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:	**Martin John Pettitt**
NMC PIN:	10H3023E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – (December 2012)
Relevant Location:	West Sussex
Type of case:	Misconduct
Panel members:	Museji Ahmed Takolia (Chair, Lay member) Jonathan Coombes (Registrant member) June Robertson (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 Pettitt:	Not present and unrepresented
Facts proved by admission:	Charge 6
Facts proved:	Charges 1, 2, 4, 5, 8, 9, 10, 11 and 12
Facts not proved:	Charges 3, 7 and 13
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 Pettitt was not in attendance and that the Notice of Hearing letter had been sent to Mr Pettitt'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 Pettitt'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 Pettitt 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 Pettitt

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

Mr Malik referred the panel to the email from the Royal College of Nursing (RCN) dated 28 March 2024, which stated:

'*We write to inform you that we are no longer acting for Mr Martin Pettitt in these proceedings. Please ensure that our name is removed from the record and that all future correspondence is sent directly to the registrant.*

Mr Pettit has asked us to inform you that he no longer wishes to engage with these proceedings due to [PRIVATE], he [PRIVATE] and will not be returning to nursing. In addition to this, he [PRIVATE]. He instructs that he has not taken this decision lightly but that he believes that this is the correct decision for him.'

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 Pettitt. In reaching this decision, the panel considered the submissions of Mr Malik, the written email dated 28 March 2024 from the RCN on behalf of Mr Pettitt, 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 Pettitt;
- Mr Pettitt has informed the NMC that he has received the Notice of Hearing and confirmed 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 Pettitt 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 can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the result of Mr Pettitt'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 Pettitt. The panel will not take anything negative from Mr Pettitt's absence in making its findings of fact.

Details of charge

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

1. Failed to carry out and/or record an updated risk assessment for Patient A.

2. Failed to review and/or update Patient A's care plan.

3. Failed to make a formal referral for Patient A to the Crisis team.

4. Sent Patient A to Shepherds House at a time when he was unable to have his bloods taken.

5. Told Person 1 that the crisis team were available at the weekend when this was not the case.

6. On discovering that the crisis team were not available over the weekend, failed to tell Patient A and/or Person 1.

7. Recorded in the notes on 21 November 18 that you had left a message on Patient A's answerphone on 2 November 2018 to inform him that the crisis team were not available at the weekend when you had not said this in the voicemail.

8. Failed to take appropriate action after not being able to get in contact with Patient A on 2 November 2018 and/or 5 November 2018.

9. Failed to inform Person 1 that you had not seen and/or heard from Patient A since 1 November 2018.

10. Recorded in Patient A's notes that you had spoken to Person 1 on the phone on 5 November 2018 when you had not.

11. Your actions at one or more of charges 1 to 10 above contributed to the death of Patient A or in the alternative the loss of a chance of survival.

12. Your conduct at charges 7 and/or 10 in providing incorrect information in Patient A's notes was a breach of your duty of candour.

13. Your conduct at charge 7 was dishonest in that you deliberately sought to represent that you had informed Patient A that the crisis team were not available at the

weekend.

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 Pettitt'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 Pettitt on 14 January 2021. Mr Pettitt first entered onto the NMC's register on 6 December 2012.

Mr Pettitt was working as a Community Mental Health Nurse at the Worthing Assessment and Treatment Service (the ATS), which is part of Sussex Partnership NHS Foundation Trust (the Trust) Mental Health Service. Mr Pettitt started working for the ATS in August 2018.

On 29 October 2018, Mr Pettitt was on the duty rota and from this date, provided clinical care and support to Patient A in the absence of his Lead Practitioner (Registrant A) who was on annual leave between 22 October 2018 and 5 November 2018.

Patient A had a [PRIVATE] diagnosis of [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 commenced [PRIVATE].

The concerns in this case relate to Mr Pettitt's alleged failure to preserve Patient A's safety during the period in which Patient A's care was passed onto him, as part of the on-call duty team. This included amongst other allegations:

- Sending Patient A to Shepherd's House Rehabilitation Centre (Shepherd's House) for blood tests at a time when bloods could not be taken;
- Telling Person 1 (Patient A's sister) by telephone that the Crisis Resolution Home Treatment Team (the crisis team) were available over the weekend when they were not;
- Recording that he left a message on Patient A's answerphone on 2 November 2018 to inform him that the crisis team were not available at the weekend when he had not said this in the voicemail;
- A failure to take appropriate action after not being able to get into contact with Patient A on 2 November 2018 and/or 5 November 2018;
- A failure to inform Person 1 that he had not seen and/or heard from Patient A since 1 November 2018;
- Recording in Patient A's notes that he had spoken to Person 1 on the telephone on 5 November 2018, when he had not; and
- A failure to carry out a clinical risk assessment and update Patient A's care plans.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Malik, who informed the panel that Mr Pettitt had made an admission to charge 6.

The panel took account of Mr Pettitt's signed Case Management Form dated 18 September 2023, in which he had confirmed his admissions and denials. It therefore found charge 6 proved, by way of Mr Pettitt's admission.

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 Pettitt'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.

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

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

Charge 1

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

1. *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 noted that Mr Pettitt had taken responsibility for Patient A's care on 29 October 2018 because Registrant A (Patient A's Lead Practitioner) was on annual leave and Mr Pettitt was a registered nurse on the duty rota.

The panel looked closely at Mr Pettitt's '*Generic Community Nurse, Band 6*' job description document, which set out that:

'*The post holder will be an autonomous practitioner who will carry continuing responsibility for a defined caseload of service users by undertaking the following duties:*

- *To undertake assessments of individuals and their families in the designated*

care group with complex health presentations, including those service users presenting with higher levels of risk. To develop alongside the service user their care plan.

- *...*
- *To assess and manage on going risks as identified during the assessment, ensuring that this is done in collaboration with the service user and carers. To regularly review risk factors and make changes to the management of them as necessary.*'

The panel was therefore satisfied that Mr Pettitt had a duty to carry out and/or record an updated risk assessment for Patient A during the period he was responsible for Patient A's care.

The panel also took account of the written submissions from Mr Pettitt's former representative at the RCN dated 27 September 2021, which stated:

'*The Registrant instructs that whilst during this period he could have handed over various tasks to the relevant duty worker each day, he chose to remain assisting Patient A as the concerns that he was dealing with were in respect of medication and as such it was more sensible for him as a qualified nurse to assist with these queries rather than some of the other duty workers who were professionals from other disciplines such as social workers.*'

The panel noted that Mr Pettitt had dealt with Patient A's medication on 30 October 2018 and then went to visit Patient A at home on 1 November 2018.

The panel next considered Dr 4's '*First Medical Report*' dated 8 October 2019, which stated that:

'[PRIVATE]. This, again, should have resulted in a full clinical assessment by his regular team, a risk assessment and a review of his care plan.'

The panel also noted Witness 5's expert witness report dated 26 April 2022 which stated:

> '*I have highlighted within the chronology ... dates and times when these failings occurred.*
>
> *My opinion is that this may have contributed to [PRIVATE] Patient A in a number of areas:*
>
> *a) By not correctly monitoring his care and carrying out a full risk assessment when it was warranted.*'

The panel attached weight to the evidence of both experts and concluded that in light of significant events and changes in Patient A's deteriorating [PRIVATE], a risk assessment should have been carried out, but it had not been.

The panel also considered Patient A's '*carenotes*', an electronic care planning system for recording the care provided to an individual. It noted that the entries on this system were by staff, including Mr Pettitt, who had had contact with Patient A. The panel noted the two entries on 31 October 2018 by other professional colleagues, notably Colleague C and Colleague D, indicating Patient A's [PRIVATE].

Mr Pettitt's account was that he had carried out a risk assessment. The panel noted the written submissions from Mr Pettitt's former representative at the RCN dated 27 September 2021, which stated:

> '*During the period stated above the Registrant had both telephone appointments and on the 1 November 2018 a personal visit with patient during which he spoke to him about his mental and physical health, gave him advice and undertook a risk assessment with regards to his [PRIVATE]. The Registrant instructs that his assessment of patient was that he was low risk [PRIVATE]. During this visit the*

Registrant instructs that he also advised patient of the titration process and the support available to him including the use of PRN medications if required.

...

The Registrant acknowledges that there were times during the course of the week where he couldn't reach patient but that given his positive risk assessment of on [sic] the 1 November 2018 and the fact that he had been able to locate him on the 2 November 2018 at Shephard House, the Registrant instructs that there was no reason to be concerned that patient was in a state of crisis. In addition, it should be noted that patient was living independently and that he had access to the weekend support services at that point if he required them. The Registrant instructs that patient was familiar with these alternative services as he had used them in the past.

The panel then noted the transcript of Mr Pettitt's evidence at the inquest hearing, where he stated:

'...My assessment [inaudible] there's no risk in behaviour pattern or anything like that to warrant crisis team support. I could have raised it as – he said, 'Did you want to raise it as a raised risk?' but to be honest, there was no raised risk to have warranted to do that at that time.'

Whilst it was evident that Mr Pettitt did assess Patient A's risks at the time, he did not identify the increasing risk, as referenced by Dr 4. Mr Pettitt made no record or update in risk assessment documentation for Patient A. It therefore determined, on the balance of probabilities, that Mr Pettitt failed to record or update the risk assessment documentation. It found charge 1 proved.

Charge 2

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

2. *Failed to review and/or update Patient A's care plan.*

This charge is found proved.

In reaching this decision, the panel first considered whether Mr Pettitt had a duty to review and/or update Patient A's care plan. The panel noted that in the documentary and witness evidence before it, Patient A's care plan was a document titled '*CPA Personal Support Plan*'.

The panel noted that Mr Pettitt had taken responsibility for Patient A's care from 29 October 2018 as outlined in the previous charge. It was satisfied that since Mr Pettitt was in charge of Patient A's care between 29 October 2018 and 5 November 2018, he had a duty to review and/or update Patient A's care plan.

The panel took account of Patient A's CPA Personal Support Plan. It noted that no further updates had been made to the care plan since March 2018, despite the deterioration in Patient A's mental health.

The panel next took into account Dr 4's '*First Medical Report*' dated 8 October 2019, which stated that:

> '*[PRIVATE]. This meant that at a time that he was most unwell, he was no longer receiving treatment. It does not appear to have been recognised by those responsible for his care that this was the case. No care plan was put in place to acknowledge the fact that not only were [Patient A's] symptoms worsening but also [PRIVATE].*
> *...*
> *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 [PRIVATE] an outpatient appointment should have been booked with [PRIVATE] .*'

The panel considered that Dr 4 had provided clear and consistent evidence that Mr Pettitt should have reviewed and updated Patient A's care plan, but he did not.

The panel noted that Mr Pettitt had made entries in Patient A's '*carenotes*' between 29 October 2018 and 21 November 2018 (a retrospective entry about a telephone call he attempted on 2 November 2018). The panel recognised that Mr Pettitt had been recording updates in Patient A's condition and care in '*carenotes*' but it was satisfied that this did not amount to the updating of Patient A's care plan. This is because the panel concluded that the care plan related to higher level and more strategic planning of Patient A's care rather than a record of daily updates.

The panel noted that Mr Pettitt had not provided evidence in respect of this charge.

The panel therefore determined that, on the balance of probabilities, Mr Pettitt failed to review and/or update Patient A's care plan.

Charge 3

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

3. *Failed to make a formal referral for Patient A to the Crisis team.*

This charge is found NOT proved.

The difficulty with this charge is that the NMC had provided the panel with no evidence to establish the requirement to make a 'formal' referral to the crisis team.

In reaching this decision, the panel noted that Mr Pettitt had taken responsibility for Patient A's care from 29 October 2018 as outlined in the previous charge. It was satisfied that

since Mr Pettitt was in charge of Patient A's care between 29 October 2018 and 5 November 2018, he had a duty to make a referral to the crisis team where necessary.

The panel took into account Mr Pettitt's entries in Patient A's '*carenotes*' on 31 October 2018 at 09:30. These entries indicated that Mr Pettitt made a telephone call to the crisis team and spoke to Colleague D. He recorded '*explained situation with Patient A [Colleague C] will arrange monitoring once blood tests complete.*' Mr Pettitt then spoke to the manager at Shepherd's House and recorded that he *'[PRIVATE].*'

Witness 5's expert witness report dated 26 April 2022 stated that:

> '*My opinion is that this may have contributed to [PRIVATE] by Patient A in a number of areas:*
> *...*
> *d. By poor communication between different area clinical teams, and not making a formal referral to the Crisis team, leaving Patient A unsupported and vulnerable.*
> *...*
> *The communication between Martin Pettitt and the Crisis team fell below the standards expected in the nursing care of Patient A because Martin Pettitt did not make a formal referral to the Crisis team resulting in the passing over of vital information being lost. This should have happened, especially when Martin Pettitt knew that Patient A [PRIVATE], and the Crisis team would not be supporting patient A over the weekend of 2nd November 2018 to the 5th November 2018.*
> *...*
> *The failure to maintain adequate communication between health professionals relating to the care of Patient A resulted in a breakdown in communication channels between a clinician and another clinical team and this was a breach of duty. What is evident is that Martin Pettitt and a member of the Crisis team had an informal conversation over the care of Patient A but with no validity and reliability as to how they reached their conclusions without the aid of a formal assessment to guide them.*'

The panel then took into account the letter from Mr Pettitt's former representative at the RCN dated 27 October 2022, which set out comments in response to the regulatory concerns. It stated that:

> '*[Witness 3] has further stated that Colleague E believed that CRHT could support [PRIVATE] however there was no requirement to formally request crisis management support.*'

The panel had sight of the report prepared Mr Pettitt for the Coroner dated 4 January 2019. The report stated:

> '*On 2 November 2018 I contacted Shepherd House and I was advised that Patient A had not attended for a blood test [PRIVATE]. I attempted to contact Patient A to advise him of this change however he did respond and I left a message inviting him to contact our service if required. I also contacted the Crisis Resolution Home Treatment Team and they were available to offer support in the following week but declined to contact before this.*'

The panel having taken account of the evidence that Mr Pettitt had been in communication with the crisis team about Patient A's care. However, the panel had not seen any requirement from a policy or code regarding any duty to make a formal referral. It was not clear to the panel what amounted to a 'formal' referral.

It was the panel's view that whilst Mr Pettitt did speak to the crisis team, which could amount to a referral, what he did tell them did not take sufficient account of the [PRIVATE] of Patient A.

The panel therefore concluded that the NMC had not discharged its burden of proof that Mr Pettitt had a duty to make a formal referral to the crisis team. It found charge 3 not proved.

Charge 4

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

4. *Sent Patient A to Shepherds House at a time when he was unable to have his bloods taken.*

This charge is found proved.

In reaching this decision, the panel took into account Mr Pettitt's entry on Patient A's '*carenotes*' on 1 November 2018 which stated:

> '*Saw Patient A at home.*
> *...*
> *Patient A will go to Sheperd hse tomorrow for a blood test*
> *Sheperd Hse/Crisis team are aware of this.*' [sic]

The panel also noted Mr Pettitt's entry on 2 November 2018 which stated:

> '*...*
> *T/C to Sherperd Hse [sic], informed by [Colleague F] that Patient A had been there however they had no one to take bloods on duty today and have sent him to the blood clinic.*'

The panel noted Witness 3's written statement dated 8 February 2022 which stated:

> '*...On 1 November 2018 the Registrant carried out a home visit to Patient A and...I believe the Registrant mistakenly advised Patient A that he needed to return to Shepherd House for a blood test and that he would receive weekend support from*

CHRT as he had limited knowledge of local procedures having recently joined our Trust.'

The panel also took into account Witness 5's expert witness report dated 26 April 2022 which stated:

'*On this occasion I believe the actions were reasonable and the input Martin Pettitt had were [sic] to be expected. However, mistakes were evident, e.g. by sending Patient A to Shepherds House where he was unable to have his bloods taken. [PRIVATE]. It has been documented that in the Trust induction process this information was not made available to Martin Pettitt; however, it should still have been checked by Martin Pettitt beforehand. I would not class this omission as negligence but an omission in care.*'

The panel noted that Shepherd's House was unable to take Patient A's bloods due to insufficient staffing. On the basis of the evidence before it, and in light of the wording of the charge, the panel determined that Mr Pettitt had sent Patient A to Shepherd's House at a time when he was unable to have his bloods taken. It therefore found charge 4 proved.

Charge 5

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

5. *Told Person 1 that the crisis team were available at the weekend when this was not the case.*

This charge is found proved.

In reaching this decision, the panel took into account Person 1's written statement dated 1 February 2022 which stated:

'...*I asked the Registrant if the Crisis care included care over the weekend as I was concerned most offices would be closed over the weekend and he categorically said yes. I was also concerned to know the Crisis team would be available over the weekend as [PRIVATE]. Had the Registrant told me at any time that Crisis support was not going to be available, I would not have [PRIVATE]. I relied on what the Registrant told me was going to be happening and the care he had arranged for Patient A was of the understanding that the Crisis team would be providing support as they did previously, in visiting Patient A every few hours and it was a 24 hour service.*'

The panel also noted Witness 3's written statement dated 4 March 2021 which stated:

'*...Martin had previously unintentionally misinformed Patient A and [Person 1] that he would receive weekend support from the Crisis Resolution Home Treatment Team but this was not the case*.'

In addition, Witness 3's written statement dated 8 February 2022 stated that:

'*...I believe the Registrant's efforts to speak with [Person 1] were sufficient. It was just regrettable that the Registrant miscommunicated to her and Patient A that the Crisis team would be available for phone support over the weekend, when this was not the case.*'

The panel also had regard to Witness 5's expert witness report dated 26 April 2022. The report stated:

'*Martin Pettitt should have communicated to [Person 1] that her brother had not got support over the weekend in question from the Crisis team...*'

The panel then considered the '*Level 2 Comprehensive Serious Incident Review Report*' prepared for the Trust and finalised on 23 April 2019, which stated:

> '*The Practitioner contacted the Crisis Resolution Home and Treatment Team (CRHT) asking this team to provide telephone support over the weekend of the 03/11/2018 and 04/11/2018. The CRHT fed back to the Practitioner that telephone support was a service they did not provide in addition they indicated his risk profile at this time did not necessitate their input...*
>
> *...*
>
> *Response – Earlier on this day the Practitioner made a telephone call to CRHT and requested weekend telephone support in addition to asking CRHT to support [PRIVATE]. The practitioner was unaware that CRHT did not provide telephone support as a service. The Practitioner did not receive a formal response from CRHT prior to his phone call with [Patient A's] sister. The Practitioner has recollected that he did not indicate CRHT support was not in place and sincerely apologises for the way in which he relayed his feedback. His recollection is that he indicated CRHT support was a possibility.*'

The panel also took into account Mr Pettitt's response as set out in the letter from his former representative at the RCN dated 27 October 2022. It stated that:

> '*The Registrant stated that he recalls that he did not indicate CRHT support was not in place and apologises for the way in which he relayed his feedback and that his recollection is that he indicated CRHT was a possibility.*
>
> *Mr ... (serious incident lead) stated that the Registrant was unaware that CRHT did not provide weekend telephone support and that this was not included within his induction.*'

The panel was satisfied that there was sufficient evidence that Mr Pettitt had informed Person 1 that the crisis team was available over the weekend, but then did not tell her that this was not the case following contact with the crisis team.

The panel therefore found charge 5 proved.

Charge 7

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

7. *Recorded in the notes on 21 November 18 that you had left a message on Patient A's answerphone on 2 November 2018 to inform him that the crisis team were not available at the weekend when you had not said this in the voicemail.*

This charge is found NOT proved.

In reaching this decision, the panel had sight of Mr Pettitt's entry on Patient A's '*carenotes*' made retrospectively on 21 November 2018 about the telephone call he had attempted to make on 2 November 2018:

> '*retrospective entry*
> *Attempted to call Patient A (no answer) to inform him that he [sic] crisis team will not be contacting him over the weekend. Previous discussion with Patient A (when we met earlier in the week) he is aware of the 24 hour support line if needed.*'

The panel determined from Mr Pettitt's entry on Patient A's '*carenotes*' that he did not record that he had left a voicemail for Patient A informing him that the crisis team were not available at the weekend, he simply records an unanswered call. It was clear that Mr Pettitt did not inform Patient A that the crisis team were not available over the weekend. The panel therefore found charge 7 not proved.

Charge 8

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

8. *Failed to take appropriate action after not being able to get in contact with Patient A on 2 November 2018 and/or 5 November 2018.*

This charge is found proved.

In reaching this decision, the panel took into account the Trust's Active Engagement Policy which would have been in force at the time.

The panel began by considering the written submissions from Mr Pettitt's former representative at the RCN dated 27 September 2021, which stated:

> '*The Registrant acknowledges that there were times during the course of the week where he couldn't reach Patient A but that given his positive risk assessment of Patient A on the 1 November 2018 and the fact that he had been able to locate him on the 2 November 2018 at Shephard House, the Registrant instructs that there was no reason to be concerned that Patient A was [PRIVATE]...*'

The panel noted Mr Pettitt's entry in Patient A's '*carenotes*' on 2 November 2018, which stated:

> '*...*
> *T/C to Sherperd Hse [sic], informed by [Colleague F] that Patient A had been there...*'

It also noted Colleague G's entry in the '*carenotes*' on 2 November 2018, which stated:

'*Tc with Martin Pettit [sic]. Patient A had had an amber result and is not able to commence Clozapine currently...*'

In a further entry on 2 November 2018, Mr Pettitt stated that:

'*retrospective entry*
Attempted to call Patient A (no answer) ...'

The panel noted that different accounts about Patient A's attendance at Shepherd's House on 2 November 2018 created a lack of clarity about whether he was actually seen that morning.

Furthermore, Mr Pettitt knew that on 2 November 2018, Patient A had had an amber result and that the crisis team were not able to offer patient support over the weekend. Mr Pettitt made a retrospective entry in the '*carenotes*' that he had attempted to call Patient A but got no answer.

The panel then noted the transcript of Mr Pettitt's evidence at the inquest hearing which stated:

'*[Question]: So moving then onto the – when you come back to work the following week, on the Friday – sorry, on 5 November. Did you do anything on 5 November?*

[Mr Pettitt]: I tried calling and I couldn't get an answer.

[Question]: Were you concerned?.

[Mr Pettitt]: Not unduly in as much as it was kind of a pattern with [Patient A] that he quite often didn't have – answer the phone or he was out. And that was the gist of what he tended to be like, from what I could gather. I

did ask the duty worker and I believe she rang as well a bit later on in the day.'

The panel looked closely at the '*Level 2 Comprehensive Serious Incident Review Report*' which stated:

'*Friday 2nd November 2018*
Practitioner phoned [Person 1] twice towards 5.30pm to say all was well with Patient A. Patient A had contact with the Crisis Team should he need it.
...
Monday 5th November 2018
Practitioner made 2 phone calls to Patient A both of which were unanswered. The Practitioner did not visit. He asked a social worker to phone Patient A and there was no answer. She does not visit.'

Having been alerted, in particular by Person 1, to the crisis Patient A was facing, the panel noted that Mr Pettitt had exercised his own judgment of the clinical risk and decided that no further intervention was necessary.

There was some evidence before the panel that Mr Pettitt had attempted to make telephone calls to Patient A on 5 November 2018 at around 16:30. However, the panel took into account the evidence from previous risk assessments of Patient A, the number Patient A's attendances at A&E and Dr 4's evidence highlighting the significant changes in Patient A's [PRIVATE] and determined that Mr Pettitt should have been aware that Patient A's [PRIVATE] and that urgent action needed to be taken.

The panel therefore determined that Mr Pettitt had failed to take appropriate action after not being able to get in contact with Patient A on 2 November 2018 and/or 5 November 2018, and it found charge 8 proved.

Charge 9

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

9. *Failed to inform Person 1 that you had not seen and/or heard from Patient A since 1 November 2018.*

This charge is found proved.

In reaching this decision, the panel took into account Patient A's risk assessment which stated:

'*...PERMISSION GIVEN FROM PATIENT TO SHARE INFO WITH SISTER*'

The panel noted Person 1's written statement dated 1 February 2022, which provided a summary of her telephone conversation with Mr Pettitt on 2 November 2018. Person 1 went on to state in her written statement that Mr Pettitt did not speak to her on the telephone on 5 November 2018. She stated that she recalled Mr Pettitt had left her a voicemail which she listened to on the morning of 6 November 2018 in which Mr Pettitt had said that '*Patient A "sounded positive and that all was well and that he was handing back to [Registrant A] on 6 November" or words to that effect*.'

Person 1 was adamant in her oral evidence that Mr Pettitt had not spoken to her on the telephone on 5 November 2018 and she stated that she "*would not have gone away if he wasn't in safe hands*". The panel considered that Person 1's recollection was detailed and consistent with her NMC written statement and the witness statement she provided for the inquest hearing.

The panel also took into account that at that stage, Mr Pettitt was aware that the crisis team were not available over the weekend and that he had not seen and/or heard from Patient A since 1 November 2018. The panel was of the view that Mr Pettitt had a duty to

share this information with Person 1. However, based on Patient A's summary of the conversation on 2 November 2018 and the voicemail message on 6 November 2018, Mr Pettitt did not convey either of those things to her and so she was unaware of crucial matters in relation to Patient A's [PRIVATE].

The panel considered Witness 5's expert witness report dated 26 April 2022 which stated:

> '*From the care notes made available to me I note:*
> *5th November 17.30: Martin Pettitt did not write down when talking to [Person 1] that he had not seen Patient A since the 1st November 2018. His entry note reads 'I informed her of what had happened over the last few days and that I had seen [sic] at home. This helped alleviate concerns about her brother*'.

The panel also took into account the written submissions from Mr Pettitt's former representative at the RCN dated 27 September 2021, which stated:

> '*The Registrant instructs that during the relevant period he did speak with [Patient A's] sister on one occasion at the request of one of his senior managers for the purpose of providing her with a brief update. The Registrant instructs that to his knowledge there was no direction either within patient care plan or otherwise to contact patient sister routinely and as such it was not something that he did after every communication with /action with regards to his care.*'

The panel had no other evidence from Mr Pettitt relating to this charge.

The panel therefore concluded that, on the balance of probabilities, Mr Pettitt failed to inform Person 1 that he had not seen and/or heard from Patient A since 1 November 2018. It found charge 9 proved.

Charge 10

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

10. *Recorded in Patient A's notes that you had spoken to Person 1 on the phone on 5 November 2018 when you had not.*

This charge is found proved.

In reaching this decision, the panel took into account Mr Pettitt's entry on 5 November 2018 at 17:30 (the date and time for this entry is unknown). It stated:

> '*T/C to [Person 1] (sister) [PRIVATE] and has no easy way of contacting Patient A she relies on our contact to know he is safe.*
> *I informed her of what had happened over the last few days and that I had seen Patient A at home. This helped alleviate her concerns about her brother. [PRIVATE]*
> *Plan:*
> *I informed [Person 1] that I will be handing over to [Registrant A] (care coordinator) tomorrow upon his return to work.*
> *I assured [Person 1] that either I or [Registrant A] will contact her with an update tomorrow.*'

Person 1 in her written and oral evidence was very clear that she did not speak to Mr Pettitt on 5 November 2018 and that she was not informed that no one had been available to support Patient A over the weekend.

In her oral evidence, Person 1 confirmed that a voicemail had been left for her, but that she did not speak to Mr Pettitt. If she had, and she had known Patient A did not have crisis care, she would have gone straight to him.

The panel, on the balance of probabilities, preferred Person 1's evidence over that of Mr Pettitt's '*carenotes*' entry and therefore found this charge proved.

Charge 11

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

11. *Your actions at one or more of charges 1 to 10 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 Pettitt'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 Pettitt's actions at charges 1 to 10 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 Pettitt's alleged failures would

have prevented Patient A from attempting to take his own life. In his report, Witness 5 stated:

> '*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. Because of these failures within the care intervention package, it was an act of clinical negligence and this was a breach of duty. Martin Pettitt allowed Patient A an extended window of opportunity to [PRIVATE] and failed Patient A in his role of being accountable and responsible towards him...*'

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 [PRIVATE] 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*" (rather than "*would*") have been avoided.

The panel could not find, on a balance of probabilities, that Mr Pettitt's actions at charges 1 to 10 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 most concerned about the circumstances and events that took place closer to the time of Patient A's death.

The panel was of the view that the failure found at charge 8 was a key contributing factor to the loss of the chance of survival of Patient A. Mr Pettitt should have recognised that no one had seen Patient A at any point over the weekend of 3 and 4 November 2018, and he should have recognised Patient A's deteriorating condition. He should have alerted the

crisis team to this issue and this could have resulted in an urgent visit. It was the panel's view that had this been done, it may have been possible for Patient A to have survived.

The panel therefore found charge 11 proved in that Mr Pettitt's actions at one or more of charges 1 to 10 contributed to the loss of a chance of survival.

Charge 12

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

12. Your conduct at charges 7 and/or 10 in providing incorrect information in Patient A's notes was a breach of your duty of candour.

This charge is found proved.

Having found charge 7 not proved, the panel considered this charge in respect of charge 10 only.

The panel had regard to charge 10 which had been found proved:

"That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

10. Recorded in Patient A's notes that you had spoken to Person 1 on the phone on 5 November 2018 when you had not."

The panel considered that Mr Pettitt had a professional and personal duty to be open, honest and act with integrity at all times. It considered the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) which provided that:

'20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.'

The evidence before the panel was that Mr Pettitt had recorded in Patient A's notes that he had spoken to Person 1 on the phone on 5 November 2018 when he had not. Mr Pettitt's account in Patient A's notes was not consistent with the evidence given by Person 1.

The panel therefore found that Mr Pettitt breached his duty of candour by providing misleading information in Patient A's notes in respect of charge 10.

Charge 13

That you, whilst working as a community mental health nurse, between 29 October 2018 and 6 November 2018:

13. Your conduct at charge 7 was dishonest in that you deliberately sought to represent that you had informed Patient A that the crisis team were not available at the weekend.

This charge is found NOT proved.

In reaching this decision, the panel took into account its findings at charge 7.

Having found charge 7 not proved, the panel determined that charge 13 could fall away. 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

Pettitt'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 Pettitt'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 Pettitt'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 Pettitt 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 Pettitt's actions amounted to misconduct. He submitted that Mr Pettitt's failings related directly to clinical practice. Mr Malik reminded the panel of its findings on the facts and submitted that Mr Pettitt's 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 Mr Pettitt's failure to undertake such tasks appropriately had 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 Pettitt had a professional and personal duty to be open, honest and act with integrity at all times, but failed in this duty by providing incorrect information in Patient A's notes. He submitted that this was serious because honesty and integrity are fundamental tenets of the profession. Mr Malik submitted that the public expect nurses to be trustworthy and ensure they record correct information in the notes and tell the truth when they have spoken to a patient or carer, but Mr Pettitt breached the duty of candour.

Mr Malik submitted that Mr Pettitt'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 Pettitt'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 Pettitt's actions put a patient at unwarranted risk of harm. He reminded the panel of its finding that Mr Pettitt's conduct at charge 8 (that is, failing to take appropriate action after not being able to get in contact with Patient A on 2 November 2018 and/or 5 November 2018) contributed to the loss of a chance of survival. Mr Malik submitted that Mr Pettitt should have recognised that no one had seen Patient A at any point over the weekend of 3 and 4 November 2018, and he should have recognised Patient A's[PRIVATE]. Mr Malik submitted that in the absence of full insight and remediation from Mr Pettitt, the risk of repetition and future harm remains.

Mr Malik submitted that Mr Pettitt's actions have brought the nursing profession into disrepute and 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 Pettitt breached fundamental tenets of the profession.

Mr Malik submitted that Mr Pettitt'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 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*. The legal assessor also referred the panel to the correct "*test*" set out by Dame Janet Smith in her Fifth Report from the Shipman Inquiry, which referred to '*integrity*' rather than '*dishonesty*'.

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 Pettitt's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Pettitt'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

8 Work co-operatively

To achieve this, you must:

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:

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times...'.

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. It

noted that between 29 October 2018 and 6 November 2018, Mr Pettitt effectively conducted himself as Patient A's Lead Practitioner, and was working to the full scope of a Lead Practitioner as opposed to the more limited responsibilities of an on-duty practitioner.

The panel then considered each of the charges to determine whether, individually, they amounted to misconduct.

Charges 1 and 2

The panel determined that Mr Pettitt was responsible for making his own independent clinical judgement about the changing nature of risks. It noted that having taken responsibility for Patient A in place of his Lead Practitioner who was on leave, Mr Pettitt appeared to have completed a risk assessment but did not record an updated risk assessment for Patient A or review Patient A's care plan. The panel noted compelling evidence from various sources which demonstrated that Patient A's mental health condition was deteriorating.

The fact that Mr Pettitt did not update the care plan or record a risk assessment had a significant impact on the information available to other colleagues involved in Patient A's care. The panel therefore concluded that Mr Pettitt's conduct at charges 1 and 2 fell seriously short of the standards expected of a registered nurse and therefore amounted to misconduct.

Charge 4

The panel noted that Mr Pettitt had sent Patient A to Shepherd's House to have his bloods taken where it would not be possible due to staff shortages. Mr Pettitt was unaware of the staffing issues at Shepherd's House. The panel was of the view that whilst Mr Pettitt could have checked if staff were available for Patient A at Shepherd's House, that omission did not by itself amount to misconduct.

Charge 5

The panel was of the view that Mr Pettitt had told Person 1 that the crisis team were available over the weekend, because he held a genuine belief at the time that they were available. The panel took into account that Mr Pettitt was fairly new to the team and was mistaken about the availability of the crisis team. The panel therefore found that Mr Pettitt's conduct at charge 5 was not serious enough to amount to misconduct.

Charge 6

The panel noted that Person 1 had asked Mr Pettitt directly about the availability of support over the weekend as she was concerned about Patient A's welfare. Person 1 had told the panel that had she known that the crisis team were not available over the weekend, she would not have [PRIVATE] but would have gone to see her brother. The panel was of the view that by failing to tell Patient A or Person 1 that the crisis team were not available over the weekend after having found out, Mr Pettitt left Patient A at increased risk of harm. The panel determined that this was a serious failing which fell short of the standards expected of a registered nurse, and therefore found misconduct in respect of charge 6.

Charge 8

The panel noted that there was limited support available to Patient A over the weekend of 3 and 4 November 2018. Mr Pettitt had been alerted to concerns reported by Person 1 and in the panel's view, there was very clear evidence before him that Patient A's mental health condition was deteriorating and that Patient A was at increased risk, but he did not recognise it. The panel considered that Mr Pettitt failed to identify an urgent need for support and assessment for Patient A. It determined that this was not in line with the standards expected of a registered nurse, and concluded that Mr Pettitt's conduct at charge 8 was serious enough to amount to misconduct.

Charge 9

The panel noted the evidence from Person 1 that had she known Patient A did not have weekend support available, she would have been there to support him. He had already failed to tell her about that lack of support and went on to compound the issue by not informing her, at the earliest opportunity, that Patient A had not been seen since 1 November 2018. When Mr Pettitt was not able to get an answer from Patient A on the morning of 5 November 2018, he should have informed Person 1 of that fact but failed to do so. The panel determined that Mr Pettitt's failure at charge 9 was serious enough to amount to misconduct.

Charge 10

The panel noted that Person 1 had been clear in her recollection that she did not speak to Mr Pettitt on 5 November 2018, however, Mr Pettitt had gone on to record an entry in Patient A's notes that he had. The panel determined that this was intentionally misleading, did not demonstrate integrity and fell far short of the standards and behaviour expected of a registered nurse. The panel therefore found misconduct in respect of charge 10.

Charge 11

The panel had regard to the evidence before it from 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 Pettitt not recognising that Patient A's mental health was deteriorating, not noting that the significance of his frequent attendances at A&E were signs of a decline, his failure to record an updated risk assessment and update the care plan. For those reasons, the panel determined that Mr Pettitt's actions did contribute to the loss of a chance of survival and were a serious departure from the standards expected of a registered nurse and therefore amounted to misconduct.

Charge 12

The panel had regard to the NMC guidance on '*serious concerns that are more difficult to put right*'. The panel considered that registered nurses are expected to be open, honest and act with integrity at all times. It was of the view that by making misleading and false records, Mr Pettitt did not demonstrate openness, honesty or integrity. It determined that Mr Pettitt's actions in breaching the duty of candour, fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Pettitt'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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.’*

The panel reminded itself of the advice from the legal assessor that limb d) of Dame Janet Smith's "*test*" had been subsequently amended to in case law. It noted that the correct question at limb d) was:

> *'that the doctor's integrity could not be relied upon. Lack of integrity might or might not involve a risk to patients. It might or might not bring the profession into disrepute. It might be regarded as a fundamental tenet of the profession. I think it right to include it as a separate reason why a doctor might be regarded as unfit to practise, because it is relevant even when it arises in a way that is quite unrelated to the doctor's work as a doctor.'*

The panel therefore considered that its assessment of limb d) was not a question of '*dishonesty*' but rather '*integrity*'. On this basis, the panel determined that limbs a), b) c) and d) are engaged in this case. It found that Patient A was put at risk of harm as a result of Mr Pettitt's misconduct. The panel found that Mr Pettitt's misconduct breached the fundamental tenets of the nursing profession, including providing safe and effective care, and therefore brought its reputation into disrepute. The panel noted that Mr Pettitt carried out a determined act to mislead at charge 10, which demonstrated a lack of integrity. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to integrity extremely serious.

The panel considered the factors set out in the case of *Cohen v General Medical Council* and whether the concerns identified in Mr Pettitt'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.

The panel determined that the misconduct in this case is capable of being addressed. The panel was of the view that whilst difficult, a lack of integrity was not impossible to put right.

Regarding insight, the panel took account of Mr Pettitt's reflective piece. It noted that Mr Pettitt had reflected on how Patient A's case had affected him personally, but he did not

adequately demonstrate an understanding of how his actions had put patients at a risk of harm, why what he did was wrong and how this impacted negatively on the reputation of the nursing profession. Moreover, Mr Pettitt had not shown sufficient remorse nor had he reflected on the impact of his misconduct on Patient A and his family. The panel also had no evidence before it of how Mr Pettitt would manage the situation differently in the future.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, it carefully considered the evidence before it in determining whether or not Mr Pettitt has taken steps to strengthen his practice.

The panel had limited evidence of strengthened practice by way of any recent training courses undertaken by Mr Pettitt. It had sight of four testimonials from Mr Pettitt's colleagues dated between 5 August 2021 and 8 February 2022, which were supportive of him and indicated that he was a good nurse. However, the panel balanced these positive comments against its findings in relation to Mr Pettitt's contribution to the loss of a chance of survival.

Accordingly, the panel concluded that Mr Pettitt's misconduct presented risks and 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 was not satisfied that Mr Pettitt 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 Pettitt 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 Pettitt's contribution to the loss of the chance of survival. It therefore also found Mr Pettitt's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Pettitt'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 Pettitt off the register. The effect of this order is that the NMC register will show that Mr Pettitt 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 Pettitt 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:

- Patient A was a vulnerable patient;
- Mr Pettitt's actions and omissions contributed to the loss of the chance of Patient A's survival;
- Mr Pettitt has demonstrated limited remediation, insight and remorse;
- Mr Pettitt breached the duty of candour.

Mr Malik submitted that by way of mitigation:

- Mr Pettitt was relatively new in his role at the Trust, having joined in July 2018;
- Mr Pettitt had not been involved in Patient A's care prior to October 2018;
- 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 Pettitt's misconduct raised fundamental concerns about his professionalism. He submitted that trust and confidence in the profession can only be maintained by the imposition of a striking-off order. Mr Malik submitted that Mr Pettitt'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 Pettitt has accepted the concerns that have been found proved by the panel, or shown the requisite amount of insight. In addition, Mr Pettitt had carried out a determined act to mislead at charge 10, which demonstrated a lack of integrity.

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

The panel took into account the following aggravating features:

- There were a range of concerns relating to Mr Pettitt's failure to recognise Patient A's deterioration, including record keeping and risk assessments.
- Mr Pettitt's misconduct involved a particularly vulnerable patient.
- Mr Pettitt's actions and omissions contributed to the loss of the chance of Patient A's survival.
- Mr Pettitt has demonstrated limited remorse, insight or reflection into his failings.
- Mr Pettitt made a deliberate attempt to cover up his omissions/to mislead and in doing so, breached his duty of candour.

The panel also took into account the following mitigating features:

- Mr Pettitt was relatively new in his role at the Trust, having joined in July 2018;

- There appeared to be no formal handover arrangements or policies in place for the transfer of Patient A's care, when Registrant A went on leave.
- There was no up to date care plan or risk assessment for Patient A when his care was passed on to Mr Pettitt.

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 Pettitt'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 Pettitt'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 Pettitt'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 whilst most of the misconduct identified in this case can be addressed through retraining, conditions of practice would not address the more serious concerns relating to Mr Pettitt's lack of integrity and his breach of the duty of candour. In addition, given Mr Pettitt's lack of insight, the panel was not satisfied that conditions of practice could be put in place that would sufficiently protect patients from the risk of harm. There was also no evidence before the panel that Mr Pettitt 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 Pettitt'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 Pettitt's actions and omissions were not a single instance of misconduct. It considered that there were numerous instances of failure by Mr Pettitt, some of which were very serious. The panel determined that there was evidence of a deep-seated attitudinal problem by way of Mr Pettitt's lack of integrity, lack of insight and his denial of most of the charges in this case. The panel having noted that there was no evidence of repetition since the incidents, was not satisfied that Mr Pettitt has demonstrated sufficient insight. Furthermore, the panel concluded that Mr Pettitt 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 noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Pettitt's actions is fundamentally incompatible with Mr Pettitt 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 Pettitt's misconduct and his lack of insight, remorse or strengthened practice, the regulatory concerns raised fundamental questions about Mr Pettitt's professionalism.

The panel was of the view that public confidence in the profession would be undermined if Mr Pettitt was not removed from the register. It was of the view that members of the public would be most concerned to learn that Mr Pettitt's actions, which related to misconduct across numerous areas of nursing practice, contributed to the loss of the chance of Patient A, that he breached his duty of candour by falsifying records, and that there was a risk of repetition due to his lack of insight.

Mr Pettitt'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 Pettitt'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 Pettitt'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 Pettitt 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 Pettitt'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 Pettitt 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 Pettitt is sent the decision of this hearing in writing.

That concludes this determination.