals"*

The panel noted that during the incident, it was identified that Patient D was in the red zone. It also noted that Patient D had thrown a drink at staff.

The panel took account of Patient D's care plan. Within the section entitled "If I need to be restrained I prefer to be restrained by" it stated:

"Staff are to continue using a firm and calm approach in an attempt to de-escalate Patient D…

The panel also noted within the care plan that this is what is expected from staff if Patient D is in the red zone. Additionally, staff were to offer Patient D time to calm himself down in a low stimulus environment.

In your oral evidence you stated that Patient D was not responding to your more assertive approach in asking him to put his top on so you offered him to go to the de-escalation area. In light of this, and finding Charge 3e not proved, the panel was of the view that this aspect of Patient D's care plan had been followed.

However, the panel also noted that Patient D's care plan also stated:

" If Patent D is placing himself and/or others at immediate risk and all above interventions have failed, staff should engage in approved MVA techniques"

The panel bore in mind that it had found, in charge 3a(ii) proved, that you had used an inappropriate method of restraint in placing your arm around Patient D's upper chest/neck. It also noted that Witness 2 in his witness statement stated:

"…the technique deployed by the Nurse was not in line with the MVA training provided, or included in the core curriculum developed by GSA."

The panel was of the view that while steps were taken to ensure that Patient D's care plan was followed, it was only followed partially. Overall, it determined that by only partially following Patient D's care plan you fell short in ensuring it was followed in its entirety.

The panel therefore finds this charge proved.

Charge 4a, 4c and 4d

That you, a registered nurse

4. On one or more occasions, without Person A's consent or professional and/or practical reason to touch her:
    a. Touched Person A's thigh.
    c. Touched Person A's breasts.
    d. Attempted to kiss Person A.

These sub-charges are found not proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Person A, Witness 3 and your evidence.

The panel bore in mind that the evidence to support these sub-charges come from the account of Person A. There is no independent documentation and no other witnesses to these sub-charges. You have denied that this incident ever occurred.

In light of the conflicting accounts, the panel noted that a key factor in determining whether these sub-charges are proved or not proved would come down to the credibility of Person A and yourself.

Person A in her witness statement stated:

> *"These verbal comments escalated to the Nurse sexually harassing me, about halfway through our working relationship. I was in the office sat at the computers with the Nurse when they touched my thigh. I immediately told them to stop but they touched my thigh twice more and I stood up and left the office. We were the only two people in the office at the time."*

Person A was cross examined by Mr Wylde. Person A stated that this took place *"roughly near Christmas time, around November/December, I think maybe December time, early January"*. While she could not recall the exact date, she stated that this incident occurred in the afternoon.

The panel also noted that Person A, in cross examination, stated that while in the office she was not talking to you, she was working on the computer. Person A also stated that sometimes she hated working with you due to how you treated her.

However, when the panel further questioned Person A, she accepted there was a lot of "banter" and "joking about sex in general" and stated that you were being quite flirtatious. Person A also stated that while it was an awkward situation to be in, she stated that she ignored it and laughed. Person A stated that this is what led up to you actually touching her. The panel found this to be inconsistent with her original responses in cross examination.

The panel also noted that Person A's recollection of the actual event was not entirely clear. She stated that when you placed your hand on her thigh, she thought she moved your hand away. She also stated that she thought she may have stayed and worked

because she had a lot of work to get done. Person A followed this up by saying that she believed you may have put your hand back on her thigh and she removed it again but could not be completely sure.

Person A in her witness statement further stated:

> *"On another occasion, I was assisting the Nurse administer medication in the clinic. After this the hatch was closed so we were in the room by ourselves. This is standard practice so that we can count the medication, which was a two person job…I then turned my back to the Nurse to write something down. They came up from behind me, grabbed both of my breasts and attempted to kiss me. I was shocked and told them to get off, which they did. I felt uncomfortable and continued to work until I could leave."*

Person A in response to panel questions described your actions in this regard. She stated that you came from behind her, grabbed her breasts and tried to kiss her. Person A could not recall where you tried to kiss her. The panel also questioned the mechanics of this event and considered that it would be difficult to kiss someone from behind.

During Person A's oral evidence, under cross examination the panel heard of an incident that occurred on a night out on 18 May 2019. This, according to Person A's timeline of events, would have been after the events described in the sub-charges.

There are conflicting accounts as to what transpired. In assessing witness credibility, the panel began looking at the accounts of independent witnesses in relation to the night out.

In cross examination, Mr Wylde asked Person A about a night out on 18 May 2019 that your work colleagues had arranged. Person A confirmed that this night out included herself, you and Witness 3. It initially started at a Wetherspoons public house and then moved onto a club called Zinc. Mr Wylde put it to Person A that she made unwanted advances to you, Witness 3 and other male members of staff. Mr Wylde also put it to

Person A that after her advances were rejected, she became abusive. Person A denied this and said that it was not true.

Mr Wylde put to Person A that she was inebriated that evening. Person A stated that they had all been drinking that evening. The panel also noted that during panel questions, Person A volunteered the fact that she had “a few to drink” which included a gin and tonic. However, she denied going to club Zinc and stated that she had gone home after going to Wetherspoons due to being inebriated.

In your oral evidence, you stated that the atmosphere was relaxed during the night out on that evening on 18 May 2019, until Person A became inebriated. You then stated that Person A suggested that you take her home so you could “sleep together”. You stated that this was directed at you and then it went on to several other men later on in the night. You stated that the more intoxicated and disinhibited Person A became, the more advances she made. You then stated that her behaviour became more abusive and derogatory the more the night went on until you had to pull her to one side and speak to Person A about her behaviour which you deemed to be unacceptable.

Witness 3 appeared to support your version of event. Witness 3 in his witness statement stated:

> *“On the 18/05/2019 a number of work colleagues arranged to meet, whereby a member of staff, Person A joined us. I remember being at a pub Wetherspoon and following that at a club named ZINC as the night progressed. I have photographic evidence of all persons attending on my phone…At some point, Person A’s behaviours became very sexually inappropriate. She was making advances and swearing at a number of males within the group, including myself and Mr Hoskins…*
>
> *My relationship with Person A was purely professional. However, on the night being referenced, her overfamiliar and unwanted behaviours included making*

sexually suggestive comments to myself, Mr Hoskins and other male staff present."

The panel noted that Witness 3's witness statement came with a photograph of what he stated was of the night out on 18 May 2019. The picture had Person A, yourself and Witness 3 with other work colleagues. Witness 3 stated that the picture was taken at club zinc.

Witness 3 reiterated the details of his witness statement in his oral evidence. Witness 3 stated that Person A's behaviour was witnessed by his partner at the time which caused problems in his personal life. The panel found this to be compelling evidence and noted that his account appeared to support your recollection of the event.

The panel noted that Witness 3 was a band 8b senior nurse who was in a position of authority. Person A denied being at Zinc, while you and Witness 3 confirmed that she was and Witness 3 provided a photograph. The panel noted that you and Witness 3 no longer work together. Additionally, it noted that Witness 3 did not appear to have any grievance against Person A. It also considered that there was no reason for Witness 3, being a band 8b senior nurse, to lie to his regulator.

The panel also noted that you had stated that you made a complaint regarding Person A's behaviour on the night of 18 May 2019. This appeared to be supported by Person A in her witness statement where she stated:

"After sending the complaint letter I was invited to an interview with [the Wellbeing Lead] and another person…During the interview I felt as though I was being investigated. The fact that I had been on a staff night out with colleagues including the Nurse, was raised…"

In light of the above the panel accepted your account and the account of Witness 3 and, as a consequence, were not persuaded by Person A's account on the events on 18 May 2019.

The panel considered that the events on 18 May 2019 are a factor when considering the charges 4a, 4c and 4d. It bore in mind that Mr Wylde put to the panel that the events on 18 May 2019 appeared to trigger a series of complaints made by Person A about you including the allegations in this charge.

Person A in her witness statement then stated:

> *"Ultimately, I hated working with the Nurse, as I found them controlling and confrontational. At the time of my complaint, I did not complain about the sexual harassment as I knew it would be my word against the Nurse's word, and my main concern was with the Nurse's behaviour towards patients. In hindsight, I feel I should have included the sexual harassment in my complaint.*
>
> *I wanted to make a formal complaint…so I sent a letter setting out all of my concerns regarding the Nurse and sent it to [Witness 1] on 18 June 2019."*

The panel noted that a number of the matters were raised in Person A's letter, dated 18 June 2019. While allegations of sexist behaviour were included, the letter did not include the allegations described in charges 4a, 4c or 4d. In Person A's witness statement, she stated that she did not do this because it would be her word against yours. In cross examination, Person A confirmed that she did not make a contemporaneous professional record of the incident, nor did she report the matter.

The panel also noted that Person A, in cross examination, confirmed that she did not tell anybody about this including colleagues and only raised it when she was aware that you were being investigated by the NMC.

The panel bore in mind that Person A had made numerous complaints before. It noted that according to a document entitled “DH Concerns” Person A raised a complaint on 6 June 2019 in relation to *“inappropriate techniques and alleged sexist behaviour towards female colleagues.”* This is followed up by the aforementioned letter dated 18 June 2019. On 11 March 2020, Person A made a further complaint about you in relation to Patient D.

The panel considered that Person A appeared motivated to make formal and informal complaints. It bore in mind that Person A had stated in her witness statement that patients were her primary concern, *“my main concern was with the Nurse's behaviour towards patients”*.

However, despite this the panel noted that Person A had not raised the very serious allegations, contained within this charge, that would concern patient safety as well as the safety of female members of staff. Additionally, in cross examination, Mr Wylde put to Person A that the allegations could have had a direct impact on the safety of the female members of staff. In response to this, Person A stated, *“Possibly, but then that would be for them to make their decision on the route they wanted to go down and what they wanted to do. I can’t be responsible for everybody, all of the time, my colleagues in that respect, I mean.”*

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC’s evidence to support these sub-charges come from the account of Person A alone. There is no independent documentation and no other witnesses to support these sub-charges. It bore in mind that in cross examination when Person A described how you had placed your hand on her thigh, Person A stated that she was not talking and was working on the computer. However, when Person A was responding to questions from the panel, pertaining to the same incident, she stated that you were being flirtatious and joking, talking about sex in general. Person A then accepted that the event occurred a long time ago and that she could not remember exactly what happened. She stated that she could not recall if you made the comments to her and then touched her thigh or if you said nothing and then touched her thigh.

The panel considered the incidents described in the sub-charges to be serious. It would therefore have expected Person A's recollection of the incident to be vivid and the details of the allegations to have stayed with her. However, upon hearing Person A's account, it was of the view that her evidence lacked consistency.

The panel also noted that Person A appeared to be motivated to raise complaints about you, including a complaint pertaining to alleged sexual behaviour. However, when it came to very serious allegations, it noted that Person A did not raise a complaint at the time. Not only did she not raise a complaint, she did not tell anybody about it, not even other female members of staff in an attempt to warn them of your alleged conduct.

The panel noted that you have not provided an explanation of this incident, rather you have consistently reiterated that this event never occurred. It also noted that you have not sought to discredit Person A in denying the charge.

The panel does not believe Person A was trying to mislead the panel. However, the panel noted that the NMC had not provided the panel with information that supports the allegations described in the sub charges. This charge is not supported by any other documentation before the panel.

Therefore, the panel find these sub-charges not proved.

Charge 5

That you, a registered nurse

5. On one or more occasions, said to Person A or in the hearing distance of Person A
    a. Asked colleagues 'how many pints they would need to shag [Person A]', or words to that effect.

b. Stated ‘what do you want, our special relationship to stop?’, or words to that effect.
c. Stated ‘do you want me to stop flirting with you?’, or words to that effect.
d. Stated ‘come on, it’s going to happen at some point’, or words to that effect.
e. Took your top off, and asked Person A to give you a once over, to teach [Person A], or words to that effect.

These sub-charges are found not proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Person A and your evidence.

Person A in her witness statement stated:

> *“The Nurse was very sexually inappropriate towards me. I do not know whether they treated other female staff in this way or not but they did tell me that they had had sex with female colleagues in previous workplaces. I witnessed the Nurse and two other support workers, [Person B] and [Person C], making jokes about how many pints they would need to "shag" me. Whilst I was in the nursing office, I heard the Nurse pushing the two support workers to respond. I do not recall when this was. I felt that this was disrespectful and it made me feel very uncomfortable in my own workplace.*
>
> *After dealing with the Nurse's inappropriate comments and touching, I had had enough and told the Nurse to leave me alone. I found myself avoiding going into the clinic, where I would sort medications with the Nurse, as I knew that it would just be the two of us, and there were no cameras. I do not remember the exact date but I recall that, after I told the Nurse to leave me alone, they made comments such as "what do you want, our special relationship to stop?", "do you want me to stop flirting with you?" and "come on it is going to happen at some point", or words to*

that effect. I firmly told the Nurse that it was never going to happen and that I was not interested. I told them we only had a professional relationship and to focus on their pregnant partner. On another occasion, the Nurse told me that they did not feel well and asked if I wanted to give them a once over so they could teach me, as they knew I wanted to do my nurse training. They took their top off and I laughed trying not to take it too seriously. I then left the clinic…"

In cross examination, Person A accepted that there were no witnesses to these incidents. She stated that it was because you were "clever" and knew where the CCTV was so you would not have done what was described in the charges in front of others. While Person A reported some of these incidents, she also accepted that she did not report all of them. Person A stated that the reason she did not do this was because she would not be believed, and it would have been her word against yours.

You have denied that these incidents occurred.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support these sub-charges come from the account of Person A alone.

The panel bore in mind that in the witness statement of Person A, she had stated that two support workers, namely Person B and Person C, were present during the incident and making jokes along with you.

The panel took account of the "Complaint Investigation Report" provided by Mr Wylde. This report detailed an investigation undertaken by Person D, the Wellbeing Lead, based on the complaints Person A had made in her aforementioned letter, dated 18 June 2019. Under the heading entitled "Findings (facts established)" Person D has recorded the following:

"Conclusion for each element based on evidence:

Allegation that [Mr Hoskins] had an inappropriate conversation with [Person B] in the presence of the complainant and OTA [Person C] "over heard asking how many pints to shag her".

[Person B] has denied any knowledge of such a conversation. He has signed a statement to this effect.

[Person C] denied having any knowledge or recollection of this conversation."

The panel was mindful that this amounted to hearsay because neither Person D, Person B or Person C had attended to give evidence at this hearing nor provided a formal witness statement. As a result, there was no way to test the veracity of the contents within the report. However, panel noted that it appeared that both Person B and Person C were interviewed as part of an investigation which would have been undertaken near the time the allegations were made as it concluded on 29 July 2019. It noted that the contents of this report appeared to corroborate your account that the allegation made by Person A, namely sub-charge 5a had not occurred.

The panel also bore in mind that it had already found Person A not to be a credible witness. While it does not believe Person A was trying to mislead the panel, it noted that the NMC had not provided the panel with information that supported the allegations described in the remaining sub charges. This charge is not supported by any other documentation before the panel.

The panel therefore finds these sub-charges not proved.

Charge 6

That you, a registered nurse

6. On one or more occasions displayed an attitude that undermined female colleagues by:
    a. Indicating they could not do the job.
    b. Asking if they could handle patient confrontation.
    c. Stating the job was about strength not skills
    d. Intervening unnecessarily with patients when assistance was not requested.
    e. Choosing male colleagues over female colleagues when assistance was required.
    f. Asking Person A, in a sarcastic tone, if they thought they would be able to handle Patient F, if they kicked off

These sub-charges are found not proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Person A, Witness 4 and your evidence.

Person A in her witness statement stated:

> *"We found the nurse to be very sexist and it appeared to me from their attitude that they did not think females could do the job. They would make comments to me suggesting that I could not handle it if a patient started a confrontation. I also witnessed the nurse making suggestions that the job was about strength and not skill, again undermining the female members of staff. For instance, when I engaged with an agitated patient, the nurse would come and intervene, in my opinion unnecessarily.*
>
> *The Nurse's attitude towards female members of staff impacted upon my ability to do my job properly, as they would disregard women. For example, whenever there was a planned restraint to administer an IM to a patient already in seclusion, the Nurse would always choose the male member of staff to assist.*

An IM is medication which is administered as an injection as opposed to orally. It is done so that medication can be administered to patients even when they do not consent to the medication.

An example of an incident where the Nurse's sexist attitude impacted upon patient care is where Patient F was in seclusion and the Nurse would not allow me to go into the seclusion room with them. After a heated discussion the Nurse asked in a sarcastic tone whether I actually thought I would be able to handle Patient F if they kicked off. I recall that I was the only female member of staff present."

The panel took account of Person A's complaint letter dated 18 June 2019 and noted that there are references to "sexist behaviour towards female staff often physically pushing in front of female staff in a restraint situation".

In cross examination, Person A stated that you had discriminated on the basis of gender at work many times. She maintained that you chose male staff over female staff inappropriately. Mr Wylde put to Person A that presumably such behaviour would have been witnessed or experienced by others, particularly women. Person A stated that she did not know and "not everybody speaks up when it happens to them".

Witness 4, a HCA at the time of the incident, in her witness statement stated:

"I never felt discriminated by Darren due to my gender. He was always asking everyone before a restraint how they feel and what they feel comfortable to do, in a way to protect and ensure safety of the staff and the patients.

I never felt that he was choosing male staff over females, and he was always asking who would like to be involved in a planned intervention. I think he was trying to use a strengths-based approach, trying to utilise the members of staff that he thought they could handle the patient's aggression, again in a way to ensure safety and minimise risk. I think that was very important considering that most of the

patients were big, strong men that they were not easy to manipulate or hold down if needed.

…

During the time on Quantock, there were very few incidents and in general I remember that we were called the "dream team", as Quantock was working really well at the time.

I have worked with Darren for more than a year, and I have seen him trying to keep everyone safe and to go back to their homes without harm. He would be one of the few staff that were keeping professional boundaries and the patients knew that when he was on shift, they would be treated with respect.

He was honest and was able to build good rapport with patients and colleagues, creating a positive and satisfactory work environment. He was striving for safety and minimising risk, and I believe all his actions were stemming from that principle. There were times that he might have looked stressed, but normally he would laugh it out and continued joking to keep a positive environment."

In response to panel questions Witness 4 was asked what it was like working with you. Witness 4 stated that you were very consistent and had good boundaries therefore she would know she would be safe working on her shift.

In response to panel questions, you denied that you had undermined female colleagues by stating that the job was about strength and not skills. You said that you worked on Mendip Ward which was predominantly female staffed ward and stated that you valued your female colleagues. You said that you were always thankful for their skills and their level of commitment. You stated that it was not about physical strength, but rather individual staff capabilities and knowing what skill levels they have, regardless of whether they be male or female, and adapting those skills to each situation.

The panel took account of the aforementioned “Complaint Investigation Report” of an investigation undertaken by Person D based on the complaints made by Person A in her aforementioned letter, dated 18 June 2019. Person D has recorded the following:

> *“Allegation that Darren Hoskins…are sexist towards female staff in restraint situations and often take over during these incidents. - Darren has said that he assesses each situation before responding to it. In an interview, [staff member] has reported that sometimes the men lead and take over but also sometimes allow permanent female staff to restrain patients. There is evidence that this is inconsistent. Based on the above there is some evidence that during some situations the identified staff take over the restraint but it is difficult to understand the context of this. There is evidence that permanent female staff are preferred. However, the male staff who were interviewed have stated that they risk assess the situation and act based on this.”.*

The panel was mindful that this amounted to hearsay because neither Person D nor those interviewed had attended to give evidence at this hearing nor provided a formal witness statement. As a result, there was no way to test the veracity of the contents within the report. However, it is noted that the contents of this report appeared to support your account and the account of Witness 4.

The panel also bore in mind it had heard evidence that you were employee of the month soon after you had joined the hospital which was confirmed by Witness 1. It also noted that in your oral evidence you stated that you had three commendations, one of which related to your successful selection and management of an all-female team during an incident which was successfully de-escalated. Witness 1 stated she was aware that you had received these commendations.

The panel reminded itself that you were the Nurse in charge and had to make management decisions. It also noted that in evidence you stated that you were constantly undertaking risk assessments in order to keep patients and staff safe. The panel was of

the view that these management decisions may have come across as sexist to Person A, but you had to make a risk assessment as you had explained previously. Additionally, your comment regarding Person A being able to handle Patient F may have come across as sarcastic to Person A. However, it bore in mind that it heard evidence that there was a breakdown in your professional relationship with Person A. Further, Person A stated that in cross examination that she did not like working with you. It was of the view that this may have been a reason as to why your comment may have come across as sarcastic. Nevertheless, there insufficient evidence to support that this was said in a sarcastic tone.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support these sub-charges come from the account of Person A alone. There is insufficient evidence before the panel to support these sub-charges.

The panel also bore in mind that it had already found Person A not to be a credible witness. While it does not believe Person A was trying to mislead the panel, it noted that the NMC had not provided the panel with information that supported the allegations described in the sub charges.

In contrast, the panel found Witness 4 to be a credible witness. It was of the view that she had no reason to lie and described you as a supportive, fair member of staff and that you went out your way to make her feel safe. Further, Witness 4, stated in her witness statement that you were *"striving for safety and minimising risk, and I believe all his actions were stemming from that principle."*

The panel therefore finds these sub-charges not proved.

Charge 7

That you, a registered nurse

7. On one or more occasions acted in a manner that was confrontational in that you:
    a. Brushed patients away with hand gestures.
    b. Failed to disengage with Patient E.
    c. Antagonised Patient E to escalate the situation.

These sub-charges are found not proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Person A, Witness 4 and your evidence.

The panel noted that in order to find the charge proved, it would have to be satisfied that the actions described in the sub-charges were done in a manner that was confrontational.

Person A in her witness statement stated:

> *"Over approximately 18 months of working with the Nurse on Quantock Ward I found them to be very confrontational towards patients. The Nurse was regularly rude to patients and in my opinion would provoke patients. I also witnessed the Nurse 'brush patients off', using hand gestures to get them to go away on many occasions. I found that the Nurse would not use verbal de-escalation, leading to them needing to restrain patients far too often. The Nurse would also not listen to other staff members when we were trying to assist them with patients. All of this led to the Nurse having a confrontational attitude.*
>
> *…During the shift Patient E had been in their room and came out into the communal lounge and asked the Nurse, who was Nurse in Charge, if they could bring their speakers into the communal lounge to rap and listen to music with the other patients. It was known within the Ward that Patient E loved rapping and music, and would spend a lot of time writing music and raps. The Nurse told Patient E that they could not bring their speakers into the communal lounge, following*

which a back and forth conversation took place between Patient E and the Nurse, with Patient E explaining that their peers wanted to listen to the music, and the Nurse saying that not everyone wanted to. At this time, I was completing one to one observations of a patient and sat on a chair with that patient, within around a metre from the Nurse and Patient E. The conversation escalated into an argument…The Nurse, who was actively participating in the argument, walked away from Patient E and then came back again. I felt as though I was watching the kind of argument I expect to see on the streets, not within a Hospital environment between a patient and nurse.

In situations such as the above incident, I would expect the Nurse to disengage from any confrontation in order to de-escalate the patient, but the Nurse kept coming back and antagonising Patient E. I felt that the way in which the Nurse dealt with Patient E was unprofessional and that the Nurse's failure to disengage or allow me to take over led to the confrontation escalating…"

In cross examination, Person A stated that you would brush off patients with hand gestures on multiple occasions. She also stated that this occurred in almost every shift she worked.

Person A in her Witness statement stated:

"*As above, this is only one example of the Nurse's attitude towards patients, and I regularly felt that they were acting in a confrontational manner towards the patients."*

In cross examination, Person A stated that this occurred over a 12-to-13-month period. Person A was then asked if, presumably, another member of staff would have seen this and she stated yes but "not everybody speaks up".

In cross examination you stated that you had a good relationship with Patient E and he looked to you as a father figure. You also stated that you did disengage with Patient E, however because Patient E was bullying staff, they wanted you to intervene due to your relationship with him. You stated that you engaged with Patient E through the morning, and you were reinforcing the ward rules which he did not like.

With regards to the allegation that you brushed patients away with hand gestures, you stated in cross examination your level of engagement with patients in a clinical setting would indicate the good relationship you had with patients.

Witness 4 in her witness statement stated:

> *"I have never witnessed Darren to brush off patients with hand gestures or ignoring them. He would speak to them and even when he was busy, he would explain that and would say that he will speak to them in a moment because he is doing something else now.*
>
> *Darren had good rapport with all the patients, and they had banter between them, which someone might mistake for antagonising."*

Witness 4 reiterated this in her oral evidence. She confirmed that the banter she witnessed generally was not confrontational and was in a "joking way". She stated that a patient may say something, and staff may respond in a way that seem inappropriate or may seem like they were trying to agitate the patient intentionally. However, she stated that you were not trying to do this intentionally.

Witness 4 also provided an example of your banter which related to football or sports where you supported one team and the patient supported another. She stated that if you said something that was a bit too much for a patient you would apologise and say you did not mean it.

The panel accepted that Person A observed you brush away patients with hand gestures, and fail to engage with Patient E. From her perspective this may well have appeared to antagonise Patient E. However, in the circumstances, the panel was not satisfied that this was done in a confrontational manner. Rather, this was done as part of your duties as a mental health nurse, and you were the Nurse in Charge who had a particularly good relationship with Patient E.

The panel therefore finds this charge not proved.

Charge 8

That you, a registered nurse

7. Your actions at charge 4 above were done in pursuit of or to obtain sexual gratification.

This charge is found not proved.

The panel did not find any of the sub-charges in charge 4 proved. Therefore, it did not need to consider charge 8.

The panel therefore finds this charge not proved.

Charge 9a, 9b(i) and 9b(ii)

That you, a registered nurse

8. Your actions at all or any of charges 4, 5, and 6f above harassed Person A
    a. It was unwanted conduct of a sexual nature.
    b. Your actions had the purpose or effect of:
        i. Violating Person A's dignity

ii. Creating an intimidating hostile, degrading, humiliating or offensive environment for Person A

These sub-charges are found not proved.

The panel did not find any of the sub-charges in charge 4 or 5 proved. It also did not find any of the sub-charges under charge 6 proved. Therefore, it did not need to consider charges 9a, 9b(i) or 9b(ii).

The panel therefore finds these sub-charges not proved.

Submissions on misconduct and impairment

Ms Danti invited the panel to take the view that the facts found proved amount to misconduct. She referred the panel to The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code), and referred the panel to the following standards where, in the NMC's view, your actions amounted to misconduct: 1.1, 1.2, 1.5, 2.1, 2.3, 2.6, 3.1, 3.4, 4.3, 6.2, 7.2, 7.3, 10.1, 10.2, 10.3, 13.1, 13.4, 14.1, 14.2, 14.3, 15.3, 18.3, 19.1, 19.2, 19.4, 20.1, 20.3, 20.5 and 20.8.

Ms Danti highlighted that you were a nurse with 26 years of experience who held a position of power. She submitted that the facts found proved illustrated an abuse of that power, resulting in physical and emotional harm to patients and occurred on more than one occasion during a short period of time. She reminded the panel that Patient A was elderly, frail, receiving end of life care and had also been detained under the Mental Health Act. Further, your conduct put Patient D at unnecessary risk of harm, as well as your colleagues.

In relation to charge 2, Ms Danti noted your admission, and that Patient A suffered a hip fracture following being restrained. She stated that had the records been accurate, they would have assisted the subsequent investigations.

Ms Danti submitted that your conduct and the breaches of the Code were extremely serious and fell below the standards expected of a registered nurse. She submitted that both individually and collectively, the breaches amounted to misconduct.

Ms Danti then moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2008] EWHC 581 (Admin).

Ms Danti noted the bundle of documents provided by you which included two detailed reflective statements, numerous testimonials, and a substantial amount of training certificates and professional development material. She told the panel that your reflective statements appeared to focus on how you were perceived, and that you stated that others were in awe of you. The documents you provided included patient notes intended to evidence accurate record keeping. Ms Danti highlighted that none of the notes provided related to a serious incident of restraint. Therefore, the notes did not address the concerns around correctly/appropriately restraining patients.

Despite this evidence of reflection and remediation put forward, Ms Danti invited the panel to make a finding of current impairment on the grounds of public interest to mark the seriousness of your misconduct. She submitted that the facts found proved include record keeping failures, the failure to follow patient care plans and inappropriate manual handling, which are all sufficiently serious to meet the threshold for a finding of current impairment on public interest grounds.

Mr Wylde submitted that you have provided an ‘impressive’ amount of remediation and that your case should resolve at this stage and go no further. He submitted that whilst you accept that your actions amounted to misconduct, you do not accept that your fitness to practise is currently impaired on public protection or public interest grounds.

Mr Wylde told the panel that you are a good nurse with decades of experience. He referred the panel to the numerous character references as well as your detailed and lengthy reflective statements and submitted that they were indicative of your commitment to nursing. He informed the panel that you have moved your area of clinical practice so that you will not be overworked, and you have been unable to reflect on similar incidents as no similar incidents have occurred.

Mr Wylde submitted that the incidents involving Patient A and Patient D were isolated incidents and not a pattern of unchecked behaviour. He submitted that the facts found proved arose from a ‘dynamic’ and ‘challenging’ environment and whilst the incidents were regrettable, the depths of your insight, empathy and remorse are clear. He highlighted that you have undertaken a great deal of training in relevant areas including record keeping and patient restraint techniques. Further, that your reflective statement demonstrated remorse. In view of your insight and remediation, he submitted that the panel could be satisfied that the incidents would not be repeated.

Decision and reasons on misconduct

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant’s ability to practise kindly, safely, and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

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.'*

The panel also 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*, Calhaem v GMC* [2007] EWHC 2606 (Admin) *and Meadows v GMC* [2006] EWHC 146 (Admin).

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. The panel determined that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code.

In relation to charges 1 and 3, the panel decided that your actions amounted to breaches of the following standards:

1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively
1.5 respect and uphold people's human rights

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

2.3 encourage and empower people to share in decisions about their treatment and care

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

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

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

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

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

In relation to charge 2, the panel decided that your actions amounted to breaches of the following standards:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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
20.8 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 the facts found proved, individually and collectively, were sufficiently serious to amount to misconduct.

The panel bore in mind that the incidents involving Patient A and Patient D both occurred within a few months of each other. Patient A and Patient D were both extremely vulnerable patients. Further, your actions not only put patients at risk but also your colleagues. It considered your conduct to be concerning especially given your years of experience and that you were in a position of authority, and a role model for other colleagues.

The incidents set out in charges one and three were not everyday occurrences. They were exceptional. The panel appreciated that they were dynamic and challenging. Because the incidents were so challenging the panel considered it was even more important that accurate records were documented.

The panel decided that your 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, your fitness to practise is currently impaired.

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *…*

The panel determined that three limbs of the test set out in Grant were engaged.

The panel finds that patients were put at risk and were caused physical and emotional harm because of your misconduct. Your misconduct therefore breached the fundamental tenets of the nursing profession and brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case is capable of being remediated. Therefore, the panel carefully considered the evidence before it in determining whether you have taken sufficient steps to strengthen your practice.

The panel had regard to the bundle of documents provided by you which included two detailed reflective statements, numerous testimonials, and a substantial amount of training certificates and professional development material. It noted your evidence of training in food hygiene and safety, immediate life support, patient consent, safeguarding adults (level 1 and 2), safeguarding children (level 3), information governance and data security, amongst other areas.

The panel considered that only a very small number of training certificates were relevant to your misconduct, and the panel would have expected, in light of the charges, to see evidence of appropriate training to address the issues identified.

The panel considered that your reflective statement demonstrated only developing insight and were concerned with the following passage:

'It is difficult to put into words my genuine belief that I did the right thing although things went wrong, and when reflecting on the training delivered, I acknowledge that the same training can be interpreted differently although taught the same and in my experience, is always dependent upon extrinsic factors;

- *1 patient behaving differently*
- *2 attempting de escalation*
- *3 using PMVA as taught as the last resort to prevent an assault.*

…

In my reflection of the incident on the day, I believed right up to the point of engagement that the team had followed the correct procedures taught by Elysium and this was also reflected in the training that I subsequently undertook.

It was the last option, and I certainly would not have intentionally injured the patient.'

Although you demonstrate remorse, the panel was not satisfied that you are clear in your mind that you would need to act differently in future. The panel considered that your reflective statement demonstrated only developing insight, and it determined that you are still in the early stages of your journey of understanding what you would need to do differently if you were to find yourself in similar circumstances in the future.

The panel is of the view that in the absence of complete insight there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are 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 therefore 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 your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months with a review. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Ms Danti invited the panel to impose a conditions of practice order for a period of 12 months with a review.

Ms Danti identified the following aggravating features:

- Your insight is incomplete;
- You have demonstrated remorse but failed to explain what you would do differently in future;
- Lack of evidence of strengthened practice;
- The misconduct occurred on more than one occasion;
- Your failure to strengthen your practice relates to two areas of practice: restraint and record keeping.

Ms Danti submitted that to impose a suspension or striking-off order would be disproportionate given that the concerns in your case are remediable. She invited the panel therefore to impose a conditions of practice order for a period of 12 months with a review.

Mr Wylde highlighted that the concerns in your case are remediable and stated that you would only be able to sufficiently remediate your practice whilst working as a registered nurse. He submitted that there were workable, measurable, and proportionate conditions which could be put in place. Therefore, the most appropriate sanction would be that of a conditions of practice order.

Mr Wylde agreed with Ms Danti that a conditions of practice order for a period of 12 months would be the most appropriate length of time to allow for you to address the continuing issues identified by the panel.

Mr Wylde proposed the conditions including the following:

- The creation and utilisation of a professional development plan;
- Regular reflective meetings with a line manager;
- Training in the area of managing violence and aggression

Decision and reasons on sanction

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

The panel identified the following aggravating features:

- Your insight is incomplete;
- You have demonstrated remorse but failed to explain what you would do differently in future;

- Lack of evidence of strengthened practice in the particular areas of concern;
- The misconduct occurred on more than one occasion;
- The misconduct resulted in harm to patients;
- Failures in performing in a position if trust.

The panel identified the following mitigating features:

- You have accepted and understand the panel's findings;
- You have demonstrated good nursing practice since the misconduct
- You were working in an exceptional and challenging environment at the time of the incidents.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The sanctions guidance (SG) states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that you have had an unblemished career of 26 years as a nurse at the time of the incidents. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practice as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case given that the misconduct is remediable, and you have demonstrated developing insight and a strong desire and willingness to fully address the issues identified.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession

and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. *You must restrict your nursing practice to a single substantive employer, which may not be an agency.*

2. *You must ensure that you are supervised by your line manager, mentor or supervisor any time you are working. Your supervision must consist of monthly meetings to discuss your clinical caseload.*

3. *You must keep a reflective practice profile. The profile will:*

   • Detail every case where you undertake or assist with vulnerable patients and/or conflict situations and/or challenging patients.
   • Set out the nature of the care given.
   • Be signed by your line manager, mentor or supervisor each time.
   • Contain feedback from your line manager, mentor or supervisor on how you gave the care.

   You must send your case officer a copy of the profile one month prior to the review of this order.

4. *You must send your case officer evidence that you have successfully completed training on managing violence and aggression.*

5. *You must provide the NMC with a certificate to evidence completion of training on non-abusive psychological and physical intervention (NAPPI), at least one month prior to the review of this order.*

6. *You must keep us informed about anywhere you are working by telling your case officer within seven days of accepting or leaving any employment.*

7. *You must keep us informed about anywhere you are studying by:*
   a) *Telling your case officer within seven days of accepting any course of study.*
   b) *Giving your case officer the name and contact details of the organisation offering that course of study.*

8. *You must immediately give a copy of these conditions to:*
   a) *Any organisation or person you work for.*
   b) *Any employers you apply to for work (at the time of application).*
   c) *Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.*
   d) *Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.*

9. *You must tell your case officer, within seven days of your becoming aware of:*
   a) *Any clinical incident you are involved in.*

b) Any investigation started against you.

c) Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

a) Any current or future employer.

b) Any educational establishment.

c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- An up-to-date reflective statement focusing on the issues identified by the panel;
- Your attendance and continued engagement with the NMC.

Interim order

As the conditions of practice 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 heard submissions from Ms Danti who, in view of the panel's

decisions on current impairment and sanction, applied for an interim conditions of practice order for a period of 18 months to cover any potential appeal period.

Mr Wylde did not oppose Ms Danti's application for an interim order.

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

The panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the conditions of practice sanction takes effect.

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 considered that not to make an interim order would be inconsistent with its previous decisions.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to allow for any potential appeal period.

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

That concludes this determination.