Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting
23 – 25 October 2024

Virtual Meeting

Name of Registrant:	Raymon James Garlan
NMC PIN	18H0242O
Part(s) of the register:	Registered Nurse Adult (2018)
Relevant Location:	Edinburgh
Type of case:	Misconduct
Panel members:	Adrian Smith (Chair, lay member) Alison Thomson (Registrant member) James Carr (Lay member)
Legal Assessor:	Joseph Magee
Hearings Coordinator:	Leigham Malcolm
Facts proved:	Charges 1, 2, 3, 4, 5, 6, 7a, 7b, 7c & 8 (in relation to misconduct) Charge 1a (in relation to the conviction)
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mr Garlan's registered email address by secure email on 10 September 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations in respect of misconduct as well as a time frame during which the meeting would be held virtually.

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

The panel noted that the Rules do not require evidence of delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered email address.

Details of charges in respect of misconduct

That you a registered nurse;

In relation to Resident A:

1. *Failed to document in Resident A's daily notes that you had restrained Resident A on 16 March 2023.*

2. *Failed to escalate to the Care Home Manager that you had restrained Resident A on 16 March 2023.*

3. *Failed to complete an incident form confirming that you had restrained Resident A on 16 March 2023.*

4. *Failed to inform Resident A's relatives that you had restrained them A on 16 March 2023*

5. *On or around 17 March 2023 when asked by Colleague A how Resident A sustained a bruise to the face declared, 'that you did not know how the resident sustained a bruise but that she had been agitated the night before, and had been in and out of other residents rooms' or words to that effect.*

6. *In your local statement dated 20 March 2023 failed to document that you had restrained Resident A on 16 March 2023.*

7. *You conduct in charges 1 and/or 2 and/or 3 and/or 4 and/or 5 and/or 6 demonstrated a lack of integrity in that you were attempting to conceal the incident for you own benefit in order to avoid:*

   a. *Potential disciplinary proceedings, and/or*

   b. *Dismissal from employment, and/or*

   c. *A potential criminal investigation.*

8. Your actions in charge 5 and/or charge 6 were dishonest in that you was attempting to mislead Colleague A into believing that any injury that Resident A sustained was not caused by you when you knew that this was not true.

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

Background

Mr Garlan has been a Registered Nurse in the UK since 16 August 2018, specialising in adult nursing. On 7 April 2023, the Nursing and Midwifery Council ("NMC") received a referral from Morningside Manor Nursing Home ("the Home") raising concerns about Mr Garlan's practice.

The concerns related to an incident that occurred on a nightshift from 16 to 17 March 2023, involving Resident A. At around 21:00 hours on 16 March 2023, while Resident A was in another resident's room, Mr Garlan allegedly physically restrained Resident A by placing his hand firmly over their mouth. It is alleged that Resident A was screaming or shouting, and Mr Garlan walked her to the nurses' station, during which both Mr Garlan and Resident A allegedly fell to the floor. It is reported that Mr Garlan and another staff member (Colleague A) then helped Resident A up from the floor.

The incident allegedly resulted to bruising around Resident A's chin area. It is alleged that following the incident, Mr Garlan failed to record in Resident A's daily notes that he had restrained Resident A and failed to complete an incident form regarding the matter. Further, Mr Garlan did not escalate the matter to the Care Home Manager (Witness 1) to make them aware that he had restrained Resident A and also failed to inform the relatives of Resident A about the incident.

On 20 March 2023, Mr Garlan provided a statement to the Care Home Manager (Witness 1), regarding the incident. In this statement, Mr Garlan described Resident A being anxious, agitated and that they had been entering other residents' rooms. Mr Garlan made

no mention of restraining Resident A, nor did he mention that Resident A had fallen, and he did not mention or attempt to explain the bruising around Resident A's chin area.

Witness 1 investigated how Resident A was injured and spoke to Colleague A who had been on duty on the nightshift in question and had been working directly with Resident A. When questioned, Colleague A initially stated that they did not know what happened, but later stated that Mr Garlan had caused the injury by grabbing Resident A around the mouth.

Witness 1 held an investigation meeting with Mr Garlan. During this meeting when asked how the injury to Resident A occurred Mr Garlan stated that he had caused it because Resident A was agitated and trying to get into another resident's room. Mr Garlan also stated it was to stop Resident A shouting and disturbing other residents. He then stated that he pulled Resident A away towards the nurses' station, put his hand around their mouth and they both fell.

On 22 March 2022, Mr Garlan provided a new, second statement in which he admitted to restraining Resident A by placing his hand firmly over their mouth and walking them to the Nurses' Station. He also admitted that both he and Patient A fell to the ground as they were entering the Nurses' Station. Following a disciplinary meeting Mr Garlan was dismissed from the Home.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations provided by 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.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The panel then considered each of the charges and made the following findings:

Charge 1

In relation to Resident A:

> *1. Failed to document in Resident A's daily notes that you had restrained Resident A on 16 March 2023.*

The panel had careful regard to all of the evidence before it, in particular Mr Garlan's second local statement dated 22 March 2023 and Resident A's Daily Care Notes for 16 March 2023.

Within Resident A's Daily Care Notes it was recorded that the resident had been a little agitated in the evening, however, there was noting to indicate that Resident A had been restrained on 16 March 2023.

Although Mr Garlan's first local statement does not mention that he restrained Resident A, Mr Garlan's second statement made on 22 March 2023 does speak to a restraint involving Resident A, and sets out the following:

> *'I put my left hand firmly over mouth. She was screaming and i walked her to the nurses station. in the distress, as we entered the nurses station we tripped over each other and fell to the floor. Myself and … assisted up and sat her on the chair opposite nurses station. i did not update the notes, make a care plan for Stress and Distress or report this to the management [sic]'*

Colleague A's local statement to the Home provided the following account:

> *'…around 20:40hrs or 21:00hrs I heard Resident A shouting and I went towards where the voice came from which is in … room and Raymond was assisting Resident A out from the room and Resident A was shouting, Raymond try to calm*

her down by cover Resident A mouth by his hand, the reason I know it that Resident A cheek was red and I should report this and I thought that Raymond would be gentle to her, I don't realise that was that hard makes Resident A cheek bruised.'

The panel also had regard to the written statement of Witness 1 provided to the NMC which stated the following:

'Mr Garlan did not care for the resident appropriately on the date of this incident. Mr Garlan should not have handled any of our residents with force, yet he did to the extent that he caused an injury. I would expect a nurse who has attended the Dementia Excellence Train the Trainer Course, and who is also our Champion and Trainer in Dementia Care to be able to handle this situation using his skills and experience.'

The panel bore in mind Colleague A's local statement dated 22 March 2023 and Resident A's contemporaneous Daily Care Notes from 16 March 2023. That evidence, as well as Mr Garlan's second statement, clearly evidences that he failed to document that he restrained Resident A as set out in the charge.

As a professional and a registered nurse, the panel concluded that Mr Garlan ought to have adhered to the duty of candour by recording the incident and making his colleagues aware in case there were further issues involving Resident A.

On the basis of the evidence before it the panel found charge 1 proved.

Charge proved.

Charge 2

2. Failed to escalate to the Care Home Manager that you had restrained Resident A on 16 March 2023.

In relation to charge 2, the panel took account of the job description for a Staff Nurse as well as Witness 1’s statement to the NMC.

The job description for a staff nurse included the following responsibilities:

- Report to Care Home Manager and in their absence to Deputy Care Home Manager on matters relating to resident’s care.
- Advise Care Home Manager/Deputy Care Home Manager of any significant changes or incidents within the Home.

Witness 1’s statement provided to the NMC set out the following:

> *‘Mr Garlan did not report what happened to any other member of the team or the Manager. He did not document what happened in the continuation notes. He did not complete an incident form. He did not notify family of the event. Reporting and Documentation is within our Policy and should have been reported to the Care Home Manager and Nurse in Charge after the event at the latest at the morning report/ handover.*
>
> *There is a formal procedure for the reporting of incidents. The Care Home Manager should be informed, I was present at the handover and I was not informed. I noticed the bruise on Resident A’s face and I questioned Mr Garlan due to him being the Nurse in Charge and he still neglected to inform me of what occurred. He is expected to provide written documentation overnight if a resident care intervention takes place, especially an incident where there is an injury or fall … It is clear within his job description and roles/ responsibilities. Please see the job description of a staff nurse…’*

In view of the job description and Witness 1’s evidence that reporting and documenting incidents was within the Home’s policy, the panel reached the view that Mr Garlan was under a duty to escalate his restraint of Resident A as set out in the charge.

The panel also reached the view that Mr Garlan had chosen not to adhere to the Home's policies or his job description as Witness 1's evidence was clear that she and Mr Garlan were both at the handover and he had not informed her of the incident.

On the basis of the evidence before it the panel found charge 2 proved.

Charge proved.

Charge 3

> *3. Failed to complete an incident form confirming that you had restrained Resident A on 16 March 2023.*

Again, the panel took account of the job description for a Staff Nurse as well as Resident A's care notes and Witness 1's statement to the NMC.

Witness 1's statement provided to the NMC set out the following:

> *'…I would expect an incident report to have been completed, Mr Garlan has completed incident reports previously and knows this is the procedure. He did not complete one…'*

The job description for a staff nurse included a requirement to work collaboratively with others, share ideas and information. Further, Witness 1's written statement is clear that an incident report should have been carried out. The panel considered that Mr Garlan as an experienced nurse, having completed incident reports in the past, would have known and understood the need for him to complete one in this instance.

In the absence of any incident report to record that Resident A had been restrained as set out in the charge, or any record in Resident A's care notes, and in view of Witness 1's evidence, the panel found charge 3 proved.

Charge proved.

Charge 4

> *4. Failed to inform Resident A's relatives that you had restrained ~~them~~ **Resident** A on 16 March 2023*

In relation to charge four, the panel noticed what it considered to be a typographical error and considered amending the error of its own volition. The panel was of the view that the reference to *'them A'* ought to read *'Resident A'*.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that amending charge four to read *'restrained Resident A on 16 March 2016' as opposed to 'restrained them A on 16 March 2016',* was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Garlan and no injustice would be caused to either party by the proposed amendment being allowed. It decided that it was therefore appropriate to make the amendment to ensure clarity and accuracy.

In respect of charge four, the panel had regard to the Staff Nurse job description which included the following responsibility.

- Communicate with staff, residents, relatives, visitors, and other professionals in order to ensure a co-ordinated approach to resident's care.

In view of this responsibility clearly set out within the job description, the panel decided that Mr Garlan was under a duty to inform Resident A's relatives of the restraint.

Additionally, Witness 1's statement provided to the NMC set out the following:

> *'He did not notify family of the event…*
>
> *…Mr Garlan should report the fall to the family or next of kin. He neglected to report to family or next of kin. There was no documentation - all information was omitted. It is clear within his job description and roles/ responsibilities. Please see the job description of a staff nurse…'*

The panel also had regard to a timeline of event created by Witness 1 for the family of Resident A. There was evidence before the panel that the Home had informed Resident A's relatives of the incident on 17 March 2023, the day after the event. All of the evidence before the panel suggests that Mr Garlan had not informed Resident A's relatives of the incident, and that it had been Witness 1 who had done so.

On balance, the panel decided that Mr Garlan failed to inform Resident A's relatives, as set out in the charge, and found charge 4 proved.

Charge proved.

Charge 5

> *5. On or around 17 March 2023 when asked by Colleague A how Resident A sustained a bruise to the face declared, 'that you did not know how the resident sustained a bruise but that she had been agitated the night before, and had been in and out of other residents rooms' or words to that effect.*

In respect of charge five, the panel took account of Witness 1's statement provided to the NMC which set out the following:

‘I questioned Mr Garlan directly because he had been on the nightshift the night before, ie the 16th March 2023. Mr Garlan responded and indicated that he did not know how the resident sustained the bruise but that she had been agitated the night before and had been in and out of other residents’ rooms.’

The panel also had regard to Mr Garlan’s first local statement dated 20 March 2023. In this statement there is no reference to a restraint or a fall and no explanation as to how Resident A may have sustained the bruise. However, in the second local statement provided by Mr Garlan dated 22 March 2023, he provided details of the restraint and fall.

It was clear to the panel that Mr Garlan’s accounts of events had changed substantially between his first local statement provided on 20 March 2023 and his second on 22 March 2023. Any reference to Resident A being restrained was omitted in Mr Garlan’s first written local statement. Although the panel could not uncover exactly what Mr Garlan stated to Witness 1, it was satisfied that he had said words to the effect of those set out in the charge and effectively given the impression that he did not know why or how Resident A had sustained a bruise.

On the basis of the evidence before it the panel found charge 5 proved.

Charge proved.

Charge 6

6. In your local statement dated 20 March 2023 failed to document that you had restrained Resident A on 16 March 2023.

Again, the panel had regard to Mr Garlan’s first local statement dated 20 March 2023. In this statement there is no reference to the Restraint of Resident A or a fall on 16 March 2023. The panel was of the view that Mr Garlan should have been candid and recorded the incident within this statement of 20 March 2023, and not omitted it until he provided a second, supplementary statement on 22 March 2024.

Mr Garlan should have adhered to the duty of candour and explained the incident within his first local statement. The panel reached the view that he intentionally omitted the incident when providing his first statement and attempted to mislead Witness 1.

On the basis of the evidence before it the panel found charge 6 proved.

Charge proved.

Charge 7a

> *7. You conduct in charges 1 and/or 2 and/or 3 and/or 4 and/or 5 and/or 6 demonstrated a lack of integrity in that you were attempting to conceal the incident for you own benefit in order to avoid:*
>
> > *a. Potential disciplinary proceedings, and/or*

Mr Garlan's accounts of events changed substantially between his first local statement provided on 20 March 2023 and his second on 22 March 2023. The panel reached the view that he intentionally omitted the incident when providing his first statement and attempted to mislead Witness 1. Mr Garlan should have adhered to the duty of candour and described the restraint and fall within his first local statement on 20 March 2023.

In the absence of an explanation from Mr Garlan, and in view of his admission to restraining Resident A and them both falling to the floor, the panel had no other explanation other than he was trying to avoid disciplinary proceedings, dismissal or criminal proceedings.

On the basis of the evidence before it the panel found charge 7a proved.

Charge proved.

Charge 7b

b. Dismissal from employment, and/or

The panel found charge 7b proved for the same reasons set out for charge 7a.

Charge proved.

Charge 7c

c. A potential criminal investigation.

The panel found charge 7c proved for the same reasons set out for charge 7a.

Charge proved.

Charge 8

8. Your actions in charge 5 and/or charge 6 were dishonest in that you was attempting to mislead Colleague A into believing that any injury that Resident A sustained was not caused by you when you knew that this was not true.

The panel took account of all the evidence before it. Mr Garlan's first local statement does not mention that he restrained Resident A, however, his second statement made on 22 March 2023 does speak to a restraint involving Resident A.

The panel considered that Mr Garlan as an experienced nurse would have known and understood the need for him to make contemporaneous records of the incident, to be open and honest at the earliest opportunity and to inform his colleagues about the incident involving Resident A.

The panel reached the view that Mr Garlan intentionally omitted the incident when providing his first local statement, failed to inform his colleagues or Witness 1, and

attempted to mislead Witness 1. The panel decided that in all the circumstances Mr Garlan acted dishonestly by his omissions.

The panel was therefore satisfied that Mr Garlan knew and believed that he was deliberately withholding information surrounding the incident involving resident A and that his conduct was dishonest by the standards of ordinary people.

On the evidence before it, and on the balance of probabilities, the panel found charge 8 proved.

Charge proved.

Mr Garlan's conviction

After deciding on the facts in relation to misconduct, the panel was made aware that the NMC had also obtained an extract conviction from Edinburgh Sheriff Court. The panel was not made aware of Mr Garlan's conviction at the start of proceedings to prevent any prejudice in its decision making in respect of the misconduct charges.

The extract of conviction set out that Mr Raymon Garlan was convicted on 2 November 2023 and sentenced on 8 January 2024 for an offence which formed the basis of a further charge brought by the NMC at these regulatory proceedings.

The conviction charge brought by the NMC is set out below.

Charge in respect of Mr Garlan's conviction

That you a registered nurse;

1. On 2 November 2023, were convicted at the Edinburgh Sheriff Court of the following offence:

a. *On 16 March 2023 at Morningside Manor Nursing Home, 41a Balcarres Street, Edinburgh Raymon Galan [sic], then in the course of employment there as a nurse did assault REDACTED, a resident there, then 86 years old, having been born REDACTED, care of the Police Service of Scotland and did seize her on the head covering her mouth with his hand and pull her into an office there by same thereafter causing both himself and her to fall to the ground all to her injury.*

And, in light of the above, your fitness to practise is impaired by reason of your conviction.

Decision and reasons on service of Notice of Meeting

The panel gave thought to whether the NMC had satisfied its duty to inform Mr Garlan of the charge relating to his conviction and the fact that it would be considered during these proceedings.

The panel was provided with a second Notice of Meeting which had also been sent to Mr Garlan's registered email address by secure email on 10 September 2024. The panel took into account that the second Notice of Meeting provided details of the charge in respect of Mr Garlan's conviction, alongside the standard additional information.

The panel accepted the advice of the legal assessor.

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

Decision and reasons in respect of Mr Garlan's conviction

Having been provided with a copy of the extract of conviction from Edinburgh Sheriff Court, the panel finds charge 1 brought by the NMC in respect of Mr Garlan's conviction proved in accordance with Rule 31 (2) and (3), which state:

> *'**31.**— (2) Where a registrant has been convicted of a criminal offence—*
>
> *(a) a copy of the certificate of conviction, certified by a competent officer of a Court in the United Kingdom (or, in Scotland, an extract conviction) shall be conclusive proof of the conviction; and*
>
> *(b) the findings of fact upon which the conviction is based shall be admissible as proof of those facts.*
>
> *(3) The only evidence which may be adduced by the registrant in rebuttal of a conviction certified or extracted in accordance with paragraph (2)(a) is evidence for the purpose of proving that she is not the person referred to in the certificate or extract.'*

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 Garlan's fitness to practise is currently impaired by reason of his misconduct and/or his conviction. 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, the panel must decide whether, by reason of his misconduct and/or his conviction, Mr Garlan's fitness to practise is currently impaired.

Representations on misconduct and current impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

The NMC identified the following standards of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code"), which it considered Mr Garlan to have breached: 8.1, 8.2, 8.5, 8.6, 10.1, 10.2, 14.2, 14.1, 14.2, 14.3, 19.1, 20.1 and 20.2.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC highlighted that under the NMC's guidance (FTP-3a), the fact that a professional has behaved violently and abused a vulnerable patient is recognised as an extremely serious concern, striking at the heart of public confidence and professional standards. Further, these types of concerns are indicative of attitudinal issues.

In view of Mr Garlan's misconduct and conviction, The NMC invited the panel to find Mr Garlan's fitness to practise currently impaired on both public protection and public interest grounds.

Decision and reasons on misconduct

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

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 Garlan's actions did fall significantly short of the standards expected of a registered nurse, and that his actions amounted to a breach of the Code, specifically:

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel considered Mr Garlan's dishonesty to be intentional, persistent and sustained over several days. Mr Garlan had multiple opportunities to be open about the incident involving Resident A. He failed to record the incident in Resident A's notes, failed to report it to his manager or colleagues during the handover, and failed to include it in his initial local statement.

The panel considered these failures to be extremely serious. Not only did Mr Garlan fail to adhere to the duty of candour, but he also created potential for Resident A to come to further harm. The resident may have been caused further harm because of Mr Garlan's failure to document the incident or provide his colleagues with an accurate picture of the resident's state of health.

For these reasons, the panel determined that Mr Garlan's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on current impairment

The panel next went on to decide if as a result of Mr Garlan's misconduct and conviction, his 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 always expected 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 always justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel determined that Resident A was caused physical harm as a result of Mr Garlan's actions. The extract of conviction clearly sets out that Mr Garlan assaulted an 86-year-old, a vulnerable resident, by seizing her on the head, covering her mouth with his hand and pulling her into an office thereby causing them both to fall to the ground. The panel were provided with a photograph of the Resident's face which clearly showed a large area of bruising, which was clearly an injury caused by Mr Garlan during this assault. The panel was of the view that the details of Mr Garlan's conviction amounted to further breaches of the Code, specifically the following:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.5 respect and uphold people's human rights

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.4 keep to the laws of the country in which you are practising

Moreover, Mr Garlan's misconduct, which included dishonesty of a serious nature, breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel carefully considered the evidence before it in determining whether Mr Garlan has taken sufficient steps to strengthen his practice. It had regard to the NMC's guidance (FtP-15a), which states the following:

> *'Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*
>
> - *dishonesty, particularly if it was serious and sustained over a period of time, or is directly linked to the nurse, midwife or nursing associate's professional practice*
> - *incidents of violence towards, or neglect or abuse of people receiving care, children or vulnerable adults.'*

The panel took account of an undated reflective account which Mr Garlan provided to the NMC. It also took account of three training certificates Mr Garlan provided relating to the following clinical areas: Managing Risk and Minimising Restraint dated 6 January 2024, Restraint Awareness dated 15 February 2024 and Conflict Management dated 15 February 2024.

The reflective account provided to the NMC was not dated. The panel considered it to be brief and was of the view that it failed to sufficiently address the concerns raised. The reflection did not evidence any remorse in relation to Mr Garlan's assault of an 86-year-old which the panel considered to be the starting point for any meaningful reflection.

Further, the reflective account did not demonstrate meaningful insight into the facts found proved relating to misconduct or Mr Garlan's sustained dishonesty. It did not speak to any efforts at remediation and was therefore of limited value.

In light of the above, the panel reached the view that Mr Garlan's misconduct and conviction were so serious as to be incapable of remediation.

The panel had no information before it of Mr Garlan's current position. There was nothing before the panel to suggest that the risk identified in this case had been addressed and would not be repeated in the future. Further, there was no information to suggest that Mr Garlan had strengthened his nursing practice.

In these circumstances, and given the seriousness of the misconduct and conviction, the panel concluded that there is a significant risk of repetition based on Mr Garlan's lack of remorse, lack of reflection, lack of insight into his dishonesty, and lack of remediation and evidence of steps taken to strengthen his nursing practice. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

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

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

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 10 September 2024, the NMC had advised Mr Garlan that it would seek the imposition of a striking off order if the panel were to find his fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mr Garlan'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 identified the following aggravating features:

- Proven assault of an 86-year-old vulnerable resident in a care home setting.
- No evidence of any remorse.
- The registrant was dishonest within the records that he made about how a vulnerable patient sustained the injury.
- The resident may have been caused further harm because of Mr Garlan's failure to document the incident or provide his colleagues with an accurate picture of the resident's state of health.
- Mr Garlan was a senior member of staff and the nurse in charge at the time of the incident.
- Mr Garlan's actions demonstrated a lack of integrity, candour and pre-meditated and sustained dishonesty.
- Mr Garlan's actions were a breach of professionalism and a breach/abuse of trust.
- Mr Garlan has shown lack of sufficient insight and remediation.

The panel identified no mitigating features.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Garlan's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Garlan'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 Garlan's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the seriousness and the dishonest nature of the charges in this case. The misconduct identified in this case was not something that can easily be addressed through retraining. Furthermore, the panel determined that the placing of conditions on Mr Garlan's registration would not protect the public, reflect the seriousness of the issues, or satisfy the public interest in this case.

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:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel was of the view that the issues in this case involve dishonesty and attitudinal issues which are not easy to address. The panel was not satisfied that Mr Garlan has

sufficient insight into his actions or has sufficiently strengthened his nursing practice. The panel has concluded that there is a significant risk of repetition.

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 Garlan's actions is fundamentally incompatible with him remaining on the register.

For these reasons, 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?*

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

The panel had careful regard to the NMC's guidance on sanctions in cases involving dishonesty (SAN-2), which set out the following:

'Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
- *misuse of power*
- *vulnerable victims'*

The panel considered all three of these points applied in Mr Garlan's case.

Balancing all these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

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 Garlan in writing.

Decision and reasons on 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 Garlan's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

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 due to allow for any potential appeal period.

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

That concludes this determination.