Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 24 July 2024 – Thursday, 1 August 2024
Thursday, 17 October 2024 – Friday, 18 October 2024

Virtual Hearing

Name of Registrant:	**Primrose James**
NMC PIN	06B1800E
Part(s) of the register:	Registered Nurse - Sub Part 1 RNA: Adult Nurse - Level 1 - 21 July 2006
Relevant Location:	Pembrokeshire
Type of case:	Misconduct
Panel members:	Sophie Lomas (Chair, Lay member) Melanie Lumbers (Registrant member) Melanie Swinnerton (Lay member)
Legal Assessor:	Ruth Mann
Hearings Coordinator:	Margia Patwary (24 July 2024 – 1 August 2024) Eleanor Wills (17 October 2024 – 18 October 2024)
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter (24 July 2024 – 1 August 2024) Alex Radley (17 October 2024 – 18 October 2024)
Ms James:	Present and represented by John Mackell, instructed by the Royal College of Nursing (RCN)
Facts proved:	Charges 1a and 1b
Facts not proved:	Charges 1c, 1d and 2
Fitness to practise:	Impaired

Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charges

That you, a registered nurse:

1. On 31 May 2022 in relation to Patient D:

    a) Smacked him across the face; **[FOUND PROVED]**
    b) Tapped him on the cheek with your fingers; **[FOUND PROVED]**
    c) Poked him on his forehead; **[FOUND NOT PROVED]**
    d) Pressed your finger against his nose and pushed his face. **[FOUND NOT PROVED]**

2. On 31 May 2022 said to Patient D “you’re a horrible man, you will stay here and you will die here” or words to that effect. **[FOUND NOT PROVED]**

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

Panels request for additional evidence

The panel heard oral evidence on Day 2 from Witness 2 on behalf of the NMC. Witness 2 was then cross examined by Mr Mackell on your behalf.

In absence of Witness 2, the panel explained to both Mr Kabasinskas and Mr Mackell that it would be of assistance to know whether additional relevant evidence would be available. Documentary evidence had been provided in the form of a DATIX at PDF page 14 of the Exhibit bundle. However, the panel noted that on PDF page 18 of the Exhibit bundle there was reference to ‘linked incidents’ 20115 and 20117 and wanted to enquire whether the additional DATIX’s were available as this would assist with panel questions for the witness.

The panel invited representations from Mr Kabasinskas and Mr Mackell. Mr Kabasinskas submitted the panel were able to use their investigatory powers if they felt they required further relevant evidence which may be available. He advised he would review the material provided to the NMC in relation to any additional DATIX that may be relevant to the incident on 31 May 2022.

Mr Mackell had no objection to the request.

The panel heard advice from the legal assessor who reminded the panel that whilst they must be impartial and fair in their approach their role is expressly not that of a passive observer. Reference was made to the case of Professional Standards *Authority for Health and Social Care v The Nursing and Midwifery Council, Ms Winifred Nompumlelelo Jozi [2015] EWHC 764 Admin* and that disciplinary panels need to play more of an active role than a judge presiding over a criminal trial in order to ensure that a case is properly presented and that charges adequately reflect that real mischief of the case and that relevant evidence is placed before it. Reference was made to the case of Council for Regulation of Health Care Professionals v Ruscillo [2005] 1. W.L.R 717.
In relation to the procedure and timing of the request the panel were referred to Rule 24 of the NMC Rules 2004 which does not expressly deal with when it may be appropriate to consider other matters of evidence at this stage.

Following a brief adjournment Mr Kabasinskas addressed the panel and submitted that he had reviewed all the documents in the Investigative bundle and Case Examiners bundle. No further DATIX other than the one at page 14 of the exhibit bundle could be located. Mr Kabasinskas had worked on the assumption that all documents received by the NMC during their investigation were in either the Case Examiner Bundle or Investigative Bundle.

Mr Kabasinskas had not reviewed all incoming emails and attachments to the NMC.
Mr Mackell, in an attempt to assist the panel, had obtained an unredacted copy of PDF page 18 of the exhibit bundle. This provided a summary of what had been added to ‘linked incidents’ ID 20115 and 20117. Both Mr Kabasinskas and Mr Mackell had no objection to

the panel receiving into evidence unredacted PDF page 18. This was provided to the panel.

Witness 2 proceeded to answer questions of the panel.

Background

The charges arose whilst you were employed by Withybush Hospital part of Hywel Da Health Board ('the Board'). The alleged concern relates to an incident that took place at the Board at Ward 1 (Trauma and Orthopaedic ward), on 31 May 2022 at around 02:30.

During this time, you were providing care for Patient D with Witness 1, a Healthcare Assistant who was assisting you in providing personal care to Patient D. Patient D was a an 80-year old vulnerable patient who had been admitted to hospital in January 2022, with a fractured hip. He remained an inpatient due to complexities rising from his other medical conditions, some of which effected his cognitive abilities. At times he was known to strike out and sometimes hit members of staff.

The alleged incident was as follows:

Witness 1 says that firstly Patient D hit out towards you. Witness 1 then goes on to say "Primrose was stood next to the bed, and she smacked him across his face with her right hand. She then started tapping him on the cheek with her fingers on her right hand while telling him off for hitting out. She then proceeded to start poking him aggressively on his forehead saying things to him like 'you're a horrible man, you will stay here, and you will die here'. She then pressed her finger against his nose and pushed his face away from her towards me using her finger against his nose".

Witness 1 reported her concerns to the nurse in charge of the Ward (Witness 2) shortly after the incident.

The NMC was informed that you had physically and verbally abused Patient D and that subsequently the police charged you with ill-treating Patient D.

With regards to the police investigation, you pleaded not guilty and were acquitted following a trial by jury in the Crown Court.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kabasinskas on behalf of the Nursing and Midwifery Council (NMC) and by Mr Mackell on your behalf.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Healthcare Assistant at the Board
- Witness 2: Nurse in charge of Ward 1 at the Board, at the time of the alleged incident
- Witness 3: Clinical Site Nurse/Bed Manager at the Board

- Witness 4: Healthcare Assistant at the Board

The panel also heard evidence from you under oath.

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

Charge 1a

"On 31 May 2022 in relation to Patient D:

a) Smacked him across the face"

This charge is found proved.

In reaching this decision, the panel took into account Witness 1, Witness 2 and Witness 3's NMC written statement, Witness 1, Witness 2's police statement dated 10 June 2022, Witness 3's police statement dated 3 January 2023, the DATIX incident form completed on 31 May 2022 and the Crown Court transcript dated 17 May 2023. The panel also took account of your DATIX incident form and the record of your police interview which took place on 10 June 2022.

The panel noted the wording of the charge 'smacked' but determined that the word 'smacked' and 'slapped' had been used interchangeably throughout the evidence. The panel further noted that during your oral evidence, you agreed that you understood the words to mean the same thing.

The panel had regard to Witness 1's police statement in which she stated:

> *"As soon as he hit out toward her, she smacked him across the left side of his face using her right hand quite hard. She then proceeded to slap against his left cheek several times whilst telling him off for hitting out."*

The panel noted that this account was consistent with Witness 1's NMC written statement in which she stated:

> *"…I then rolled him the other way, towards Primrose, and he then hit out at her face. Primrose was stood next to the bed, and she smacked him across his face with her right hand."*
> *…Primrose then asked me if I was ok to finish off, took her gloves off and went back to the computer at the Nurse's station. I just stood there for a moment, as I was in total shock about what had just happened…"*

The panel also noted that both accounts above were consistent with Witness 1's evidence given in the Crown Court trial, as evidenced by the transcript dated 17 May 2023. In that evidence Witness 1 described how you smacked Patient D across the face with an open palm.

The above accounts of evidence were also consistent with Witness 1's oral evidence to the panel.

The panel considered Witness 1 gave clear and credible evidence about what she had seen.

The panel noted that Witness 1 in her NMC written statement and police statement stated that she informed Witness 2 as soon as she returned from her break. This was also consistent with Witness 1 and Witness 2's oral evidence.

The panel also had regard to an entry in the DATIX form dated 31 May 2022 made by Witness 2 which stated:

> *"I came back from break on nightshift and was informed by a health care assistant that the other staff nurse on duty (agency) had slapped and spoken nastily to the*

patient when he was. hitting out whilst they were washing/changing him after him being incontinent"

The panel heard evidence from Witness 2 and Witness 4 that Witness 1, who was a direct witness to the alleged incident, was left visibly shaking after the incident. Witness 2 had never seen Witness 1 like this before. Neither Witness 2 or Witness 4 directly observed the incident.

In regard to your account, you denied any assault to Patient D and that you did not deliberately hit or strike Patient D. During your oral evidence, you told the panel that you do not remember hitting Patient D and that you may have reacted with shock.

In your police interview, you stated that:

"we started changing him and when we were changing him, from nowhere he just went for me "WHAM" and the first thing that I did, you know, when someone hits you, I just blocked. So, when I blocked, to be honest I don't know where, I know I blocked."

The panel noted that although you described the blocking motion, in your earlier account to the police, you do not recall where your hand landed. Therefore, the panel found that this was inconsistent with your first account.

The panel also noted that Witness 3 in her police statement stated that:

"I said "Ok Primrose, but an allegation has been made, the situation will be escalated to the Ward sister and senior nurse manager in the morning and therefore you will need to write a statement" Primrose repeated I did not hit the patient, so I asked, so if you didn't hit the patient what did you do? Primrose proceeded to lift up her hand and made a tapping motion downwards, saying that's what I did. Whilst replying to Primrose I made a hand gesture of raising up my hand

and doing a tapping motion whilst saying it doesn't matter if you tap a patient, I then raised my hand right up and lowered it down quickly saying that both were classed as hits, the patient is vulnerable and should not have been hit in any way."…

Witness 3 in her oral evidence informed the panel that after the end on of her shift, she had made a contemporaneous note about the incident when she went home. This note was not disclosed to the panel but she stated in evidence, that she had shared the note with the police. Further, Witness 3 told the panel that although she did not see the incident, Witness 2 informed her that there had been an incident and that you had hit one of the patients on Ward 1. The panel also found Witness 3's account to be credible.

Having considered all of the evidence holistically, the panel considered that your evidence, unlike that of Witness 1 was inconsistent. Witness 1 had given clear evidence which was consistent between her various accounts, and with the contemporaneous evidence from the DATIX and witness evidence.

For those reasons, the panel accepted the evidence of Witness 1 and was satisfied that, on the balance of probabilities, on 31 May 2022 that you smacked Patient D across the face.

Therefore, this charge is found proved.

Charge 1b

"On 31 May 2022 in relation to Patient D:

b) Tapped him on the cheek with your fingers"

This charge is found proved.

In reaching this decision, the panel took into account Witness 1, Witness 2 and Witness 3's NMC written statement, Witness 1, Witness 2's police statement dated 10 June 2022,

Witness 3's police statement dated 3 January 2023, the DATIX incident form completed on 31 May 2022 and the Crown Court transcript dated 17 May 2023. The panel also took account of your DATIX incident form and the record of your police interview which took place on 10 June 2022.

Having regard to the evidence in charge 1a, the panel noted Witness 1 in her NMC written statement stated:

> *"She then started tapping him on the cheek with her fingers on her right hand while telling him off for hitting out"*

Although you denied this charge, during your oral evidence, you admitted repeatedly tapping Patient D whilst telling him he should not be hitting out at staff. You demonstrated to the panel a tapping motion with your hand and used four fingers in a repeated motion. The panel noted that you accepted tapping Patient D on his hand but did not accept tapping his cheek.

The panel also noted that in the DATIX incident form you stated:

> *…"honestly speaking I don't really remember hitting him, I may have reacted with shock to him hitting me and told him not do that. That's as much as I can say about this particular incident. However if I made my colleague feel someway about how I reaction* [SIC] *after being hit in the face unexpectedly I do apologise*".

The panel considered this contemporaneous evidence indicates that even on the day of the incident your recollection of the events was limited.

In the Crown Court you accepted you were unsure where on limb the tapping motion was performed, or how many times you tapped. After clarification was sought from the judge you accepted you could not remember these details. You informed the panel that all

evidence was provided from your memory as you had not made any notes of the alleged incident.

In its consideration of the evidence relating to this charge, the panel was of the view that Witness 1 provided clear and credible oral evidence which was also consistent with her NMC written witness statement and police statement. Whereas the panel considered that there were inconsistencies in your evidence and that your recollection may have been affected by the passage of time.

The panel was therefore of the view that, on the balance of probabilities, you had tapped Patient D on the cheek with your fingers.

Therefore, this charge is found proved.

Charge 1c

"On 31 May 2022 in relation to Patient D:

c) Poked him on his forehead;"

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1, Witness 2 and Witness 3's NMC written statement, Witness 1, Witness 2's police statement dated 10 June 2022, Witness 3's police statement dated 3 January 2023, the DATIX incident form completed on 31 May 2022 and the Crown Court transcript dated 17 May 2023. The panel also took account of your DATIX incident form and the record of your police interview which took place on 10 June 2022.

The panel had regard to Witness 1's police statement in which she stated:

“She then proceeded to aggressively poke his forehead whilst calling him a “horrible, horrible man”

The panel also noted Witness 2’s written NMC statement in which she stated:

“that he had hit out and that Primrose had 'slapped' and 'poked' him to his face and said some very nasty things to him.”

The panel noted that you denied this charge and in your police interview you denied that you poked Patient D:

“[POLICE OFFICER]: Ok, so, there’s nothing you can think of that would, that may have been mistaken for the poking to the forehead?
[YOU]: I did not poke him”

This account was also consistent in with the evidence you had previously given, as evidenced by the Crown Court transcript.

The panel noted that you were consistent from your initial statement that you did not poke Patient D on his forehead, and therefore the panel found that it could place weight on your evidence in relation to this charge. The panel reminded itself that the burden of proof rests entirely with the NMC.

The panel reminded itself of the initial DATIX entry made by Witness 2 which stated:

“I came back from break on nightshift and was informed by a health care assistant that the other staff nurse on duty (agency) had slapped and spoken nastily to the patient when he was. hitting out whilst they were washing/changing him after him being incontinent”

The panel noted this did not include any mention of poking Patient D. The panel further noted that the nursing notes completed the morning after the incident also did not include any mention of poking.

The panel was therefore of the view that there was insufficient evidence before it to support that you had poked Patient D. It considered that on this occasion the NMC had not discharged its burden of proof and therefore it found this charge not proved.

Charge 1d

"On 31 May 2022 in relation to Patient D:

d) Pressed your finger against his nose and pushed his face."

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1, Witness 2 and Witness 3's NMC written statement, Witness 1, Witness 2's police statement dated 10 June 2022, Witness 3's police statement dated 3 January 2023, the DATIX incident form completed on 31 May 2022 and the Crown Court transcript dated 17 May 2023. The panel also took account of your DATIX incident form and the record of your police interview which took place on 10 June 2022.

The panel had regard to Witness 1's police statement in which she stated:

"…and saying, 'that's why he was still here, why he'll stay here and why he'll die here'. She then pressed her finger into the right side of his nose and pressed it hard enough to move his head toward the left slightly, again whilst telling him off."

The panel noted that you consistently denied this conduct and in your police interview you denied that you had pressed your finger against Patient D's nose and pushed his face:

"[POLICE OFFICER]: Ok, and then [Witness 1] goes on to say that you've pressed your finger into the right side of his nose and pressed it hard enough to move his head towards the left.
[YOU]: That's not true either.
[POLICE OFFICER]: After, um, so you've blocked, you've done the hand tap. Have you made any other contact with him following that?
[YOU]: No. No. After we just changed, we pretty much finished changing him..."

This account was also consistent with the evidence you had previously given, as evidenced by the Crown Court transcript.

The panel reminded itself of the evidence previously referred to in relation to the DATIX and nursing notes. It considered that this was the most contemporaneous evidence and noted that there was no mention of you pressing your finger against Patient D's nose and pushing his face.

The panel further noted that Witness 3's police statement, which she said was based on a record she made for herself on 31 May 2022, makes no mention of this aspect of the allegation.

The panel noted that you were consistent from your initial statement that you did not press your finger against Patient D's nose and pushed his face. Therefore, the panel found that your account in relation to this charge was consistent and credible.

Considering all the evidence in the round, the panel was of the view that there was insufficient evidence before it to support this charge and that the NMC had not discharged its burden of proof and therefore found this charge not proved.

Charge 2

> *"On 31 May 2022 said to Patient D "you're a horrible man, you will stay here and you will die here" or words to that effect."*

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1 written NMC statement, Witness 1's police statement, Witness 1's Crown Court transcript, Witness 2's police statement and Witness 2's written NMC statement. The panel also took account of your account in the DATIX incident form, your Crown Court Transcript and your police statement.

The panel also noted Witness 1's written NMC statement in which she stated:

> *"She also said that she was saying things to him. I cant remember exactly what, but it was something like 'you're a nasty man, nobody cares about you'. Patient D was a small built person with poor mobility but known to be combative when receiving personal care and Holly informed me that this was the case during herself and Primrose tending to him."*

The panel also noted that Witness 1 expanded this account in her police statement:

> *"whilst calling him a "horrible, horrible man" and saying, 'that's why he was still here, why he'll stay here and why he'll die here'. She then pressed her finger into the right side of his nose and pressed it hard enough to move his head toward the left slightly, again whilst telling him off"*

However, the panel had regard to Witness 1's evidence in the Crown Court where she stated that she could not remember what you had said or in fact any of the words you had used whilst tapping Patient D.

The panel noted Witness 2 in her police statement stated:

> *“I can't remember what exactly xx had said that Primrose had said, but it was something like 'nobody wants you' and 'nasty man'.”*

The panel also noted Witness 2 also stated this in her NMC written statement which stated:

> *“She also said that she was saying things to him. I cant remember exactly what, but it was something like ‘you’re a nasty man, nobody cares about you’.”*

The panel also noted that Witness 3 in her police stated that she could not remember any of the words you used towards Patient D.
In regard to your account, during your oral evidence you told the panel that you used words such as:

> *“Why you try to kick, hurt us?”*
> *“Why are you always horrible to us. You kick, you scream”*
> *“I was just trying to talk to him like a person without cognitive issues”*

This was consistent with your evidence in the Crown Court where you repeated similar words.

The panel noted that this was also consistent in your police interview:

> *“stop it, why do you keep doing this, we only here to help you”.*

The panel noted that you accepted you had used the word 'horrible' but did not accept the context in which this was said or the wording of the charge.

The panel noted that Witness 1's exact and/or similar words were not repeated in her police statement and in Crown Court she could not remember any of the words that you could have potently used when speaking to Patient D. The panel was therefore of the view that there was insufficient evidence before it to support the wording used in the charge.

Taking into account the above, the panel found that your account in relation to this charge was consistent and the words stated in the charge were not used by you when you were speaking to Patient D.

The panel noted that that you are a nurse of good character and the possibility of you using words such as *"you're a horrible man, you will stay here and you will die here"* or words to that effect were highly unlikely used as the charge states.

The panel considered that on this occasion the NMC had not discharged its burden of proof and therefore, it found this charge not proved.

Decision and reasons to adjourn

At the start of day 7 the panel heard an application by Mr Mackell for an adjournment. The panel had handed down the decision on facts at the conclusion of Day 6 and Mr Mackell required further time to discuss the findings and the next stage of proceedings. Mr Mackell submitted it was his intention to submit a Registrant Bundle to assist with the misconduct and impairment determinations. This would include a detailed reflective piece from you, training certificates, personal testimonials, and written submissions.

In view of the decision on facts Mr Mackell submitted you required some time to give thought to the findings of the panel and explore and revisit your reflective piece. Mr Mackell advised the panel he would be able to proceed later this afternoon. However, it was unlikely a decision would be made prior to the conclusion of the current seven-day listing.

Mr Mackell stated that it would be your preference to have the determination on the next stage in one session, rather than having to conclude part way through the misconduct and impairment stage of proceedings. Reference was made to the sensitivity and potential repercussions which are relevant to you and this case.

Mr Mackell informed that panel that if they did determine that the case should proceed then he would require a period of time today to obtain further instructions and preparation time prior the providing a copy of a Registrant Bundle. It was submitted that in any event additional day/s would be required to conclude the case.

Mr Kabasinskas opposed the application and referred to the panel to the requirement to have regard to the public interest in the expeditious disposal of the case. He accepted that it was unlikely that all stages of the proceedings would be finalised today and referred to the impact on resources at the NMC.

The panel heard advice from the legal assessor who referred to Rule 32 of the NMC (Fitness to Practice Rules 2004) and NMC Fitness to Practice library guidance CMT-11.

The panel decided to adjourn the hearing. The panel considered that it was not going to be able to conclude the next stage of the proceedings in the allocated time. The panel had regard to the fact you had only received the written determination the previous evening and in view of the findings needed some time with your legal team to prepare for further submissions. The panel acknowledged the application to adjourn was made on your behalf and therefore there was no injustice to you. In fairness to you this will allow time to review any reflective statements or testimonials. The panel considered there to be no injustice to the NMC as it was accepted that the hearing would be part heard and that a further two days would be required in any event.

It would be of assistance if, in advance of the next hearing date, the panel are provided with a Registrant Bundle and also any information as to whether any live witness evidence will be heard.

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

Mr Radley referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* He also referred the panel to the case of *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317.

Mr Radley invited the panel to take the view that the facts found proved amount to serious professional misconduct. He submitted that your conduct falls far short of the standards expected of a Registered Nurse. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the

Code). Mr Radley identified the specific, relevant standards where your actions amounted to serious professional misconduct.

Mr Radley provided the following written submissions in relation to misconduct.

'9. The actions reported and found proven are failings directly related to the care of Mental Health Patients and the management of patients/clients who are vulnerable in life.

10. The actions proven against the Registrants are not simply breaches of a local disciplinary policy or minor concerns, they are matters at the heart of and fundamental to the professional's practice, for example compassion and integrity.

11. The Panel are also referred to the NMC guidance, "how to determine seriousness" at FTP – 3 (last updated 27/02/24).

12. FTP – 3a relating to concerns that are serious and more difficult to put right.

13. The NMC say these are serious concerns at the heart of a caring profession.

14. They can be described as serious professional misconduct because these issues relate to the nurses, role as a registered professional (A senior nurse in a. vulnerable Patient setting) and the impact on their area of practice, may affect patient care and Compassion and team working.

…

29. The Panel will in the case of 'PJ', no doubt, pay particularly attention to;

- *The period of time that the misconduct took place over,*
- *The potential serious outcome of the misconduct (E.g. – vulnerable Mental Health patients)*
- *The lack of professionalism in the behaviour*

30. These factors can have a serious effect on patient trust and confidence in the Nursing profession, especially in the case of the vulnerable patients being dealt with here. This, we say, underpins the need to identify this behaviour as serious misconduct in the case of the Registrant Ms James.'

Mr Mackell referred the panel to the cases of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin), *Nandi v General Medical Council* [2004] EWHC 2317 and *Mallon v General Medical Council* [2007] ScotCS CSIH17.

Mr Mackell provided the following written submissions in relation to misconduct.

'…8. The Panel is asked to consider the context within which these complaints have arisen. The Registrant is an experienced nurse who was, evidently, dealing with a difficult and challenging patient. Patient D's patient notes from the preceding days prior to the incident, and indeed after, demonstrate a patient with a pattern of disruptive and aggressive outbursts. A patient, through no fault of their own, who struck out regularly at staff, hitting them, pushing tables against them and striking them.

9. The Registrant volunteered to assist another staff member provide care to the Patient. This action was taken for two reasons; (i) to allow a nurse colleague to take a break and (ii) to ensure that a Health Care Assistant had help to provide care to a patient, who on occasion was aggressive and exhibited violent outbursts.

10. The oral evidence at hearing confirmed that [Witness 1] and [Witness 4] had themselves been struck and kicked by the Patient. The Registrant gave evidence of being struck by the Patient in the face. Senior staff in the hospital were aware of the incidents where the patient had struck staff. On the night in question, this Patient had been moved from the bay into the corridor as a result of existing disruptive behaviour. It is hard to underplay the challenging nature of providing care to such a patient. It is also noteworthy that after this interaction on the same evening another

staff member was reduced to tears having been assaulted by the patient. These submissions are not in any way an attempt to criticise the patient, who was living with diminished capacity, it is simply set out to show the challenging nature of providing care to this particular patient on the ward.

11. The Registrant watched Patient D try to assault [Witness 1] as they provided assistance to him. In the immediate aftermath of that attempted assault the Registrant was, herself, suddenly struck in the face by the Patient. The Registrant, in her reflective piece indicates the following: "I became a nurse to help people, I would never want to harm them. Looking back, I recognise that this was a difficult encounter and things happened very quickly. I was reacting to a fluid and moving situation. I regret reacting in a way to being hit by Patient D. I knew this patient's background, how volatile he could be, how frequently he hit out at staff so I should have been more prepared for him to hit out at me during the interaction. At the time, I was trying to block to further hitting out and I am sincerely sorry that I made contact with Patient D."

12. The Registrant has also reflected on the nature of tapping the Patient after she reacted to being struck in the face. The Registrant has explained these actions in her reflective piece: "In the aftermath of this interaction, I wanted to calm the situation and tried to use de-escalation techniques, such as speaking to him to ask him to stop hitting out and asking him to let us do our job. I think I was trying to maintain some human contact with him by gently tapping him and using "non-threatening body movements". I can see looking back, that this was not the right approach, and I should not have touched him, other than to complete the task. Given Patient D's interaction with us that night, touching him could have made the situation worse."

13. These respective charges are consistent with a nurse under pressure to appropriately react to being struck in the face, in a fast, fluid and challenging

situation. Given a split second to react the Registrant had made an obvious error of professional judgement which she has acknowledged.

14. An ability to reflect is a telltale sign of indicative insight. This is highlighted within the reflective piece but also within the choice of training courses completed. The Registrant identified courses that would suitably address any room for improvement in her professional service delivery.

15. The Registrant has completed training courses including, 'Promoting Patient Safety: through Effective Communication and Teamwork', 'Promoting Effective Communication Skills in Nursing Practice', 'Cultivating Compassionate Care for Patients', 'Distressed Behaviours and Agitation in Older People with Dementia'.

16. Of note, after the Panel's findings the Registrant reflected on demonstrating her commitment to professional development in areas relevant to these index complaints. As such, the Registrant recently completed the following training courses: 'Managing Challenging Behaviour in Adults and Children' and 'Violence and Aggression'. Completing these courses effectively demonstrates a commitment to learn from the experience, to reflect on what ought to have been done differently and develop new skills and knowledge to improve the Registrant's professional service delivery.

17. The Panel may wish to consider the case of Khan v Bar Standards Board [2018] EWHC 2184 where the person was not guilty of prof (sic) misconduct where they engaged in behaviour that is trivial, or inconsequential, or a mere temporary lapse, or otherwise excusable, or 'forgivable'.

18. The behaviour in totality here is, I submit, forgivable. The insight is clear. The reflection submitted by the Registrant demonstrates insight, candour and offers genuine learning. This is a one-off type incident which happened fleetingly during a violent outburst from a challenging patient. There was no sign of pre-meditation or

repeated misconduct. The interaction was very short and can be weighed against a career of 16 years of heretofore unblemished professional service. The Panel has heard evidence of multiple incidents of aggressive behaviour involving this patient, a fact that more senior colleagues were aware of yet it would appear no changes to care arrangements were put in place.

19. Evidently, any harm or upset caused to the Patient was temporary. There was no sign of physical injury as a result of the interaction with the Registrant. Any distress appears to be very short lived. The temporary lapse in judgment was exactly that; temporary. I would submit respectfully, that this conduct is ultimately excusable when weighed against the good character and experience of the Registrant, her long unblemished career, her experience of working over many years with challenging patients as a professional nurse, the absence of any similar type complaint ever being raised and the context on that particular evening.'

Submissions on impairment

Mr Radley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Yeong v General Medical Council* [2009] EWHC 1923 (Admin).

Mr Radley provided the following written submissions in relation to impairment.

'… 6. A decision about whether a professional's fitness to practise is impaired takes a holistic approach, so that anything that's relevant is considered. It is dependent on the individual circumstances surrounding each concern found by the panel.

7. The NMC represent that this question is answered positively. The NMC represent that the professional's fitness to practise is currently impaired.

8. The panel will no doubt ask themselves if any part of the CODE has been breached or is liable to be breached in the future. Any breach would be considered alongside other relevant factors.

9. The NMC refer the panel to the earlier concerns on the breaches of the CODE contained within the Misconduct representations.

10. The NMC say that the breach's (sic) of the Code involves breaching a fundamental tenet of the profession and the Panel would be entitled to conclude that a finding of impairment is required in the case of Ms James.

11. The finding of impairment, the NMC say, is required to mark the unacceptability of the behaviour, emphasise the importance of the fundamental tenet breached, and to reaffirm proper standards or behaviour (Yeong v GMC [2009] EWHC 1923 (Admin) [Hamer para 37.09].

12. The Fitness to Practise Panel will consider the context in which things have happened. Here the panel will be asked to consider, amongst many other aspects.

- *Any factors relating to the professional existing at the time of the charges.*
- *The professional's working environment and culture.*
- *The threatening manner to a Patient*

13. The NMC say that these features, and any others within the case, do substantially adversely affected the professional's ability to practice professionally and as a consequence the professional will not be able to demonstrate that they are currently able to practise kindly, safely and professionally.

14. The third area of context is the learning, insight and steps the professional has taken to strengthen their practice. Here the professional has provided evidence or involvement in the process and engagement in the hearing.

15. The Registrant entered NG plea so was taken to have denied the allegations causing the witnesses to attend to give evidence.

16. The Panel will consider if there is evidence that 'PJ' has addressed or taken steps to address any concerns or risks identified in the case.

17. The Registrant has provided:

- *No (sic) Acceptance of the insight / acceptance of the proven allegations*
- *details of steps taken to address the concerns raised by the proven allegations*
- *References*
- *Training logs/ courses etc*

18. Whether it is likely that the conduct will be repeated is a concern for the NMC. This will impact on the professional's ability to practise kindly, safely, and professionally, resulting in the NMC, suggest a finding of impairment.

19. The consequences of the professional's conduct risked the patients trust and confidence and is very serious

20. For these reasons the NMC say that the Registrant's fitness to practice is currently impaired.'

Mr Mackell referred the panel to the cases of *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Mackell provided the following written submissions in relation to impairment.

'…24. It is respectfully submitted that the conduct here is all remediable, has been remedied and is highly unlikely to be repeated.

25. As the Panel are aware, an assessment of impairment has one eye on the future albeit made in the context of the past conduct of this case. These complaints arose from events in one distinct incident in May 2022. We are now 29 months post the events which led to the Registrant last working as a Nurse. The evidence of current impairment is naturally diminished by the passage of time. Whilst past conduct is relevant the assessment of impairment must be 'current'.

26. A finding of misconduct does not lead inexorably to a finding that the Registrant's fitness to practise is impaired.

27. The Panel is asked to consider the following when reaching a determination as to impairment, in line with the case of Grant:

28.There is no evidence that the Registrant has exhibited any deep seated attitudinal problems nor is there evidence of any acts of dishonesty.

29. The Registrant does not diminish her role in any way, her omissions to act differently and any professional errors of judgment. The Registrant recognises she ought to have acted differently in dealing with this fast, fluid and challenging situation.

30. When considering other limbs of Grant there is a clear emphasis on whether conduct would be liable to be repeated. To answer that question in a fulsome manner it is helpful to look at the context of when these complaints arose, the actions taken by the Nurse since and the ordinarily positive regulatory career of the Registrant.

31. The panel are asked to give weight to the fact the Registrant was initially struck in the face during this interaction and reacted almost instinctively. The pattern of assaults against staff had been ongoing for some time, was known to the senior staff but there had been an absence of action to address the problem.

32. The Registrant in her reflective piece sought to provide a rationale for making contact with the patient and for tapping him thereafter. It is clear from the reflection that the Registrant has considered in great detail the effects of her actions, what ought to have been done differently and what she can do to ensure that such actions are not repeated. The reflective piece supports the contention that this event was very much a fleeting one-off in the career of the Registrant.

33. The training courses recently completed were also undertaken with a view of better equipping the Registrant to dealt with these challenging and stressful events when they occur. There has been a particular focus on improving communication with patients and seeking to de-escalating these types of events when they occur. The Registrant has proven over the years that ordinarily she can deal with such challenging situations appropriately. That is evidenced by her completely clear regulatory history. This clear history of professional service was achieved whilst working for many years in hospital and other care settings.

34. The Registrant has provided Care Assessments completed by a range of professional colleagues. All of the assessments outline an excellent delivery of care from the Registrant. Evidently, this is a competent and diligent Nurse who operated well in the professional field.

35. The Registrant has been subject to conditions of practice on an Interim Order basis. Unfortunately, the Registrant has been unable to secure further employment under the existing conditions. Notwithstanding that deficit, the Registrant has completed her continuous professional development training. This points to a nurse who is keen to address regulatory concerns identified in this instance and to

demonstrate any failings on show have been duly remedied. It is also indicative of an individual who is highly unlikely to repeat such errors of judgment.

36. The Registrant's reflective piece refers candidly to her approach to nursing, particularly those challenging incidents which occur from time to time. She states the following:

> *"I have experienced many difficult behaviours but would not change it for anything as my satisfaction comes from seeing a patient coming in to hospital not able to walk or do anything for themselves and after all the experiences with them the good, the bad, and the ugly they walk out on their own feeling much better clinically, physically and mentally, for me that's my job satisfaction and I miss that experience a lot. If I were to go back to work, I will try my best to engage in more techniques to create a more positive and calmer environment. In conclusion, nursing a patient with challenging behaviour is a complex but rewarding aspect of our nursing profession. It requires compassion, patient centred approach, the right environment, support from management as well as the ability to adapt and communicate effectively. I am grateful for this opportunity to reflect on this experience and am committed to applying these lessons to improving patient care in the future."*

37. An available Testimonial from a former colleague confirms the following:

> *"I have known Primrose James for 8 years. We worked together for a year at Admiral Court before I left for my Nursing Degree which I have now completed. She has inspired me to become a nurse with the way she was passionate with her job and treated every patient with respect and dignity."*

38. In these charges there in an absence of dishonesty nor is there any evident attitudinal issues or concerns. Evidently, the Registrant has shown insight and

reflected on her conduct. The Registrant has a clear and unblemished regulatory record over 16 years. This conduct all relates to a single one off interaction with a challenging and violent patient for a very short period of time. The circumstances can be seen as unique in the career of the Registrant. Additional training has been undertaken to remedy concerns, upskill and improve knowledge in the interim since May 2022. The Testimonial and Care Assessment evidence demonstrates a competent, hardworking and diligent Nurse. It is submitted that this is a view that can be attached to the Registrant currently.

39. As such, the Panel is respectfully invited to find that the Registrant is not currently impaired.'

The panel accepted the advice of the legal assessor which included reference to the relevant NMC guidance and a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *General Medical Council v Meadow* [2007] QB 462 (Admin), *Cheatle v General Medical Council* [2009] EWHC 645 (Admin)*, Cohen v General Medical Council* [2008] EWHC 581 (Admin), *Khan v Bar Standards Boards* [2018] EWHC 2184, *Yeong v General Medical Council* [2009] EWHC 1923 (Admin), *Nursing Midwifery Council v Jalloh* [2023] EWHC 3331 (Admin) and *Sawati v General Medical Council* [2022] EWHC 283 (Admin).

Decision and reasons on misconduct

When considering whether the facts found proved amount to misconduct the panel had regard to the contextual circumstances in which your conduct arose.

The panel took into account that the working environment on Ward 1 could be difficult, in that there appeared to be a lack of training or support for staff or hospital policy in relation to patients who could be challenging and/or violent and/or unpredictable. There was no evidence that your agency provided you with this training either. The panel also took into consideration that Patient D was a vulnerable patient with dementia who could at times be

particularly challenging. The panel noted that it was not uncommon for Patient D to hit out at members of staff in an aggressive manner at times, due to his underlying medical conditions. The panel noted that Patient D had been an inpatient on Ward 1 for around six months and that, on the evidence, limited support had been provided to help manage Patient D's behaviour. The panel acknowledged that you initially got involved with Patient D 's care in order to assist a colleague, who you were working the night shift with, allowing the other member of staff to take their break.

However, the panel took into account that you have worked with dementia patients for approximately 15 years and were therefore experienced in caring for patients with dementia. The panel also noted that Patient D at times had acted aggressively and assaulted other members of staff, however none responded in the way you did, they did not physically retaliate.

The panel had regard to the nature of charges found proved and determined that they are serious involving physical assault on a vulnerable patient. The panel took into account the evidence before it and noted that no physical injury was noted or observed as a result of your conduct with Patient D. However, the panel concluded that there was a significant risk of psychological harm and/or distress to both Patient D and his family.

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 your actions did fall significantly short of the standards expected of a Registered Nurse, and that your actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

***1.1** treat people with kindness, respect and compassion*

***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*

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 *maintain the knowledge and skills you need for safe and effective practice*

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 *take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

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*

20.3 *be aware at all times of how your behaviour can affect and influence the behaviour of other people*

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

20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that given the nature of the facts found proved and balancing all of the factors set out above that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

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

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

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

d) *...'*

The panel determined that a patient was physically mistreated and put at potential risk of psychological harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel therefore determined that limbs a, b and c of the *'Grant'* test are engaged.

Regarding insight, the panel considered that you have developing insight at this time. The panel took into account your reflective piece dated October 2024. The panel determined that your reflection largely focuses on the facts regarding the incident. The panel noted that you acknowledged the findings of the panel and provided a detailed explanation of how you would handle a similar situation differently in the future. However, the panel decided that you have not, at this time, demonstrated a sufficient understanding of how your actions negatively impacted Patient D and their family nor have you demonstrated a sufficient understanding of how your actions negatively impacted your colleagues and the reputation of the nursing profession.

The panel concluded that your actions were a reaction to a stressful situation and were wholly out of character. The panel however was not satisfied that you have demonstrated an understanding of why you reacted the way you did, especially given your considerable experience as a Registered Nurse. Further the panel would have liked to have seen some reflection as to the root cause of your behaviour which led to the facts found proved and how you would address said behaviour to prevent reoccurrence in the future. The panel was not satisfied that you have provided sufficient in-depth personal reflection, to reassure it that if you were again in a similar situation, you would not be at risk of reacting in a similar way.

The panel acknowledged that cases involving physical assault of any patient, in particular a vulnerable patient, are inherently difficult to remediate. However, the panel was satisfied that the misconduct in this case has the potential of being addressed. The panel had regard to the specific context of this case, as previously detailed, and noted that there is no evidence of deep-seated attitudinal issues nor of previous behavioural concerns. The panel noted that this was a singular instance of misconduct which appears to be totally out of character in the context of an otherwise unblemished career.

The panel therefore considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel had sight of numerous training

certificates which you provided. The panel had specific regard to the following relevant training you have undertaken in relation to the area of regulatory concern:

- Promoting patient safety through effective communication and teamwork, dated 8 July 2023 (2 hours CPD)
- Promoting effective communication skills in nursing practice, dated 12 July 2023 (2 hours CPD)
- Cultivating compassionate care for patients, service users and residents, dated 23 November 2023 (2 hours CPD)
- Distressed behaviours and agitation in older people with dementia, dated 23 November 2023 (2 hours CPD)
- Managing challenging behaviour in adults and children including positive behaviour support, dated 13 August 2024 (1 hour CPD)
- Violence and Aggression, dated 8 August 2024

The panel noted that whilst you have undertaken a lot of training over several dates the relevant courses have been taken online and are relatively short, in that most of the courses undertaken are accredited as two hours of Continuing Professional Development (CPD). The panel would have liked to have seen a greater focus on training in relation to general care of patients with dementia and/or Parkinsons, given the context of the charges. Further, the panel noted that given the reactive nature of your actions it would have liked to have seen more in person training, specifically in managing difficult/stressful situations. The panel considered that you have demonstrated that you have undertaken and successfully completed relevant training, but you have not provided sufficient evidence of how you would implement what you have learnt in your practice and how you would handle stressful situations in your broader practice.

The panel took into consideration the testimonials you provided and noted that they all attested to the fact that you are a kind, loyal and compassionate individual. However, the panel noted that you have not provided any testimonials from any Registered Nurses or managers who have worked with you previously. Therefore, the panel did not have before

it any testimonials in relation to your clinical practice. However, the panel took into account that during witness evidence it heard no concerns regarding your clinical practice except in relation to this singular instance of misconduct.

The panel determined that the fact that you have undertaken some reflection and relevant training has reduced the risk of repetition. However, the panel concluded that there still remains a risk of repetition given that your insight is developing, and you have not yet identified or addressed the root cause of your behaviour which led to the facts found proved. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection given the risk of repetition and consequently the real risk of harm.

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 required. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case given the nature of the charges found proved. Further a finding of impairment is required in order to declare and uphold the professional standards of conduct expected of a Registered Nurse.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

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 which included reference to the case of *Nursing Midwifery Council v Jalloh* [2023] EWHC 3331 (Admin).

Submissions on sanction

Mr Radley referred the panel to the case of *Huang v Secretary of State for the Home Department* [2007] UKHL 11.

Mr Radley submitted that the following aggravating features are present in this case:

- *'Registered nurses occupy a position of privilege and trust and maintain professional boundaries;*
- *lack of insight into failings;*
- *Impact on the profession;*
- *The three limbs of the Grant test are engaged;*
- *A Patient was placed in unwarranted risk of harm/ physical distress;*
- *Breaching a fundamental tenet;*
- *Lack of understanding of the seriousness of her actions in the reflections;*
- *Public interest has been engaged.'*

Mr Radley submitted the following mitigating features are present in this case:

- *'No previous regulatory or disciplinary findings;*

- *No direct lasting patient harm;*
- *Age and experience.'*

Mr Radley invited the panel to impose a striking-off order due to the lack of insight, the hostile environment that would have been created for Patient D and the lack of appropriate reflection regarding your misconduct.

Mr Mackell referred the panel to the cases of *Fatnani v General Medical Council* [2007] EWCA Civ 46, *Giele v General Medical Council* [2005] EWHC 2143 (Admin) and *De Freitas v Permanent Secretary* [1999] 1AC 69.

Mr Mackell provided the following written submissions in relation to sanction.

'History:

8. The Registrant has spent 16 years working as a nurse. The Registrant enjoys a clear regulatory record with the NMC. There have been no findings of a regulatory nature previously. As we sit today the Registrant has a clear regulatory record in so far as findings, save for these index matters. It is submitted that the Registrant's employment and professional history demonstrates that this nurse is one who is competent, hardworking and dedicated to her patients.

9. The Panel has access to professional and personal testimonial evidence on behalf of the Registrant. The References were freely given in support of the Registrant and speak to her character.

…

12. The Registrant has provided Care Assessments completed by a range of professional colleagues. All of the assessments outline an excellent delivery of care

from the Registrant. Evidently, this is a competent and diligent Nurse who operated well in the professional field.

13. The absence of any regulatory concerns previously, no evidence of a history of conduct complaints, no in-house/local disciplinary issues, positive employment assessments and positive professional and personal testimonial evidence suggests a longstanding competent and diligent nurse of good character.

14. In keeping with Giele is there any public interest in ending the career of such a Nurse?

Approach of the Registrant:

15. The Registrant from an early stage accepted physical contact took place in this interaction with Patient D. Following police investigation and criminal proceedings at Court it was determined that no criminal conduct had been evidenced.

16. The Registrant answered questions with police, at court and during these Regulatory proceedings. The Registrant has not been ostrich-like, burying her head in the sand. Co-operation has been complete as has engagement in all investigatory proceedings.

17. This approach supports the contention that the Registrant took the matter seriously, recognised the significance of the complaints raised and has demonstrated insight in her reflective piece. That insight has also been borne out in the choice of additional training completed by the Registrant.

Dishonesty and Attitudinal Concerns:

18. There is an absence of dishonesty or deep seated attitudinal concerns from the charges on this occasion.

19. The misconduct and impairment identified relate to, in the submission of the Registrant, matters which can be remedied and where the risk can be suitably managed.

Misconduct and Impairment Findings:

20. The Panel has previously been advised of the challenging environment within which these two complaints arose. The context is no doubt clearly understood by the Panel having listened to and considered evidence of the Patient's history, the previous episodes of violence and aggression, the stress surrounding the incident itself and the fast and fluid situation within which the Registrant found herself.

…

24. The Registrant agrees with this summary and wishes to be afforded an opportunity to effectively demonstrate how this misconduct may be addressed.

Insight:

25. The Registrant has set out how she has learned from this episode in her reflection. The Nurse has learned from this experience, completed training modules to address the concerns identified from these complaints. The Nurse has had the best part of 2.5 years to reflect on their actions.

26. The Reflection from the Registrant provide further information demonstrating insight as follows:

…

27. The Registrant has also reflected on what ought to have been done differently, assessed her own actions and identified ways to improve service delivery to provide safe nursing to Patient D:

…

28. In so far as what should have been done differently, the Registrant has reflected as follows:

…

29. The Registrant expresses remorse and sincere apologies for making physical contact with Patient D:

…

30. The Registrant concluded her reflection with her views as to future ambitions and hopes in the nursing profession:

…

Impact on Registrant:

31. The Registrant has paid a toll to date because of the complaints raised against her. The Registrant lost her employment and was unable to secure employment with the Conditions of Practice in place, on an interim Order basis.

32. The Registrant has been subject to police investigation and criminal trial. Whilst ultimately exonerated of any criminal conduct the panel will appreciate the associated stress of dealing with such proceedings.

33. The Registrant also ruminated on the complaints and has found the proceedings to be stressful. The Panel will understand the impact that proceedings will naturally have on a nurse. The Registrant is keen to move on with her career in a manner that is suitable and acceptable to the panel.

34. Evidently, the Registrant has faced significant challenges and endured damage to her reputation and career as a result of these proceedings. Such submissions don't seek to diminish the misconduct and impairment found however it is simply a way of assisting the Panel when determining what may be a proportionate outcome to the matter when considering all relevant factors engaged in this case.

Outcome:

35. As the Panel is all too aware there is a familiar and well-trodden path to consider a step-wise approach to sanctions. In that regard the Panel is encouraged to consider lesser sanctions before imposing a greater sanction.

36. On this occasion, the Panel will no doubt wish to reflect the misconduct found and the circumstances surrounding the complaints arising. The public no doubt expect nurses to adhere to appropriate standards of conduct.
37. The Registrant has not been able to work since these complaints arose. The Registrant was unable to secure employment with the Interim Order in place.

38. The Panel found in their determination on Impairment they were satisfied that the misconduct has the potential of being addressed.

39. Separately, the Panel set out that the concerns in this instance occurred: as a singular instance of misconduct which appears to be totally out of character in the context of an otherwise unblemished career.

40. The concerns in this case can all be remedied.

41. There is a clear indication from the facts of this case that additional training particularly in dealing with challenging patients, providing nursing care to patients with Dementia and/or Parkinsons and safeguarding vulnerable adults, will provide additional insight, will upskill and equip the Registrant to deal effectively with a patient if a similar challenging situation were to arise in the future. Such insight and additional training will invariably provide assurance to the public that the risk of repetition has been reduced significantly.

42. It may be that the panel considers it appropriate for the Registrant to be subject to indirect supervision where the presence of a mentor or manager will assist and support the Registrant when performing clinical tasks for a period. Overall, these concerns ought to be viewed through a prism of 16 years of sound clinical service delivery and an unblemished professional career up to this point.

43. A period of suspension will make it more difficult for the Registrant to return to nursing practice shortly and gain the required additional experience to demonstrate to the public and indeed the Regulator that confidence can be maintained. The Registrant accepts without challenge that it is entirely a matter for the Panel to determine a proportionate sanction in this matter.
44. Moving to strike off the Registrant will have a significant impact on her. The Registrant maintains familial financial commitments. The Registrant has been, in effect, working as a nurse for nearly 20 years and this is the profession that she has loved and enjoyed. Ending the career of the Registrant will have a devastating personal impact.

45. Is striking off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards? The complaints here do not in themselves relate to honesty, trustworthiness or probity. This may be seen as a one-off incident, which occurred fleetingly in a stressful and challenging professional environment after the Registrant was struck in the face.

46. Once the full facts are examined and all the evidence scrutinised it is submitted that a well informed member of the public would understand the rationale for not considering a strike-off as the necessary outcome on this occasion. Taking such a route of resolution does not, in my respectful view, undermine public confidence.

47. There is no evidence of deep seated attitudinal or personality problems in this case. Separately, the Registrant has shown good and developing insight into the reasons which led to the temporary lapse of judgment exhibited. The Registrant is agreeable to work with any conditions. In the absence of any general clinical competency issues raised by the facts of this case it is submitted that a Conditions of Practice Order is a proportionate outcome to the case.

48.Conditions could be put in place that are workable, relevant and measurable in this instance to address concerns identified.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Conduct which put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- You have provided evidence of having undertaken some relevant training in the area of regulatory concern
- Previous good character

The panel considered the level of insight you have demonstrated regarding the facts found proved. The panel, for the reasons as previously identified, determined that your insight is still developing at this time and therefore it is neither a mitigating nor aggravating feature. The panel was also mindful of the contextual circumstances, as previously identified, in which the misconduct arose.

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 no action would not adequately protect the public, nor sufficiently address the public interest concerns identified.

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

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

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

The panel determined that a conditions of practice order is not appropriate nor proportionate in this case, given the nature of the charges and the risks identified.

In reaching this decision the panel took into account that you have undertaken some relevant training. Further you have engaged with proceedings and demonstrated some insight into your misconduct. The panel therefore determined that you have demonstrated a potential and willingness to retrain to address the area of regulatory concern. The panel also noted that it had previously determined that there is no evidence before it of harmful deep-seated personality or attitudinal issues.

However, the panel took into account that it has previously identified that your conduct which led to the facts found proved was a reaction to a stressful situation. The panel therefore determined that your conduct demonstrates behavioural issues which are inherently more difficult to remediate. The panel took into consideration that you have not provided evidence, at this time, of sufficient insight in relation to the root cause of your behaviour and how you would address said behaviour to prevent reoccurrence. Further the panel noted that you have not undertaken relevant training regarding managing your own behaviour in stressful and/or challenging situations nor how to manage agitated patients with dementia and/or Parkinsons. The panel noted that there is no evidence before it of any other concerns having been raised regarding your clinical practice.

In light of the behavioural concerns identified, which have not yet been sufficiently addressed, the panel determined that you pose a risk to the public. The panel concluded that a conditions of practice order could not be formulated which would adequately protect the public. Furthermore, the panel determined that, given the serious nature of the charges found proved, in that they involve physical assault of a vulnerable patient, a conditions of practice order would not be sufficient to address the public interest concerns identified.

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… has insight and does not pose a significant risk of repeating behaviour;*

The panel referred to the NMC guidance titled '*Considering sanctions for serious cases'*, reference *'SAN-2'* last updated 27 February 2024. The panel had specific regard to the following excerpts of the guidance.

> *'Abuse or neglect of children or vulnerable people will always be treated seriously'*
>
> *'…as these behaviours can have a particularly severe impact on public confidence, a professional's ability to uphold the standards and values set out in the Code, and the safety of those who use services, any nurse, midwife or nursing associate who is found to have behaved in this way will be at risk of being removed from the register. If the panel decides to impose a less severe sanction, they will need to make sure they explain the reasons for their decision clearly and carefully.'*

The panel considered your case with particular care given that your misconduct did involve assault of a vulnerable patient. The panel had regard to its previous findings in relation to the specific contextual circumstances of your case.

> *'The panel took into account that the working environment on Ward 1 could be difficult, in that there appeared to be a lack of training or support for staff or hospital policy in relation to patients who could be challenging and/or violent and/or unpredictable. There was no evidence that your agency provided you with this training either. The panel also took into consideration that Patient D was a vulnerable patient with dementia who could at times be particularly challenging. The panel noted that it was not uncommon for Patient D to hit out at members of staff in an aggressive manner at times, due to his underlying medical conditions. The panel noted that Patient D had been an inpatient on Ward 1 for around six months and that, on the evidence, limited support had been provided to help manage Patient D's behaviour. The panel acknowledged that you initially got involved with Patient D's care in order to assist a colleague, who you were working the night shift with, allowing the other member of staff to take their break.*
>
> *However, the panel took into account that you have worked with dementia patients for approximately 15 years and were therefore experienced in caring for patients with dementia. The panel also noted that Patient D at times had acted aggressively and assaulted other members of staff, however none responded in the way you did, they did not physically retaliate*.'

The panel took into account that your actions were a reaction to a stressful situation. The panel noted that this was a singular instance of misconduct which appears to be totally out of character in the context of an otherwise unblemished career. The panel took into consideration that there was no evidence of harmful deep-seated personality or attitudinal problems nor any previous behavioural concerns. The panel noted that there has been no evidence of repetition of behaviour since the incident, however the panel was mindful that

you have not practised as a Registered Nurse since the incident, and it had no information before it regarding your current employment.

The panel had regard to its previous finding that your misconduct is potentially capable of remediation and the effort you have made to date to strengthen your practice through training. However, the panel noted that you have not yet sufficiently remedied your misconduct, in that you have not demonstrated sufficient strengthening of practice nor sufficient insight, but you have shown considerable reflection and apologised for your failings. The panel determined that your insight at this time is still developing in that you have not addressed the root cause of your behaviour and how to address said behaviour. Further you have not yet demonstrated sufficient understanding of the impact of your actions on Patient D and their family, colleagues, the nursing profession and the wider public. The panel took into account that the reflection and insight you have demonstrated thus far and the relevant training you have undertaken has reduced the risk you present to the public. However there still remains a risk of repetition and subsequently a risk of harm and therefore an order which prevents you from practising as a Registered Nurse at this time, is required.

The panel determined that a well-informed member of the public aware of the nature of the charges and the specific contextual circumstances in which they arose would be satisfied that a suspension order sufficiently addresses the concerns identified. The panel concluded the public's trust and confidence in the profession would not be undermined by the imposition of a suspension order. Further the panel took into account that there is a public interest in allowing an experienced nurse to return to the register having demonstrated sufficient insight and strengthening of practice in the area of regulatory concern.

It did go on to consider whether a striking-off order would be proportionate. Taking account of all the information before it, specifically all your efforts both after the incident and since the charges were found proved, and the contextual circumstances of the case as previously outlined, the panel concluded that it would be disproportionate. The panel

was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. The panel determined that there is a lesser sanction which will adequately protect the public and sufficiently address the public interest. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 12 months with review was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Your continued engagement with NMC proceedings;
- A further written reflective piece addressing:
    - The root cause of your behaviour which led to the misconduct;
    - How you would address said behaviour;
    - The impact of your actions on:
        - Patient D and their family;

    - Colleagues;
    - The nursing profession; and
    - The wider public.

- Evidence of having undertaken any strengthening of practice specifically in relation to managing your *own* behaviour and reactions in challenging and difficult situations;
- Testimonials from your employers;
- Information in relation to your current employment and your intentions in relation to your future practice.

This will be confirmed to you in writing.

Interim order

As the suspension 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 your own interests until the suspension 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 Radley. He invited the panel to impose an interim suspension order for a period of 18 months in order to protect the public and sufficiently address the public interest during any period of appeal.

The panel also took into account the submissions of Mr Mackell. He raised no objection to the application made by the NMC and submitted that it is a matter for the panel.

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 in order to adequately protect the public and sufficiently address the public interest during the period of any appeal.

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

That concludes this determination.