Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 13 May 2024 – Friday 24 May 2024
Friday 7 June 2024 – Friday 21 June 2024

Virtual Hearing

Name of Registrant:	**Iorwerth David John**	
NMC PIN:	91C0791E	
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – (May 1994)	
Relevant Location:	West Sussex	
Type of case:	Misconduct	
Panel members:	Museji Ahmed Takolia Jonathan Coombes June Robertson	(Chair, Lay member) (Registrant member) (Lay member)
Legal Assessor:	Caroline Hartley (13 – 14 May 2024, 16 May 2024 – 21 June 2024) Alice Robertson Rickard (15 May 2024)	
Hearings Coordinator:	Rene Aktar (13 – 15 and 17 May 2024) Charis Benefo (16, 20 May 2024 – 21 June 2024)	
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter	
Mr John:	Not present and unrepresented	
Facts proved by admission:	Charges 1c)iii, 1c)iv, 3b, 5b, 7 and 9	
Facts proved:	Charges 1a, 1b, 1c)i, 1c)ii, 2a, 2b, 3a, 3c, 5a, 6a, 6b and 8	
Facts not proved:	Charges 4a, 4b, 10 and 11	

Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr John was not in attendance and that the Notice of Hearing letter had been sent to Mr John's registered email address by secure email on 8 April 2024.

Mr Malik, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mr John

The panel next considered whether it should proceed in the absence of Mr John. It had regard to Rule 21 and heard the submissions of Mr Malik who invited the panel to continue in the absence of Mr John. He submitted that Mr John had voluntarily absented himself.

Mr Malik referred the panel to the telephone note detailing a call between the NMC Case Officer and Mr John on 13 May 2024 which stated:

‘I informed the registrant that I was calling to find out if he would be participating in the hearing virtually and physically (Days 2&3) as the hearing will then go back to virtual. Reg informed me that he [PRIVATE] and wants a line drawing [sic] under all of this now. He stated that he is happy for the hearing to proceed in his absence. Reg stated that he into [sic] represented and not even that he will never work as a nurse again due to [PRIVATE] and in the interest of everyone the matter can go ahead without him. The Registrant stated that has some references and other papers that he wanted the panel to have sight of at impairment stages so he will send them over via recorded delivery tomorrow.

Reg stated that he is happy or [sic] the matter to go ahead without him as he will not be participating virtually or in person...’

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *‘with the utmost care and caution’* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Mr John;
- Mr John has informed the NMC that he has received the Notice of Hearing and confirmed that he is content for the hearing to proceed in his absence;

- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Five witnesses are due to attend to give live evidence, one witness will attend in-person to give evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr John in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he will not be able to challenge the evidence relied upon by the NMC in person, and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and it can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is because of Mr John's decision not to attend the hearing, waive his rights to attend, and/or be represented, and not to provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr John. The panel will not take anything negative from Mr John's absence in making its findings of fact.

Details of charge

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

1. Between August 2018 and November 2018, despite Patient A's condition deteriorating:
   a. Failed to assess and/or update Patient A's care plan.
   b. Failed to carry out and/or record an updated risk assessment for Patient A.
   c. Did not:
      i. Arrange for Patient A to be urgently seen by a psychiatrist or seen earlier than the appointment planned for 16 November 2018;
      ii. Discuss Patient A at a MDT meeting and/or at a case formulation;
      iii. Discuss Patient A's situation with your supervisor;
      iv. Refer Patient A to the voices clinic despite noting on 12 September 2018 that you would.

2. After being informed by Patient A on 12 September 2018 and/or 8 October 2018 that he was omitting doses of his Clozapine, did not:
   a. Arrange a medical review with a Consultant prior to the one planned on 16 November 2018.
   b. Contact the Denzapine Monitoring Service for advice.

3. After being informed by Person 1 on 15 October 2018 that Patient A had started smoking cigarettes:
   a. Failed to liaise with and/or provide Patient A with information on the impact that this would have on the effectiveness of his Clozapine medication.
   b. Failed to record the information within Patient A's care notes.
   c. Did not seek medical advice from a Consultant and/or the Denzapine Monitoring Service.

4. Failed to make contact with Patient A as requested by:
    a. A colleague on 17 September 2018.
    b. A colleague and/or the Accident and Emergency Department on 24 September 2018.

5. In relation to Person 1's emails to you between May and October 2018:
    a. Failed to respond in a thorough and/or timely manner.
    b. Did not ensure that the information in them and/or that the emails themselves were saved to Patient A's care notes.

6. Prior to going on leave on 22 October 2018:
    a. Did not provide Person 1 with details of who to contact in your absence.
    b. Did not provide an adequate handover and/or make colleagues aware of the recent deterioration in Patient A's mental health.

7. Failed to record in Patient A's care notes that you had spoken to Patient A on 16 October 2018 and/or your rationale for telling Person 1 that Patient A was on an *"even keel"* on that date.

8. Your actions at one or more of charges 1 to 7 above contributed to the death of Patient A or in the alternative the loss of a chance of survival.

9. Submitted a report to the Coroner stating that you saw Patient A every month when that was not the case.

10. Your conduct at charge 9 in providing incorrect information in a statement was a breach of your duty of candour.

11. Your conduct at charge 9 was dishonest in that you deliberately sought to represent that you had seen Pat A more regularly than you had.

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

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

Mr Malik made a request that this case be held partly in private on the basis that proper exploration of Mr John's case involves reference to [PRIVATE]. The application was made pursuant to Rule 19.

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

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

Background

The NMC received a referral in respect of Mr John on 23 December 2019. Mr John first entered onto the NMC's register on 22 May 1994.

Mr John was working as a Community Mental Health Nurse and Lead Practitioner/Care Coordinator at the Worthing Assessment and Treatment Service (the ATS), which is part of Sussex Partnership NHS Foundation Trust (the Trust) Mental Health Service. Mr John started working for the ATS in August 1995.

In 2016, Mr John was allocated as Lead Practitioner for Patient A who had a [PRIVATE] diagnosis of [PRIVATE].

[PRIVATE]. Patient A took his own life on [PRIVATE]. On [PRIVATE], the HM Coroner for West Sussex (the Coroner) commenced an investigation into Patient A's death and an inquest hearing took place [PRIVATE].

The concerns in this case relate to Mr John's alleged failure to act on or escalate the deterioration of Patient A's mental health condition and other significant events in his care. This included amongst other allegations:

- A failure to assess and/or update Patient A's care plan;
- A failure to carry out and/or record an updated risk assessment;
- Not referring Patient A to be seen urgently by a psychiatrist;
- Not discussing Patient A at a multidisciplinary team meeting (MDT), despite Patient A's deteriorating condition;
- A failure to provide information to Patient A in respect of his smoking tobacco and its effect on his medication;
- A failure to provide contact details to Person 1 for use in his absence;
- A failure to contact Patient A when requested to do so;
- A failure to respond in a timely manner to Person 1's emails between May and October 2018;
- Not handing over care to the on call team in an appropriate manner;
- Not contacting the Denzapine Monitoring Service for advice in relation to the missed doses.

Mr John was on annual leave between 22 October 2018 and 5 November 2018, and Patient A's care was passed on to the duty team and so to Registrant B during this period.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Malik who indicated that Mr John had made admissions to charges 1c)iii, 1c)iv, 3b, 5b, 7 and 9.

The panel took account of Mr John's signed Case Management Form dated 18 July 2022, on which he had indicated his admissions and denials. It therefore found charges 1c)iii, 1c)iv, 3b, 5b, 7 and 9 proved, by way of Mr John's admissions.

In reaching its decisions on the disputed facts, the panel took into account all the evidence in this case together with the submissions made by Mr Malik on behalf of the NMC.

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:

- Person 1: Patient A's sister;
- Witness 2: Team Leader for the ATS and Mr John's manager and supervisor at the time of the concerns;
- Witness 3: Clinical Operations Manager for Adult Mental Health Services at the Trust at the time of the concerns;
- Dr 4: Consultant Psychiatrist who was instructed by the HM Coroner for West Sussex to provide a report concerning Patient A; and

- Witness 5: Independent Nursing and Healthcare Services Consultant and Expert Witness instructed by the NMC to provide a report.

The panel also took account of the witness statement from the following witness on behalf of the NMC:

- Witness 6: Mr John's Clinical Supervisor.

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

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

Charge 1

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

1. *Between August 2018 and November 2018, despite Patient A's condition deteriorating*

The panel first considered the stem of charge 1, in particular the suggestion that Patient A's mental health was deteriorating between August 2018 and November 2018. The panel turned its attention to the evidence from the NMC's witnesses about the circumstances surrounding Patient A's condition, in order to determine whether Patient A's condition was, in fact, deteriorating before his death in November 2018.

[PRIVATE]

The panel therefore concluded that there was sufficient evidence to find that, on the balance of probabilities, Patient A's mental health condition was deteriorating between August 2018 and November 2018.

Furthermore, the panel concluded on the basis of all the evidence listed above, that had Mr John, as Patient A's Lead Practitioner, properly and fully reviewed and analysed all the sources of information available to him, he would and could have recognised the deterioration in Patient A's mental health condition. In particular, as Dr 4 observed that Patient A's frequent attendances at A&E should have alerted the practitioner to a decline in his condition. The panel therefore preferred the expert evidence to that of Mr John and decided that Mr John should have recognised the deterioration which would, in turn, have enabled him to deal more appropriately with the care of Patient A.

The panel then went on to consider the specific charges as follows:

Charge 1a

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

1. *Between August 2018 and November 2018, despite Patient A's condition deteriorating.*
    a. *Failed to assess and/or update Patient A's care plan.*

This charge is found proved.

In reaching this decision, the panel first considered whether Mr John had a duty to assess and/or update Patient A's care plan. The panel had sight of the Trust's Care Programme Approach (CPA) Policy, [PRIVATE], and noted that Mr John was Patient A's Lead Practitioner. Accordingly, Mr John was responsible for the following:

‘*3.3.1 Participate in the assessment of the service user’s needs and associated risks. In Adult services, this may be undertaken by the ATC prior to a lead practitioner being allocated.*
3.3.2 Maintain an up to date record of their care and treatment on Carenotes.
...
Additional for people on CPA
3.3.11 Work with the service user to formulate a comprehensive personal support plan, which includes safety and contingency plans and advance statements. Ensure copies are shared as appropriate.
3.3.12 Ensure that everyone involved in the personal support plan is clear about lines of communication and feels able to raise concerns or comments easily.’

The panel was therefore satisfied that as Patient A’s Lead Practitioner, there was a duty on Mr John to assess and/or update Patient A’s care plan/‘*CPA Personal Support Plan*’.

The panel also took account of Witness 3’s written statement dated 4 March 2021 which stated the following:

‘*In reviewing the health records, I believe Iorwerth reviewed the CPA care plan for Patient A on 13 June 2017 and 16 March 2018 and it is evident the content of the main body of the care plan remained the same and did not take account of changing circumstances. Out [sic] Carenotes system has a replan function allowing clinicians to pull forward information from a previous care plan in order that information is not lost however the care plan should be amended to reflect changes.*’

The panel noted Witness 3’s evidence that Patient A’s care plan was not amended to reflect his changing circumstances. It noted that this had not been disputed by Mr John. It considered that the care plan had been inadequately and poorly reviewed in 2018 and no further updates had been made since March 2018, despite the deterioration in Patient A’s mental health.

The panel also looked closely at the accounts recorded by Mr John in Patient A's '*carenotes*', an electronic care planning system for recording the care provided to an individual. It noted that some of the entries on this system had been completed by Mr John, and that it was more routinely updated by staff who had had contact with Patient A. The panel concluded, however, that the routine updating of '*carenotes*' is not the same as updating the care plan.

Witness 5's expert witness report dated 18 October 2021 stated:

> '*12/9/2018*
> *Patient A is visited at home by Iorwerth John who [PRIVATE]*
> *Within the progress notes:*
> • *...*
> • *There is no mention of updating Patients A's care plan*
> *...*
> *17/9/2018.*
> *From the notes made available to me there is nothing in the progress notes that Iorwerth John followed through with this...*
> *...*
> *There were a number of serious failings of clinical interventions by not correctly planning a relevant care pathway and monitoring the care of Patient A.'*

In live evidence, Witness 5 was asked by Mr Malik about the impact of not updating the care plan for a deteriorating patient and Witness 5 responded "*how can other professionals follow care pathways if it's not updated?*"

Dr 4's '*First Medical Report*' dated 8 October 2019 stated that:

‘...*It is my opinion that the pattern of emergency help seeking and [Patient A’s] reported symptoms that should have led to a review of his care by his lead clinician and an updating of his ... care plan.*’

The panel noted that Dr 4 was very explicit about the failures in relation to Patient A’s care plan and in oral evidence, he told the panel that “*new risks require a new care plan, [PRIVATE], the stopping of the Clozapine, the smoking, should have meant that he got a better and deeper understanding of what was happening and he didn’t*”.

The panel took into account the regulatory response form completed by Mr John’s former representative and dated 21 August 2020. This document did not specifically acknowledge this charge, but provided a general acknowledgement that there were concerns about Mr John’s completion of care plans and record keeping.

The panel considered that there was clear and consistent evidence to support the allegation that Mr John failed to assess and/or update Patient A’s care plan between August and November 2018. It therefore found charge 1a proved.

Charge 1b

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

1. *Between August 2018 and November 2018, despite Patient A’s condition deteriorating.*
    - b. *Failed to carry out and/or record an updated risk assessment for Patient A.*

This charge is found proved.

In reaching this decision, the panel first considered whether Mr John had a duty to carry out and/or record an updated risk assessment for Patient A. The panel had sight of the

Trust’s Care Programme Approach Policy and noted that Mr John was Patient A’s Lead Practitioner. Accordingly, Mr John was responsible for the following:

> ‘*3.3.5 Ensure that appropriate risk assessments, outcomes measures, and PBR cluster allocation are completed and reviewed as necessary.*’

The panel was therefore satisfied that as Patient A’s Lead Practitioner, there was a duty for Mr John to carry out and/or record an updated risk assessment at the relevant time.

The panel heard from Dr 4 and Witness 5 that there was a requirement for the practitioner to report and consider risks at the point where a significant change has taken place.

Dr 4’s ‘*First Medical Report*’ dated 8 October 2019 stated that:

> ‘...*It is my opinion that the pattern of emergency help seeking and [Patient A’s] reported symptoms that should have led to a review of his care by his lead clinician and an updating of his risk assessment...*’

In oral evidence, Dr 4 said that Mr John’s risk assessment should have been cross-sectional and he ought to have looked broadly at what had happened with Patient A, rather than what Mr John thought of the patient on the one occasion when he saw him.

The panel decided that there was a clear duty on Mr John to undertake a risk assessment for Patient A and it accepted the expert evidence of Dr 4. The panel took the view that it was reasonable for Mr John to take into account the assessments of other practitioners who had seen Patient A during that period, including those from Patient A’s visits to A&E between August and September 2018. However, under the terms of the Trust’s CPA Policy, Mr John as Lead Practitioner had a responsibility to assess for himself and record significant changes that may pose risks for a patient whose mental health was deteriorating, as was the case with Patient A.

The panel noted Witness 5's expert report dated 18 October 2021 which stated:

> '*12/9/2018*
> *Patient A is visited at home by Iorwerth John [PRIVATE]*
> *Within the progress notes:*
> • *...*
> • *There is no mention of updating the risk assessment care plan'.*

The panel noted the form to the NMC from Mr John dated 26 March 2020, which stated:

> '*I last saw the patient on 8th Oct 2018 and I had moved the appointment forward due to attendance at A&E*
> *...*
> *Patient A did not have a history of [PRIVATE] and as presenting risks had not changed the risk assessment was not updated from May 2018, the care plan and risk would have reviewed at the planned CPA review in November 2018*'.

The panel also noted the transcript of Mr John's evidence at the inquest hearing [PRIVATE]. Mr John had stated that:

> '*[Mr John]:* *We do risk assessments every time we see someone.*
> *...*
> *[Mr John]:* *Well it would be part of out general chat with somebody...*
> *...*
> *[Mr John]:* *So every time we visit somebody, we don't necessarily have to do a risk assessment, if the risk hasn't changed.*
>
> *[Question]:* *I see. So you didn't do a risk assessment on that day?*
>
> *[Mr John]:* *Not a formal risk assessment on the Trust paperwork, but we would have talked between [inaudible] about if he was feeling [PRIVATE],*

what plans he had, did he have plans for the future? How was he managing? All of that is taken into account.'

In addition, Mr John stated that the risk had not increased because '*Patient A was very, very clear that he wasn't [PRIVATE].*'

The panel noted from Patient A's '*carenotes*' that four other practitioners in other environments had seen Patient A and assessed the risk as low.

Whilst Mr John stated that he had carried out a risk assessment, he did not record it. The panel had no documentary evidence which would substantiate Mr John's assertion. The panel was therefore not in a position to know whether he did or did not carry out a risk assessment. Accordingly, the panel made no findings in relation to whether Mr John carried out a risk assessment but did determine that he failed to record an updated risk assessment for Patient A. It therefore found charge 1b proved.

Charge 1c)i

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

1. *Between August 2018 and November 2018, despite Patient A's condition deteriorating.*
    c. *Did not:*
        i. *Arrange for Patient A to be urgently seen by a psychiatrist or seen earlier than the appointment planned for 16 November 2018.*

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's written statement dated 4 March 2021 which stated:

‘*I understand Iorwerth last visited [Patient A] on 8 October 2018 and this appointment was brought forward because [Patient A] had recently presented to out of hours services. [Patient A] has disclosed to Iorwerth that he had missed three doses of his morning medication of Clozaril... Iorwerth was sufficiently concerned to arrange an outpatient appointment for 16 November 2018 and [Patient A] had not had his annual medical review. There is a shared responsibility for clinicians and secretaries to ensure patients have annual medical reviews. There is facility to request earlier or urgent reviews however Iorwerth had encouraged [Patient A] to remain compliant and to consider other treatment options at his medical review...*’

The panel was satisfied that Mr John had booked Patient A’s appointment with the psychiatrist for 16 November 2018.

The panel had heard from Witness 2 and Witness 3 that if a practitioner required an urgent appointment for a patient, they would be able to get one within two days. However, the panel had no evidence of where the requirement for Patient A ‘to be seen urgently’ by a psychiatrist was made and by whom. It noted the Cambridge Dictionary definition of ‘*urgently*’:

‘*In a way that needs attention very soon, especially before anything else, because of being very important.*’

The panel took into account Dr 4’s ‘*First Medical Report*’ dated 8 October 2019 which stated:

‘*In the period prior to his death [Patient A] saw many different practitioners. It is my opinion that what was necessary was not that [Patient A] necessarily see a consultant psychiatrist, rather that he be reviewed by an experienced clinician, who could have been his lead practitioner or care coordinator. This clinician may have recognised that [Patient A’s] mental health was deteriorating.*

...

It is my opinion that if [Patient A] had been reviewed, there would have been a change in his care plan. This would have included the following

...

d. In view of the deterioration in his health and the fact that he hadn't seen a psychiatrist for a long time, an outpatient appointment should have been booked with a consultant psychiatrist.'

In addition, the panel had regard to the transcript of Dr 4's evidence at the inquest hearing, where he said that patients were usually seen by the consultant psychiatrist about once a year, although the consultant was there '*for when things start going wrong and the patient starts getting unwell*'. He described that in his practice, frequency varies '*unless there was a problem and if there is a problem I would expect them to be brought to my attention and to see them then*'. The panel saw no reference in Dr 4's evidence to urgency or how quickly the psychiatrist should see patients.

The panel determined that Mr John's actions of booking an appointment for Patient A at the earliest available date met the requirement for Patient A to have a psychiatric appointment. It considered that it was possible for Mr John to make use of the facilities to secure an even earlier appointment for Patient A, but there was no evidence that he did so because he did not deem it as an urgent referral.

In light of the wording of the charge, the panel found that whilst Mr John booked the appointment for Patient A to be seen by a psychiatrist on 16 November 2018, he did not arrange for an urgent appointment, or for Patient A to be seen on an earlier date. It therefore found this charge proved.

Charge 1c)ii

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

1. *Between August 2018 and November 2018, despite Patient A's condition*

deteriorating.

c. Did not:

ii. Discuss Patient A at a MDT meeting and/or at a case formulation

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's oral evidence that Mr John had not discussed Patient A at the MDT meeting.

The panel also took account of the evidence of Witness 6 who confirmed, in her written statement dated 16 February 2021, that:

> '*Patient A was not brought to a case formulation.*'

In his commentary document to the NMC attaching the Final Serious Incident Report, Witness 3 stated:

> '*The case was not specifically discussed in the MDT meeting however the case was reviewed by a Duty Worker and Consultant Psychiatrist in the absence of IJ. IJ had already arranged a CPA Review for [Patient A] and they were due to meet with a Consultant Psychiatrist on 16 November 2018 to review his treatment and care.*'

The panel had no evidence from Mr John in respect of this charge.

The panel accepted Witness 3 and Witness 6's evidence and found, on the balance of probabilities, that between August and November 2018, despite Patient A's deteriorating condition, Mr John did not discuss Patient A at a MDT meeting and/or at a case formulation. It therefore found this charge proved.

Charge 2a

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

2. *After being informed by Patient A on 12 September 2018 and/or 8 October 2018 that he was omitting doses of his Clozapine, did not:*
   a. *Arrange a medical review with a Consultant prior to the one planned on 16 November 2018.*

This charge is found proved.

In reaching this decision, the panel took into account that this charge related specifically to Patient A omitting three 50mg morning doses of Clozapine some weeks prior to the visit to Patient A's home by Mr John.

The panel considered the Trust's Procedure and Guidance for the use of Clozapine Policy which was in force at the time of the incident. In particular, the panel noted the following sections of the policy:

'*3.2 Clinical Team: Nurse Responsibilities*

3.2.2 Patient support and information

- *Co-ordinate patient care to help avoid adverse drug reactions, and unplanned or inappropriate omissions of dose administration wherever possible: communicate and maintain contact with each patient and their carers, key-workers, and with in-patient units, DMS, pharmacy, medical staff, GP's and the local pathology lab, as necessary*
- *Ensure that when a patient has missed more than 2 days of treatment, the doctor writes a new prescription, and pharmacy provides an appropriately labelled named-patient supply of tablets to enable the patient to re-titrate their dose as per trust policy, to avoid potentially serious adverse effects...*'

The panel was satisfied that as Patient A's Lead Practitioner, Mr John was expected to arrange a medical review with a Consultant wherever there were unplanned or inappropriate omissions of Clozapine doses.

Witness 5 had reviewed Patient A's notes and in his expert witness report dated 18 October 2021, he stated:

> '*12/9/2018*
> *Patient A is visited at home by Iorwerth John ... [PRIVATE]*
> *Within the progress notes:*
> • *There is no mention of having a review with Patient A's- RC. (Registered Consultant)*
> • *...*'

The panel took account of Mr John's entry in Patient A's '*carenotes*' on 12 September 2018, which stated:

> '*Seen at home*
> *...*
> *I reminded [Patient A] that he has been omitting his morning dose Clorazil [PRIVATE]*
> *...*
> *Plan*
> *CPN to continue to monitor mood/mental state*
> *CPN to refer [Patient A] to voices clinic*
> *CPA/medical review to be arranged*'

The panel found that contrary to the information in Witness 5's report, Mr John had made reference to arranging a medical review in Patient A's notes. However, there was no evidence before the panel that Mr John had arranged a medical review with a consultant prior to the one planned on 16 November 2018.

The panel therefore found charge 2a proved.

Charge 2b

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

2. *After being informed by Patient A on 12 September 2018 and/or 8 October 2018 that he was omitting doses of his Clozapine, did not:*
   b. *Contact the Denzapine Monitoring Service for advice.*

This charge is found proved.

In reaching this decision, the panel took into account Mr John's entry in Patient A's '*carenotes*' on 12 September 2018. It stated:

> '*...*
> *Plan*
> *CPN to continue to monitor mood/mental state*
> *CPN to refer [Patient A] to voices clinic*
> *CPA/medical review to be arranged*'

The panel noted that there was no reference in Patient A's '*carenotes*' by Mr John to make a referral to the Denzapine Monitoring Service.

There was also no evidence before the panel that Mr John contacted the Denzapine Monitoring Service for advice.

The panel therefore found charge 2b proved.

Charge 3a

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

3. *After being informed by Person 1 on 15 October 2018 that Patient A had started smoking cigarettes:*
   a. *Failed to liaise with and/or provide Patient A with information on the impact that this would have on the effectiveness of his Clozapine medication.*

This charge is found proved.

In reaching this decision, the panel took into account the Trust's Procedure and Guidance for the use of Clozapine Policy, which was in force at the time of the incident. In particular, the panel noted the following sections of the policy:

> '*3.2 Clinical Team: Nurse Responsibilities*
> *3.2.3 Patient support and information*
> - *...*
> - *Monitor for and advise patients and carers on the side effects of clozapine and on the effects smoking can have on clozapine treatment...*'

The panel was satisfied that as Patient A's Lead Practitioner, Mr John had a duty to liaise with and/or provide Patient A with information on the impact that smoking would have on the effectiveness of Clozapine.

The panel noted Person 1's email to Mr John dated 15 October 2018 which stated:

> *'Now [Patient A] is smoking cigarettes heavily and vaping as usual.'*

Witness 5's expert witness report dated 18 October 2021 stated:

> '*15/10/2018*

[Person 1] (sister of Patient A) contacts Iorwerth John and informs him that Patient A was smoking excessively. She understood and was worried because she knew that smoking reduces the effect of Clozapine by up to 50%. According to the notes made available to me Patient A was smoking in the region of 80 cigarettes a day.'

There was no evidence before the panel of Mr John having spoken to Patient A about the impact of smoking on the effectiveness of Clozapine. In particular, there are no recordings in Patient A's '*carenotes*' of this issue on or following 15 October 2018 to evidence any discussion with Patient A, or any action in providing information to him, or of Mr John asking a colleague to undertake this task on his behalf.

The panel therefore found this charge proved.

Charge 3c

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

3. *After being informed by Person 1 on 15 October 2018 that Patient A had started smoking cigarettes:*
    c. *Did not seek medical advice from a Consultant and/or the Denzapine Monitoring Service.*

This charge is found proved.

The panel could find nothing in the '*carenotes*' on or following 15 October 2018 to evidence that Mr John made a referral or sought medical advice from a Consultant and/or the Denzapine Monitoring Service. Indeed, the panel could not find any evidence at all as above that Mr John had taken up this issue in line with the Trust policy.

The panel therefore found charge 3c proved.

Charge 4a

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

4. *Failed to make contact with Patient A as requested by:*
    a. *A colleague on 17 September 2018.*

This charge is found NOT proved.

In reaching this decision, the panel took into account that this charge related to Patient A's call to the ATS duty line on 14 September 2018. Patient A had spoken to Colleague A and discussed his condition at that time. Colleague A recorded in Patient A's '*carenotes*':

> '...*I have assured [Patient A] that I will speak to [Mr John] on Monday and ask him to make contact...*'

However, there was no evidence before the panel that Colleague A had actually followed this up with Mr John for him to arrange to contact Patient A. The panel had not seen a written statement or any other evidence from Colleague A to this effect.

The panel noted that the next entry of Mr John making contact with Patient A was on 8 October 2018.

In the absence of evidence that Colleague A actually communicated a request to Mr John to make contact with Patient A on '*Monday*' or 17 September 2018, the panel could not find a failure by Mr John to make contact with Patient A. It therefore found this charge not proved.

Charge 4b

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

4. *Failed to make contact with Patient A as requested by:*
    b. *A colleague and/or the Accident and Emergency Department on 24 September 2018.*

This charge is found NOT proved.

In reaching this decision, the panel took into account that this charge related to Patient A's visit to A&E on [PRIVATE]. Patient A was attended to by Colleague B, who recorded in the '*carenotes*' Patient A's condition at the time, as follows:

> *'...*
> *Plan:*
> *...*
> *3. Liaison to contact lead practitioner and ask him to make contact with Patient A on Monday 24 September 2018...*'

However, there was no evidence before the panel that a request to make contact with Patient A had actually been made to Mr John by a colleague and/or the A&E department. In addition, the panel had not received a written statement or any other evidence from Colleague B.

The panel noted that the next entry of Mr John making contact with Patient A was on 8 October 2018.

In the absence of evidence that a colleague and/or the A&E department actually communicated a request to Mr John to contact Patient A on 24 September 2018, the panel could not find a failure by Mr John to make contact with Patient A. It therefore found this charge not proved.

Charge 5a

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

5. *In relation to Person 1's emails to you between May and October 2018:*
    a. *Failed to respond in a thorough and/or timely manner.*

This charge is found proved.

In reaching this decision, the panel took into account the Trust's CPA Policy, which was in force at the time of the incident. In particular, the panel noted the following sections of the policy:

> '*The lead practitioner must maintain regular contact with the service user, carer and other members of the care team to ensure relevance of the personal support plan to current situation.*
>
> *The lead practitioner must ensure that the service user and carer are given the opportunity to be actively involved in all decision making processes and that choices, where expressed, are respected wherever possible.*'

The panel was satisfied that as Patient A's Lead Practitioner, Mr John had a general duty to stay in touch with patients' carers and maintain regular contact.

The panel took particular note of Person 1's written statement dated 27 August 2021 which stated:

> '*[PRIVATE]. I emailed Iorwerth regularly in 2018 when [Patient A's] condition was deteriorating. I only received a response on two occasions. Once in 19 July 2017 and 16 October 2018. Iorwerth did not seek my input or contribution [PRIVATE].*'

In oral evidence, Person 1 told the panel that "*he did not respond, his responses were short, dismissive... impossible to get hold of him. He was silent on the phone. He had other patients apparently and referred to 50 cases*".

The panel took into account that between 26 May 2018 and 16 October 2018, there were multiple communications by email and telephone call from Person 1 to Mr John. Person 1 had emailed Mr John on 26 May 2018, 13 June 2018, 1 July 2018, 26 September 2018 and 15 October 2018, whilst Mr John had responded by sending one email to her on 16 October 2018.

When asked at the Coroner's Inquest, Mr John replied that he had sent emails and spoken to Person 1 on the telephone. However, there was no documented evidence of such communications before the panel to confirm his account which contradicted the evidence of Person 1. The panel was presented with evidence of email correspondence and heard oral evidence from Person 1 who it had no reason to disbelieve. Accordingly, the panel preferred the live evidence of Person 1 over the evidence of Mr John.

Person 1 had sent five emails to Mr John, and it took him almost five months to respond to her once in October 2018. The panel determined that in doing so, Mr John had failed to respond to Person 1 in a thorough and/or timely manner. It therefore found this charge proved.

Charge 6a

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

6. *Prior to going on leave on 22 October 2018:*
    a. *Did not provide Person 1 with details of who to contact in your absence.*

This charge is found proved.

In reaching this decision, the panel took into account Person 1's oral evidence that Mr John did not provide her with details of who to contact in his absence. Person 1 told the panel that she had asked Patient A for the relevant contact details, but that Patient A did not have them.

There was also no evidence before the panel that Person 1 had been provided with any such details by Mr John.

Mr John did not respond to this charge in his communications with the NMC.

The panel therefore found charge 6a proved.

Charge 6b

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

6. *Prior to going on leave on 22 October 2018:*
    b. *Did not provide an adequate handover and/or make colleagues aware of the recent deterioration in Patient A's mental health.*

This charge is found proved.

In reaching this decision, the panel took into account that there was no evidence of a handover of Patient A's condition by Mr John prior to his going on leave.

The panel noted that as Patient A's Lead Practitioner, Mr John had consistently taken a view based on the assessments made by other clinical practitioners that Patient A had presented with a low risk. It was clear to the panel that Mr John did not feel that Patient A's condition had deteriorated or that he presented a specific risk that required flagging or a handover. In addition, it noted that Mr John appeared to have relied upon the '*carenotes*' system to provide information to the duty team.

The panel also took account of Witness 2's written statement dated 3 February 2022 which stated:

> '*...There is no handover from the practitioners to the duty worker when they go on annual leave. The duty worker is responsible for reading a service user's notes, care plan and risk assessments, as and when a call comes in about the particular service user.*'

In spite of this local practice, it should have been obvious to Mr John that Patient A's condition was deteriorating and he should have alerted, at the very least, the MDT so that Patient A's case could have been discussed by the team in his absence.

The panel therefore found this charge proved.

Charge 8

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

8. *Your actions at one or more of charges 1 to 7 above contributed to the death of Patient A or in the alternative the loss of a chance of survival.*

This charge is found proved.

In reaching this decision, the panel began by considering the opinions of the two expert witnesses as to whether Mr John's actions contributed to the death of Patient A.

The panel noted Dr 4's opinion in his '*First Medical Report*' that if Patient A had been reviewed, there would have been a change in his care plan. He went on to report that:

> '*[PRIVATE]*'

Dr 4 told the panel in oral evidence that no person should ever have to take a decision on a patient's care by themselves, and he emphasised the importance of teamwork. The panel noted that Dr 4 had not been specifically asked whether Mr John's actions at charges 1 to 7 contributed to the death of Patient A or in the alternative the loss of a chance of survival. Dr 4 provided an opinion that had Patient A's care been reviewed by anyone else, with changes to his care plan, including providing more frequent observations and increased support, there would have been a different outcome.

The panel then took into account the evidence given by Witness 5 who had specifically been asked by the NMC to provide a report on whether Mr John's alleged failures would have prevented Patient A from attempting to take his own life. In his report, Witness 5 stated:

> '*My overriding instructions are to provide an opinion as to whether the alleged failure of monitoring, care and support from Iorwerth John would, on the balance of probabilities, have prevented [Patient A] from attempting to take his own life which is alleged was caused by a breach of duty of the Defendants, its servants or agents.*'

Witness 5's expert witness report further stated:

> '*It is my opinion that had mental health examinations and risk assessments been completed and acted upon and correct patient observation linked with a more positive, robust, supervised community care package for all aspects of [Patient A] presenting mental health problems taken place, on the balance of probability the tragic event on [PRIVATE] would have been avoided.*'

However, under questioning from the panel, Witness 5 changed his conclusion and stated that Patient A's death "*could*" have been avoided.

The panel could not find, on a balance of probabilities, that Mr John's actions at charges 1 to 7 contributed to Patient A's death, [PRIVATE]. As a result the panel focussed on the alternative, second part of the charge, 'the loss of a chance of survival'.

The panel was mindful of charge 1c)ii, namely that between August and November 2018, despite Patient A's condition deteriorating, Mr John did not discuss Patient A at a MDT meeting and/or at a case formulation, which the panel had found proved.

The panel concluded that had Mr John recognised Patient A's mental health deterioration, he would have been more likely to refer Patient A to the MDT, thereby involving a much broader group of medical professionals. This may have resulted in a comprehensive assessment, package of care and support being put in place, including for example, the Crisis Resolution Home Treatment Team. In the panel's view, this may have improved Patient A's chance of survival.

The panel therefore determined that by Mr John not discussing Patient A at a MDT meeting and/or at a case formulation, he contributed to the loss of a chance of Patient A's survival.

The panel was also mindful of the other charges it had found proved, where it had found that they all appeared to confirm the need for a discussion or assessment by the MDT. The panel concluded that Mr John's omissions were a significant oversight that could have increased Patient A's chance of survival. However, for the panel, the most significant factor was the fact that Mr John failed to recognise the deterioration of Patient A's mental health condition.

The panel therefore found charge 8 proved in that Mr John's actions at one or more of charges 1 to 7 contributed to the loss of a chance of Patient A's survival.

Charge 10

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

10. *Your conduct at charge 9 in providing incorrect information in a statement was a breach of your duty of candour.*

This charge is found NOT proved.

In reaching this decision, the panel had regard to charge 9 which Mr John had made an admission to:

> *"That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:*
>
> 9. *Submitted a report to the Coroner stating that you saw Patient A every month when that was not the case.*"

The panel considered that Mr John had a professional and personal duty to be open, honest and act with integrity at all times. It took into account the NMC's joint guidance with the General Medical Council on the duty of candour:

> '*Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested...*'

The panel had sight of the report prepared by Mr John for the Coroner dated 10 December 2018. The report stated:

> '*I acted as Lead Practitioner to [Patient A] and I visited him on a monthly basis and arranged medical reviews as required...*'

The evidence before the panel was that Mr John had visited Patient A four times on 16 March 2018, 13 June 2018, 21 September 2018 and 8 October 2018, and he had spoken

to Patient A on 21 March 2018 and 29 March 2018. Mr John had therefore not seen Patient A as he claimed.

The panel then considered the transcript of Mr John's evidence at the inquest hearing:

> '*[Question]:* *From the time of [PRIVATE] when you're putting in increased support, how often were you seeing him??*
>
> *[Mr John]:* *It varied, it could be monthly, could be weekly. Well, I think it was mostly monthly.*
>
> *...*
>
> *[Question]:* *Okay. So your statement is slightly misleading when you say you visited him on a monthly basis, because that's not right is it? You didn't visit him every month?*
>
> *[Mr John]:* *No, I guess that's not right*'

The panel was satisfied that with the benefit of hindsight and after being taken to the specific evidence and told that his statement was incorrect, Mr John accepted that he had got it wrong. Mr John's action in accepting that he had got it wrong, was in the panel's view, an act of candour. The panel therefore found this charge not proved.

Charge 11

That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:

11. *Your conduct at charge 9 was dishonest in that you deliberately sought to represent that you had seen Pat A more regularly than you had.*

This charge is found NOT proved.

In reaching this decision, the panel had regard to charge 9 which Mr John had made an admission to:

> *"That you, a registered mental health nurse, whilst working as the Lead Practitioner for Patient A:*
>
> *9. Submitted a report to the Coroner stating that you saw Patient A every month when that was not the case."*

The panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 in which the Supreme Court, giving judgment, stated as follows:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The panel considered whether Mr John honestly believed that he had visited Patient A every month as he had stated in his report to the Coroner, or whether he set out to deliberately mislead the Coroner in his report.

The panel noted that it was not unreasonable for the Coroner to expect the evidence provided by Mr John in his report to be accurate. The '*carenotes*' recorded Mr John's contact with Patient A and he could have relied upon those entries to provide an accurate report to the Coroner.

The evidence before the panel was that Mr John had visited Patient A four times on 16 March 2018, 13 June 2018, 21 September 2018 and 8 October 2018, and he had spoken to Patient A on 21 March 2018 and 29 March 2018. Mr John had therefore not seen Patient A as he claimed.

The panel also took into account the statements from Mr John's other colleagues which suggested that Mr John had otherwise acted consistently and in a patient-centred manner, even though he was 'lax' with record keeping and updating patient notes.

The panel found no evidence otherwise before it of Mr John attempting to mislead. The panel considered that Mr John appeared to be of good character, with an otherwise unblemished history of professional conduct.

The panel noted that Mr John accepted that he had got it wrong after being corrected at the inquest hearing. The panel was satisfied that, on the balance of probabilities, at the time of making the statement, Mr John held the genuine belief that he had seen Patient A every month, until under questioning at the inquest, having been taken to the specific evidence, he accepted his error.

The panel determined, by applying the objective standards of ordinary decent people, that Mr John's conduct at charge 9 was not dishonest. The panel did not consider that Mr John deliberately sought to mislead or represent that he had seen Patient A more regularly than he had. It therefore found this charge not proved.

Fitness to practise

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

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

Mr Malik invited the panel to take the view that the facts found proved amounted to misconduct. He referred the panel to the cases of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, *Calhaem v GMC* [2007] EWHC 2606 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Mr Malik submitted that Mr John's actions fell short of the professional standards expected as set out in 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code), and highlighted the parts of the Code that Mr John had breached.

Mr Malik submitted that when considering the seriousness of the misconduct, the panel would take into account evidence of any relevant contextual factors. He submitted, however, that in this case, there were none.

Mr Malik identified the specific, relevant standards where Mr John's actions amounted to misconduct. He submitted that Mr John's failings related directly to clinical practice. Mr Malik submitted that the conduct was serious in that it related to failures in respect of

basic, but important aspects of nursing which should have at all times been undertaken effectively and appropriately. He submitted that failure to undertake such tasks appropriately have the potential for serious, unwarranted, patient harm as was evident from the sad circumstances of this case and the outcome for Patient A.

Mr Malik submitted that Mr John's conduct also fell short of the local Trust's CPA policy which was in force at the time of the incident. He submitted that as Patient A's Lead Practitioner, Mr John had a general duty to stay in touch with patients' carers and maintain regular contact. He highlighted the panel's finding that Mr John had failed to respond to Person 1 in a thorough and/or timely manner, and the evidence about the impact this had on Patient A's sister.

Mr Malik submitted that Mr John's conduct also fell short of the Trust's procedure and guidance for the use of Clozapine policy. Mr Malik submitted that by breaching his duty, Mr John was not being accountable in his role for caring for Patient A, which was a negligent act.

Mr Malik submitted that the fact that Mr John failed to assess and/or update Patient A's care plan and failed to carry out and/or record an updated risk assessment for Patient A was a breach of duty because it amounted to poor record keeping which was also a negligent act.

Mr Malik submitted that the panel's finding that by not discussing Patient A at an MDT meeting and/or at case formulation, Mr John contributed to the loss of a chance of Patient's A's survival. He submitted that this was an extremely serious charge found proved.

Mr Malik submitted that Mr John's conduct was a serious departure from the Code, and fellow practitioners would consider such a departure deplorable. He submitted that the charges found proved fell far short of what would have been expected of a registered nurse and amounted to misconduct.

Submissions on impairment

Mr Malik 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)*, Yeong v GMC* [2009] EWHC 1923 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Malik submitted that the question that would help the panel decide whether Mr John's professional fitness to practise is impaired is "*can the nurse, midwife or nursing associate practise kindly, safely and professionally*?".

Mr Malik submitted that Mr John's actions put a patient at unwarranted risk of harm. He invited the panel to consider Witness 5's clear oral evidence where he was of the opinion that Patient A's death could have been avoided. Mr Malik highlighted the panel's conclusion about Mr John having contributed to the loss of a chance of Patient A's survival, and submitted that in the absence of full insight and remediation the risk of repetition and future harm remains.

Mr Malik submitted that Mr John's actions have brought the nursing profession into disrepute and that he has breached fundamental tenets of the nursing profession by failing to promote professionalism and trust (not keeping to and upholding the standards and values as set out in The Code). He submitted that providing a high standard of care is a fundamental tenet of the nursing profession, and the provisions of the Code also constitute tenets of the nursing profession. Mr Malik submitted that by failing to provide a high standard of care at all times and comply with the core principles of the Code as set out above, Mr John breached fundamental tenets of the profession.

Mr Malik submitted that Mr John's conduct undermined the public's trust and confidence in the profession and could result in patients, and members of the public, being deterred from seeking nursing assistance when needed.

Mr Malik invited the panel to conclude that a finding of impairment is required in this case to mark the unacceptability of the behaviour, emphasise the importance of the fundamental tenets breached, and to reaffirm proper standards or behaviour.

The panel also had regard to the documents sent by Mr John, comprising of various feedback emails from colleagues relating to his revalidation in May 2021.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cheatle v GMC* [2009] EWHC 645 (Admin) and *Roylance v General Medical Council*.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* 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.'*

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

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

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

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

To achieve this, you must:

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

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

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.6 share information to identify and reduce risk

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:

10.1 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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

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'.

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

The panel began by considering the charges found proved in this case. It considered each of the charges in turn to determine whether, individually, they amounted to misconduct.

<u>Charges 1a and 1b</u>

The panel noted that charges 1a and 1b related to Mr John's failure to assess and/or update Patient A's care plan and his failure to record a risk assessment against the background of compelling evidence before it that Patient A's mental health was deteriorating. The panel determined that Mr John was responsible for making his own

independent clinical judgement about the changing nature of risks. The panel considered the fact that Mr John did not assess and/or update the care plan and risk assessment, which had a significant impact on the subsequent handover process when he went on leave in October 2022. Patient A's care was passed on to the duty team on 22 October 2018. The panel therefore concluded that Mr John's conduct at charges 1a and 1b fell seriously short of the standards expected of a registered nurse and therefore amounted to misconduct.

Charge 1c)i

The panel noted that Patient A's appointment with the psychiatrist had already been booked via the administration team at the earliest available appointment (16 November 2018) following a request by Mr John. It had no evidence before it to suggest that there was any requirement for Mr John to arrange for an urgent appointment, or for Patient A to be seen earlier than the appointment already planned.

The panel was mindful of Dr 4's evidence that it was not just about sending Patient A to a psychiatrist, but the broader context of having a clinical professional recognise Patient A's deteriorating mental health condition and then acting accordingly, for example by referring him to the MDT. The panel therefore determined that Mr John's conduct in respect of this charge would not be regarded as deplorable. It therefore found no misconduct in relation to charge 1c)i.

Charges 1c)ii and 1c)iii

The panel decided that it should have been clear to Mr John that Patient A's mental health condition was deteriorating, but he failed to recognise it. It considered that this information, from a number of different sources, should have led Mr John to recognise the deterioration and to refer Patient A to the MDT and/or his supervisor. Had this occurred, they could have identified there were major issues and concerns, created a new care plan and then acted on it, with a chance of preventing Patient A from taking his own life on this occasion.

The panel determined that Mr John's conduct at charges 1c)ii and 1c)iii fell seriously short of the standards expected of a registered nurse and therefore amounted to misconduct.

Charge 1c)iv

The panel noted the evidence from Witness 3 in the transcript of his evidence at the inquest hearing that:

> '*The hearing voices group, for me to some extent, is arguably neither here nor there. Hearing voices group runs for specific periods of time at specific times of the year, so there are only periods of time that you can actually refer to the voices group, it doesn't run all of the time. So that's not really a concern, but I do hear the concerns just around access for a medical review.*'

The panel was unclear as to how Mr John referring Patient A to the voices clinic, despite noting on 12 September 2018 that he would, would have made a significant difference in Patient A's care. On this basis, the panel was not satisfied that Mr John's omission at charge 1c)iv was serious enough to amount to misconduct.

Charges 2a and 2b

The panel took into account that it appeared from the evidence that Patient A had only missed three morning doses of his Clozapine. However it considered that this was an important medication in Patient A's treatment and that after being alerted to this information by Patient A and failing to act, Mr John had failed in his responsibility to follow the Trust's policy. [PRIVATE]. Further, in his entries in Patient A's '*carenotes*', Mr John had indicated that he would arrange a medical review with the consultant. The panel noted that the policy was clear that if there were any concerns, then the matter should be referred to the consultant. In light of the potential impact this had on Patient A's care and treatment, the panel determined that Mr John's conduct at charges 2a and 2b was serious enough to amount to misconduct.

Charges 3a and 3c

The panel had heard from Witness 5 that smoking could cause up to a 50% reduction in the effectiveness of Clozapine. It noted that this was a key medication in Patient A's treatment which had been prescribed as a last resort intervention. The panel determined that Mr John should have provided information to Patient A on the impact of smoking on the effectiveness of his medication and sought medical advice from a consultant and/or the Denzapine Monitoring Service. It found that Mr John's not doing so was a serious departure from the standards expected of a registered nurse, and therefore amounted to misconduct.

Charge 3b

The panel took into account the information provided to Mr John by Person 1 that Patient A was smoking cigarettes. It considered that this was important information to include in the care notes, particularly because of the significance of Clozapine in Patient A's treatment and the impact of smoking on the effectiveness of this medication. Mr John should have noted this information in Patient A's '*carenotes*' and updated the risk assessment and care plan accordingly. On this basis, the panel determined that Mr John's failure to record the information in Patient A's care notes was serious enough to amount to misconduct.

Charge 5a

The panel noted that Person 1 was a key contact, who above anyone else outside the mental health team, needed to be kept informed of Patient A's health and welfare. It had been identified in Patient A's care notes that Person 1 should be kept informed. The panel considered that by not contacting Person 1 in that role, Mr John failed in his duty to make sure she was kept up to date on Patient A's care and condition.

The panel determined that by failing to respond thoroughly and/or in a timely manner, or at all, to various emails from Person 1, Mr John fell short of the standards and behaviour expected of a registered nurse, and not doing so was serious enough to amount to misconduct.

Charge 5b

In respect of this charge, the panel determined that Mr John not saving Patient's emails or the information in them to Patient A's care notes, was serious enough to amount to misconduct because whilst there was no formal handover, no one who followed on in caring for Patient A would have known about the issues raised in those communications, for example Patient A's smoking.

Charge 6a

The panel accepted that Person 1 was a key contact for Patient A. However, it noted that Patient A had the information of who to contact in Mr John's absence available to him and that he had used these contacts previously. The panel therefore found that whilst it would have been preferable for Person 1 to receive details of who to contact in Mr John's absence, Mr Pettitt not doing so did not amount to misconduct.

Charge 6b

The panel had concluded that it had compelling evidence that Patient A's mental health condition was deteriorating and that Mr John had not identified this, or recorded it in Patient A's care plan. A failure to record information or update the care plan meant that the duty team did not receive important information that it may have relied upon in this case.

The panel considered that Mr John's omission had a significant impact on the patient's follow up care and the treatment given by the team to Patient A after Mr John went on leave. Mr John was Patient A's Lead Practitioner and had failed in his duty to recognise deterioration and make colleagues aware of the deterioration. Patient A's risk assessments and care notes were not up to date and so the information before the duty team after Mr John went on leave was limited. The panel concluded that by Mr John not providing an adequate handover and/or making colleagues aware of Patient A's deteriorating mental health condition, this was a serious departure of the standards expected of a registered nurse and amounted to misconduct.

Charge 7

The panel was of the view that whilst it would have been preferable for Mr John to record in Patient A's care notes that he had spoken to Patient A on 16 October 2018 and/or his rationale for telling Person 1 that Patient A was on an "*even keel*", this would not have made a significant difference to the outcome for Patient A. The panel considered that, in any event, Mr John had made the wrong judgement and whilst this was another example of his poor record keeping, it was not serious enough to amount to misconduct on its own.

Charge 8

The panel took into account the evidence of Dr 4 and Witness 5 which stated that Patient A's death could have been avoided. The panel acknowledged that this was a result of Mr John not recognising that Patient A's mental health was deteriorating, not noting his frequent attendances at A&E were signs of a decline and his failure to involve the MDT. For those reasons, the panel determined that Mr John's actions contributing to the loss of a chance of survival were a serious departure from the standards expected of a registered nurse and therefore amounted to misconduct.

Charge 9

The panel noted that Mr John had made an error in relation to the information he provided in the report to the Coroner. There was no evidence before the panel that he intended to mislead the Coroner. The panel therefore found that Mr John's conduct at charge 9 was not serious enough to amount to misconduct.

Decision and reasons on impairment

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

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

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

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only*

whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) ...'

The panel determined that limbs a), b) and c) are engaged in this case. It found that Patient A was put at risk of harm as a result of Mr John's misconduct. The panel found that Mr John's misconduct breached the fundamental tenets of the nursing profession, including providing safe and effective care and communicating effectively, and therefore brought its reputation into disrepute.

The panel considered the factors set out in the case of *Cohen v General Medical Council* and whether the concerns identified in Mr John's nursing practice were capable of being addressed, whether they have been addressed and whether there was a risk of repetition of a similar kind at some point in the future.

There was no evidence before the panel that Mr John had acknowledged that his actions or omissions amounted to departures from expected practice. The panel saw no evidence of any reflection that Mr John had into the impact of his misconduct on Patient A. It was not provided with any evidence demonstrating Mr John's understanding of why what he did was wrong, how his actions put patients at risk of harm and how they impacted negatively on the reputation of the nursing profession. The panel also had no evidence before it that Mr John would manage a similar situation differently in the future.

The panel was satisfied that the misconduct in this case is capable of being addressed. It carefully considered the evidence before it in determining whether or not Mr John has taken steps to strengthen his practice. However, the panel had not seen any up to date evidence that Mr John has strengthened his practice and addressed the areas of concern.

The panel took into account the emails from Mr John's colleagues in relation to his revalidation in May 2021. These email testimonials commented Mr John's good practice, but did not indicate that they were written in the knowledge of the concerns in these proceedings. The panel therefore considered that they were of limited use. The panel noted the supportive comments of the NMC witnesses who had worked with Mr John within their written statements which indicated that he was a good nurse. However, the panel balanced these positive comments against its findings in relation to Mr John's contribution to the loss of a chance of survival.

Accordingly, the panel concluded that Mr John's misconduct presented risks which are likely to be repeated in the future. It found that there is a risk of repetition and that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

The panel had seen some evidence from Mr John's colleagues which confirmed that he was a kind professional who acted sincerely and in good faith. However, the panel was of the view that Mr John's clinical judgement in relation to a deteriorating patient was poor. The panel therefore determined that whilst Mr John can practise kindly, it was not satisfied that he can practise safely and professionally.

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

The panel determined that a finding of impairment on public interest grounds is also required because Mr John had put patients at risk of harm through his misconduct. The panel considered that a well-informed member of the public would be concerned if a finding of impairment were not made to mark the public interest.

Finally, the panel concluded that public confidence in the profession and the NMC as a regulator would be undermined if a finding of impairment were not made in this case which concerned failures around Patient A's deteriorating mental health condition and Mr John's contribution to the loss of the chance of survival. It therefore also found Mr John's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr John off the register. The effect of this order is that the NMC register will show that Mr John has been struck-off the register.

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

Submissions on sanction

Mr Malik informed the panel that in the Notice of Hearing, dated 8 April 2024, the NMC had advised Mr John that it would seek the imposition of a striking-off order if the panel found his fitness to practise currently impaired. He submitted that a striking-off order is the most appropriate and proportionate sanction in this case.

Mr Malik proposed that the following aggravating features were present in this case:

- It was not an isolated incident;
- There were a range of concerns relating to lack of escalation, medication management, record keeping and risk assessments;
- Patient A was a vulnerable patient;
- Mr John's actions and omissions contributed to the loss of the chance of Patient A's survival;
- Mr John has demonstrated limited remediation, insight and remorse.

Mr Malik submitted that by way of mitigation:

- Mr John was working on a part-time basis and was on leave when Patient A died;
- There was no formal handover process in place at the Trust for when staff went on

leave;

- The Trust did not appear to have safety mechanisms in place for completing risk assessments or standard reviews.

Mr Malik referred the panel to the SG and submitted that the nature and seriousness of Mr John's misconduct raised fundamental concerns about his professionalism. He submitted that Mr John's actions were a significant departure from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. Mr Malik highlighted the panel's findings on impairment, and submitted that there was nothing to suggest that Mr John has accepted the concerns that have been found proved by the panel, or shown the requisite amount of insight.

Mr Malik submitted that the concerns in this case are difficult to address or put right and constitute a serious breach of nursing standards. He submitted that the findings in this case demonstrated that Mr John's actions were serious and to allow him to continue practising would undermine public confidence in the profession and the NMC as a regulatory body.

Mr Malik submitted that a striking-off order is a sanction that the higher courts would expect, and any other sanction would be unduly lenient.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- There was a pattern of misconduct which took place over a period of time.
- There were a range of concerns relating to Mr John's failure to recognise Patient A's deterioration, including a lack of escalation, record keeping and risk assessments.
- Mr John's misconduct involved a particularly vulnerable patient.
- Mr John's actions and omissions contributed to the loss of the chance of Patient A's survival.
- Mr John has demonstrated limited remorse, insight or reflection into his failings.

The panel also took into account the following mitigating features:

- Mr John raised concerns about a high workload at the time.
- Mr John was working in an environment where there were poor practices in relation to record keeping and handover arrangements.

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

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

The panel next considered whether placing conditions of practice on Mr John's registration would be a sufficient and appropriate response. It was mindful that any conditions imposed must be proportionate, measurable and workable. The panel was of the view that some of the misconduct identified in this case can be addressed through retraining. However, the panel concluded that Mr John's failure to accept the serious nature of the concerns, alongside his lack of insight meant that conditions of practice could not be put in place that would sufficiently protect patients from the risk of harm in future. There was also no evidence before the panel that Mr John would be willing to comply with a conditions of practice order.

The panel therefore determined that there are no practical or workable conditions that could be formulated. Furthermore, the panel concluded that placing conditions on Mr John's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour...*

The panel noted that Mr John's actions and omissions were not a single instance of misconduct. It considered that there were numerous instances of failure by Mr John, some of which were very serious. The panel determined that there was evidence of an attitudinal problem by way of Mr John's lack of insight and his denial of most of the charges in this

case. The panel noted that there was no evidence of repetition since the incidents, however the panel was not satisfied that Mr John has demonstrated sufficient insight. Furthermore, the panel concluded that Mr John poses a significant risk of repeating the behaviour.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel also noted that the serious breach of the fundamental tenets of the profession evidenced by Mr John's actions is fundamentally incompatible with Mr John remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel determined that, in light of the seriousness of Mr John's misconduct and his lack of insight, remorse or strengthened practice, the regulatory concerns raised fundamental questions about Mr John's professionalism.

The panel was of the view that public confidence in the profession would be undermined if Mr John was not removed from the register. It was of the view that members of the public would be most concerned to learn that Mr John's actions, which related to misconduct

across numerous areas of nursing practice, contributed to the loss of the chance of Patient A's survival, and that there was a risk of repetition due to his lack of insight.

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

The panel therefore concluded that a striking-off order is the only sanction which will be sufficient to protect patients, members of the public, and maintain professional standards because a lesser sanction would not reflect the seriousness of the misconduct in this case, nor address the ongoing risk of repetition identified by the panel.

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

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

This will be confirmed to Mr John in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of

this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr John's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Malik. He invited the panel to make an interim suspension order for a period of 18 months to cover any appeal period until the substantive striking-off order takes effect.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to ensure that Mr John cannot practise unrestricted before the substantive striking-off order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.