**Nursing and Midwifery Council**

**Fitness to Practise Committee**

**Substantive Meeting**
**Monday, 9 September 2024 – Wednesday, 11 September 2024**

Virtual Meeting

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| **Name of Registrant:** | **Cornelius Shaun O'Brien** |
| **NMC PIN** | 97I0868S |
| **Part(s) of the register:** | Registered Nurse - Sub Part 1:<br>RNMH: Mental Health Nurse, Level 1 (22 September 2000) |
| **Relevant Location:** | Glasgow |
| **Type of case:** | Misconduct |
| **Panel members:** | Richard Youds (Chair, Lay member)<br>Allwin Mercer (Registrant member)<br>Colin Sturgeon (Lay member) |
| **Legal Assessor:** | Ruth Mann |
| **Hearings Coordinator:** | Audrey Chikosha |
| **Facts proved:** | Charges 1a, 1b, 1c, 1d, 1e, 1f, 2, |
| **Facts not proved:** | Charges 3a, 3b, 3c, 3d |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Conditions of practice order (12 months)** |
| **Interim order:** | **Interim conditions of practice 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 O'Brien's registered address by recorded delivery and by first class post on 22 July 2024.

The panel accepted the advice of the legal assessor who referred to Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) and Fitness to Practise Library Guidance PRE-6 (Notice of our hearings and meetings).

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually.

In the light of all of the information available, the panel was satisfied that Mr O'Brien 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 Nursing and Midwifery Council (NMC) does not have to show that Mr O'Brien has read or accessed the notice, only that it was sent to the correct postal address, giving enough notice of the hearing in line with the legal requirements. It is the responsibility of any registrant to maintain an effective and up-to-date registered address.

**Details of charge**

That you, a registered nurse,

1. On 15 October 2018, upon being notified by HCA 1 and HCA 2 that they heard a "popping" and/or "cracking" sound when dressing Resident A, you:
    a) Did not record that you carried out a physical examination on Resident A.
    b) Did not record the concerns raised by the health care assistants in the Communications Book.
    c) Did not complete an Accident/Incident Form.

d) Did not record the incident in the General Practitioners (GP) book.
e) Did not record the incident in Resident A's care plan.
f) Did not escalate the concerns to a doctor and/or contact the Out of Hours National Health Service number.

2. On 16 October 2018, during the handover, did not inform Nurse A that HCA 1 and HCA 2 heard a "popping" or "cracking" sound when dressing Resident A during the nightshift on 15/16 October 2018.

3. On 17 October 2018, upon being notified by HCA 3 and HCA 4 that Resident A had bruising to her arm and forehead you:

a) Did not escalate the concerns to a doctor.
b) Did not to record the concerns raised by the health care assistants.
c) Did not handover to Nurse A the concerns raised by HCA 3 and HCA 4.
d) Incorrectly informed HCA 3 and HCA 4 that Nurse A had checked Resident A and that she had informed you that "her arm was not broken" or words to that effect.

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

**Background**

On 19 November 2018, the NMC received a referral regarding Mr O'Brien from Victoria House Care Home ("the Home"). The Home is a 50 bedded residential nursing home caring for residents who have various stages of dementia. At the time of the concerns raised in the referral, Mr O'Brien was working at the Home as a nurse. Concerns were raised about the care Mr O'Brien provided to Resident A on 15 October 2018.

Resident A was particularly frail and required the use of a hoist in order to enable transfer from and out of bed. Resident A was being helped into bed by two Health Care Assistants. Her clothing was being changed as she was being readied for bed

when they allegedly heard what they described as the sound of a ‘pop’ or a ‘crack.’ This was allegedly reported to Mr O’Brien who was the nurse in charge on the night shift. The Registrant attended Resident A.

It is alleged that Mr O’Brien failed to escalate, at the time, that the healthcare assistants heard a noise from Resident A’s arm when dressing her. Mr O'Brien allegedly did not document that he had carried out an assessment on Resident A. Mr O’Brien allegedly did not also escalate the concerns to a doctor later in the week when bruising showed on Resident A’s arm. It is also alleged that he failed to make a full record of what the healthcare assistants reported to him, including that they had heard a noise from Resident A’s arm. Mr O’Brien allegedly failed to handover to his colleague nurse that the healthcare assistants had heard a noise from Resident A’s arm when they were dressing her. Three days later, Resident A was taken to hospital and a fractured wrist was identified. The type of fracture raised concerns and an ASP (Adult Safeguarding Procedure) planning meeting was held. The meeting highlighted poor communication and lack of documentation in this case.

**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 made by the NMC, together with a telephone note of a phone call from Mr O'Brien to the NMC on 4 August 2020 in which *“he confirmed he will not be disputing the case and does not want to attend the hearing”*

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Manager 1. Home manager who conducted the internal disciplinary investigation.

- Witness 2: Nurse A

The panel also had sight of local investigation accounts from HCA 1, HCA 2, HCA 3, HCA 4, Dr 1 and Mr O'Brien.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. Reference Rule 31 of the 2004 Rules, case of *Enemuwe v Nursing and Midwifery Council* [2015] EWHC 2081 and Fitness to Practice Library Guidance DMA-6 (Evidence – updated 30.8.24). It considered the documentary evidence provided by the NMC

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

**Charge 1a)**

*"On 15 October 2018, upon being notified by HCA 1 and HCA 2 that they heard a "popping" and/or "cracking" sound when dressing Resident A, you:*
*a) Did not record that you carried out a physical examination on Resident A."*

**This charge is found proved.**

In reaching this decision, the panel took into account the local investigation accounts of Mr O'Brien, HCA 1, HCA 2. The panel bore in mind that all three accounts recall that Mr O'Brien was informed about the "popping" sound. It is also stated by all three that Mr O'Brien undertook a physical examination after which he stated that Resident A was fine. None of the statements refer to any records being documented by Mr O'Brien following the examination. This is supported by the statement of Nurse A who said she was not aware of the incident until the following night.

Furthermore, the panel also had sight of the relevant daily notes which had no comments on the relevant date regarding the incident and the physical examination.

The panel found that these sources were reliable and credible and not contradictory. It was therefore satisfied that on the balance of probabilities this charge is found proved.

**Charge 1b)**

"*"On 15 October 2018, upon being notified by HCA 1 and HCA 2 that they heard a "popping" and/or "cracking" sound when dressing Resident A, you:*

b) Did not record the concerns raised by the health care assistants in the Communications Book."

**This charge is found proved.**

The panel bore in mind the same evidence as above and noted that there were no records before it today to indicate that Mr O'Brien had taken a note of the concerns. It noted that Mr O'Brien stated he did not find the concerns to be serious upon examination however, he did not keep any record of it at all. This is further supported by Nurse A's statement dated 7 October 2019 outlining the procedures Mr O'Brien should have taken following a concern being raised to him and she stated that none of the procedures were completed, including making an entry in the communications book.

The panel therefore found this charge proved.

**Charge 1c)**

*"On 15 October 2018, upon being notified by HCA 1 and HCA 2 that they heard a "popping" and/or "cracking" sound when dressing Resident A, you:*

c) Did not complete an Accident/Incident Form"

**This charge is found proved.**

The panel bore in mind the local disciplinary meeting notes and the witness statement of Nurse A. The panel noted that Mr O'Brien admits to not having recorded the incident properly or followed The Home's procedures.

Nurse A, in her witness statement dated 7 October 2019 stated that she would have expected Mr O'Brien to have completed an incident form so that staff can follow up and monitor the issue.

The panel considered the statement of Nurse A to be reliable and consistent. It noted that the first statement Nurse A wrote regarding the incident was in 2018 a few days after the incident, this account has remained consistent in her documentary evidence. The panel therefore determined that on the balance of probabilities and in the absence of any contradictory information, that this charge has been found proved.

**Charge 1d)**

"*"On 15 October 2018, upon being notified by HCA 1 and HCA 2 that they heard a "popping" and/or "cracking" sound when dressing Resident A, you:*

d) Did not record the incident in the General Practitioners (GP) book."

**This charge is found proved.**

The panel once again bore in mind the witness statement of Nurse A. She stated that Mr O'Brien had not made an entry in the GP book on 15 October 2018. Resident A was only put in the GP book on the night of 17 October 2018 after bruising was noticed on the resident's arm.

It was also admitted by Mr O'Brien in his local statement and during the local disciplinary hearing that he did not complete the proper records or escalate the matter.

The panel therefore found this charged to be proved.

**Charge 1e)**

"*On 15 October 2018, upon being notified by HCA 1 and HCA 2 that they heard a "popping" and/or "cracking" sound when dressing Resident A, you:*

*e) Did not record the incident in Resident A's care plan"*

**This charge is found proved.**

The panel took into account the statement of Manager 1 and Nurse A. They both outline the proper processes that a registered nurse should take following report of a concern and physical examination of a patient.

The panel noted that the incident was escalated on 17 October 2018 after intervention from Nurse A. The panel had evidence that no entry was made in Resident A's daily notes prior to this date in relation to the incident.

**Charge 1f)**

"*On 15 October 2018, upon being notified by HCA 1 and HCA 2 that they heard a "popping" and/or "cracking" sound when dressing Resident A, you:*

*f) Did not escalate the concerns to a doctor and/or contact the Out of Hours National Health Service number.*"

**This charge is found proved.**

The panel had evidence before it that the first time the incident was referred to the doctor was on 17 October 2018, when both Mr O'Brien and Nurse A saw bruising on Resident A's arm. The panel noted that in his own statement and the local disciplinary hearing notes, Mr O'Brien stated that he did not think there was anything wrong with the resident following the incident on 15 October 2018.

Although the panel considered that Mr O'Brien did not think there was a need for escalation, in accordance with what was expected as outlined by Manager 1 and Nurse A, Mr O'Brien failed to meet the standard.

The panel therefore found this charge proved.

**Charge 2)**

> "*On 16 October 2018, during the handover, did not inform Nurse A that HCA 1 and HCA 2 heard a "popping" or "cracking" sound when dressing Resident A during the nightshift on 15/16 October 2018"*

**This charge is found proved.**

In reaching this decision, the panel took into account the local disciplinary hearing notes, the local investigation meeting notes, and the account of Manager 1 and Nurse A.

The panel noted that Mr O'Brien was the nurse in charge on the night shift on Monday 15 October 2018 until handover on Tuesday 16 October 2018 and therefore it was his obligation to pass on any information regarding the incident to Nurse A during handover. It was stated in Nurse A's statement that she was not informed of the incident and that the handover was very brief from Mr O'Brien.

Mr O'Brien also states in his account and meeting notes that he did not inform Nurse A until bruising appeared rather than following the incident when it happened.

The panel therefore finds this charge proved.

**Charges 3a)**

> "On 17 October 2018, upon being notified by HCA 3 and HCA 4 that Resident A had bruising to her arm and forehead you:
>
> a) Did not escalate the concerns to a doctor."

**This charge is found NOT proved.**

The panel bore in mind the accounts of HCA 3 and HCA 4. These accounts were seemingly provided as part of the local investigation. The NMC had not provided signed and dated statements from HCA 3 and HCA 4 as such no account contained a statement of truth. The panel also noted that neither account make mention of bruising on Resident A's forehead.

The panel also took into account that within the written accounts of HCA 3 and HCA 4 they both state that the bruising was reported to Mr O'Brien at 06:00 on Thursday 18 October 2018. However, according to the evidence of Mr O'Brien and Nurse A, the matter had been escalated on the evening of 17 October 2018, and Resident A had already been added to the GP book to be seen by a doctor the following day.

Given the inconsistencies in the chronology, the panel therefore found that this charge is not proved.

**Charge 3b)**

> "On 17 October 2018, upon being notified by HCA 3 and HCA 4 that Resident A had bruising to her arm and forehead you:
>
> b) Did not to record the concerns raised by the health care assistants."

**This charge is found NOT proved.**

The panel took into account similar factors as above, it noted that again, neither account from HCA 3 nor HCA 4 mention bruising on the forehead. Furthermore, their evidence is contradicted by that of Nurse A and Mr O'Brien which support that the bruising was identified on the evening of 17 October 2018. This was prior to when HCA 3 and 4 state to have raised the concerns in the early hours on 18 October 2018.

The panel therefore found this charge to not be proved.

**Charge 3c)**

> "On 17 October 2018, upon being notified by HCA 3 and HCA 4 that Resident A had bruising to her arm and forehead you:
>
> c) Did not handover to Nurse A the concerns raised by HCA 3 and HCA"

**This charge is found NOT proved.**

The panel bore in mind the accounts of HCA 3 and HCA 4. The panel noted that they report that they raised their concerns to Mr O'Brien at 06:00 on Thursday 18 October 2018. At this time, Nurse A was aware of the incident and the bruising on Resident A, they were already monitoring her and had put an entry in the GP book on Wednesday 17 October 2018 for her to be seen the next day (18 October 2018).

As a result of the evidential discrepancy between HCA 3 and HCA 4, and Nurse A and Mr O'Brien, the panel found this charge not proved.

**Charge 3d)**

> "On 17 October 2018, upon being notified by HCA 3 and HCA 4 that Resident A had bruising to her arm and forehead you:
>
> d) Incorrectly informed HCA 3 and HCA 4 that Nurse A had checked Resident A and that she had informed you that "her arm was not broken" or words to that effect."

**This charge is found NOT proved.**

The panel noted that in accordance with the accounts provided by HCA 3 and HCA 4, this did not occur on the date stated in the charge. The panel noted that HCA 3 and HCA 4 raised their concerns on 18 October 2018. At this point, Nurse A had examined Resident A and escalated the matter.

The panel therefore found this charge to not be proved.

**Fitness to practise**

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr O'Brien 's fitness to practise is currently impaired. It was at this stage in the meeting the panel were made aware of an NMC Addendum Statement of Case. This outlined that at the time of the referral, Mr O'Brien had a Warning in place. This was in relation to an NMC case relating to Mr O'Brien communicating with vulnerable residents with a lack of compassion and without proper regard for their needs. This Warning was issued on 3 December 2018. The Addendum also referenced a previous NMC referral in 2009 where poor record keeping was found proven.

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, Mr O'Brien 's fitness to practise is currently impaired as a result of that misconduct.

**Representations on misconduct and 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 invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Mr O'Brien's actions amounted to misconduct, specifically provisions 1.2, 4, 8.5, 10.1, 10.2, 10.3, 20.1.

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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Mr O'Brien's fitness to practise impaired on the grounds that the areas of concern identified relate to basic nursing skills and practice, failings in record-keeping, documenting care provided to a resident and escalating concerns.
The NMC consider the misconduct serious because the actions of Mr O'Brien fall significantly short of what would be expected of a registered nurse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Jackson J in Calheam v GMC* [2007] EWHC 2606 (Admin), *Schodlock v GMC* [2015] EWCA Civ 769 and *Ahmedsowdia v GMC* [2021] EWHC 3466 (Admin).

**Decision and reasons on misconduct**

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 O'Brien's actions did fall significantly short of the standards expected of a registered nurse, and that Mr O'Brien's actions amounted to a breach of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***

*To achieve this, you must:*

*1.2 Make sure you deliver the fundamentals of care effectively*

***4 Act in the best interests of people at all times***

***8 Work cooperatively***

*To achieve this, you must:*

*8.2 maintain effective communication with colleagues*

*8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

*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 includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.*

*To achieve this, you must:*

*10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event*

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

***20 Uphold the reputation of your profession at all times***

*To achieve this, you must:*

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the misconduct in charges 1a, 1b,1c and 1e were serious failings of basic nursing practice. This conduct fell short of what is

expected of a registered nurse. Mr O'Brien made a conscious choice not to document the incident and the clinical assessment. During the local investigation he stated that he did not know why he had not made these records and did not offer any further explanation.

With regards to charges 1d and 1f, the panel noted Mr O'Brien from his local account, made a clinal judgement and he believed there was no serious problem with Resident A. Therefore, the panel did not find that these concerns in these charges amounted to misconduct.

In Charge 2, the panel also considered that Mr O'Brien's actions fell short of the standards expected by a registered nurse. The panel noted that Resident A was particularly vulnerable and unable to communicate and as such, a handover should have been completed to ensure the proper care and monitoring was provided to her.

The panel found that Mr O'Brien's 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, Mr O'Brien's fitness to practise is currently impaired.

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and

the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/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*

The panel determined that limbs a, b and c are engaged.

The panel finds that Resident A was put at risk. Mr O'Brien's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mr O'Brien made some admissions during the internal investigation however it did not evidence remorse or reflection. Furthermore, Mr O'Brien has disengaged with the NMC and has not provided any evidence of reflection or understanding of what he did wrong. As such the panel determined that his insight is limited.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr O'Brien has taken steps to strengthen his practice. The panel had no information before it to demonstrate that he has strengthened his practice. It also had no information regarding his current employment status.

The panel was of the view that there is a risk of repetition based on the lack of evidence of insight, reflection and strengthened practice. Furthermore, it had sight of the Addendum bundle which outlined that at the time the NMC received the referral for this case, Mr O'Brien was subject of a warning for previous regulatory concerns. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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 because a fully informed member of the public would be concerned to find that a registered nurse facing these charges which involve a vulnerable Resident is found to not be impaired in their practice.

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

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

**Sanction**

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Mr O'Brien's name on the NMC register will show that he is subject to a conditions of practice order and anyone who enquires about his registration will be informed of this order.

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

**Representations on sanction**

The panel took into account the NMC submissions:

> *'Taking no further action or imposing a caution order would not be sufficient to mitigate the risks in this case, nor would it protect the public or satisfy the public interest in this case.*
>
> *Given the concerns in this case relate solely to clinical failings, which further training could address, a conditions of practice order would be sufficient to address the risks identified. Conditions can be created that can be monitored and assessed. It would be appropriate and proportionate in these circumstances to impose a conditions of practice order as it would adequately protect the public and satisfy the public interest.*

*With regard to our sanctions guidance the following aspects have led us to this conclusion:*

*• The concerns in this case can be properly addressed through training and reflection.*
*• The incidents in question appear during an isolated period over 2-3 days and the concerns are related to specific areas of clinical practice.*
*• Conditions could be formulated which are practicable, workable and measurable.*

*A suspension order would be disproportionate and punitive in such a case where there is a lesser sanction that would sufficiently protect the public and meet the wider public interest.*

*A conditions of practice order for a period of 9 months with a review is a proportionate order. 9 months will allow Mr O'Brien sufficient time to comply with the conditions, address the concerns raised in his practice and undertake meaningful reflection. A review is required to enable a future panel to assess whether he has complied with the conditions, developed insight and has addressed the deficiencies in his practice*.'

**Decision and reasons on sanction**

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

The panel took into account the following aggravating features:

- Mr O'Brien has had previous regulatory or disciplinary findings
- The charges relate to a vulnerable resident.

- Actions which could put patients at the risk of harm – Mr O'Brien's lack of escalation meant that the patient may have been in pain/discomfort for 2 days until her fractured wrist was noticed.

The panel could not identify any mitigating factors in this case.

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 O'Brien'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 O'Brien's 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 Mr O'Brien's 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;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. There are clear and identifiable areas of practice that can be addressed, and the panel was satisfied that there was no evidence of general incompetence. The panel considered that workable conditions could be formulated to protect the public moving forward.

The panel was of the view that it was in the public interest that, with appropriate safeguards, Mr O'Brien should be able to return to practise as a nurse. It considered that a suspension order at this time, would be disproportionate.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case because there are conditions that are practicable, workable and measurable in the circumstances. Furthermore, the concerns can be properly addressed through training.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

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

> 'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.
>
> 1. You must make sure you are indirectly supervised by a registered nurse any time you are working. Your supervision must consist of

working at all times on the same shift as but not always directly supervised by another registered nurse.

2. You must work with your line manager/ mentor/ supervisor to create a personal development plan (PDP). Your PDP must address the regulatory concerns namely, the importance of record keeping and escalating concerns. You must:

   a) send your case office a copy of your PDP before any review hearing or meeting
   b) Send your case officer a report from your line manager/ mentor/ supervisor before any review hearing or meeting. This report must show your progress towards achieving the aims set out in your PDP.

3. You must engage with your line manager/mentor/supervisor on a monthly basis to ensure that you are making progress towards aims set in your PDP which include:
   a) meeting with your line manager/ mentor/ supervisor at least every month to discuss your progress towards achieving the aims set out in your PDP.

4. You must keep us informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

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

6. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

7. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

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

    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months. This is to allow Mr O'Brien sufficient time to find employment and engage with the conditions of practice order.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mr O’Brien has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- A written reflective account addressing the regulatory concerns
- Evidence of paid or unpaid work
- Evidence of continuing professional development
- Up-to-date testimonials and references from your employer or any voluntary work
- Engagement with the NMC
- Attendance at the next review hearing

This will be confirmed to Mr O'Brien in writing.

**Interim order**

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It 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 O'Brien 's own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

**Representations on interim order**

The panel took account of the representations made by the NMC that:

> *'If a finding is made that the registrant's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
>
> *If a finding is made that the registrant's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registrant we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.'*

**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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.