Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 27 January 2025 – Friday 31 January 2025

Virtual Hearing

Name of Registrant:	**Paul Vincent Flynn**
NMC PIN	89C0052S
Part(s) of the register:	Registered Nurse General (Level 2) – 18 October 1990
Relevant Location:	East Dunbartonshire
Type of case:	Misconduct
Panel members:	Deborah Jones (Chair lay member) Paul Leighton (Lay member) Elaine Karen Biscoe (Registrant member)
Legal Assessor:	Alice Robertson Rickard
Hearings Coordinator:	Adaobi Ibuaka
Nursing and Midwifery Council:	Represented by Mr Ben Anson Jones, NMC Case Presenter
Mr Flynn:	Not present and unrepresented
Facts proved:	Charges 1b, 1c, 1d(i), 1d(ii), 1d(iii), 1e, and 2
Facts not proved:	Charges 1a, and 3
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Flynn was not in attendance and that the Notice of Hearing letter had been sent to Mr Flynn's registered email address by secure email on 10 December 2024.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mr Flynn.

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

Mr Anson Jones submitted that there had been very limited engagement by Mr Flynn with the NMC in relation to these proceedings, other than an email in early January

which mentioned a family bereavement. As a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mr Flynn
- Mr Flynn has not engaged meaningfully with the NMC and has not responded to any of the letters sent to him about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A number of witnesses have been warned to attend remotely today to give live evidence, others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2022;
- [PRIVATE]
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Flynn in proceeding in his absence. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated, and it has the benefit of written representations from Mr Flynn. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Flynn's decision to absent himself from the hearing.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Flynn.

Details of charge

That you, a registered nurse,

1. On 19 July 2022, in relation to resident MM,

    a) Manually lifted her back into bed.

    b) Did not call an ambulance and/ or seek medical assistance.

    c) Colluded with colleague 1 to cover up a fall sustained.

    d) Did not record:

        i. Details of the examination you carried out.
        ii. Any fall having occurred.
        iii. Your clinical findings at 7.20am.

    e) Upon being told one leg appeared shorter than the other, laughed and said, "did it get shorter overnight?" or words to that effect.

2. Your actions as set out at charge 1(c) were dishonest in that you were aware Resident MM had suffered a fall but colluded with colleague 1 to mislead other colleagues to believe no fall had taken place.

3. Your actions as set out at charge 1(d)(ii) were dishonest in that you intentionally made no record of Resident MM's fall to conceal that you manually lifted her back to bed and did not seek medical assistance.

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

Background

These charges arise from a referral that was made to the NMC by Mr Flynn's employer at the time, [PRIVATE] Care Home, (the Home). Mr Flynn was employed as a registered nurse at the Home and was undertaking a night shift as the nurse in charge on the night of the 18 to the 19 of July 2022.

It is alleged that at 02:00 hours on the 19 July 2022, Witness 1 was responding to a buzzer on floor two when she heard Resident MM cry out for help. When she arrived in Resident MM's bedroom, she found her on the floor laying in urine. Witness 1 left the room to get the help of Mr Flynn. Witness 1 states that Mr Flynn arrived in the room and examined Resident MM. He stated that she was fine and asked Witness 1 to assist in putting Resident MM back to bed. A hoist was not used, as it should have been according to the Home's policy. Instead, Mr Flynn lifted Resident MM by the shoulders and Witness 1 lifted her by the legs and they placed her back into her bed.

It is alleged that there is no documentation relating to this incident during the night.

It is further alleged that at around 07:00hrs the same day, Mr Flynn was called by Witness 3 to examine Resident MM, who had been found by care staff to be in pain. It is alleged that when Mr Flynn was advised that one leg appeared to be shorter than the other, he laughed and asked *"did it get shorter overnight".* Mr Flynn examined Resident MM and said he would seek a second opinion from the day

nurse who was due to arrive. It is alleged that Mr Flynn did not document the examination in Resident MM's care records.

Resident MM was admitted to hospital and subsequently found to have a fractured left femur, which the hospital attributed to a trauma, requiring surgery.

It is further alleged Mr Flynn colluded with Witness 3 to cover up the fall and that his actions were dishonest.

During the local investigation Mr Flynn denied that the fall had occurred as alleged.

Decision and reasons on facts

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: Health Care Assistant at the Home.
- Witness 2: Manager of the Home at the time of the incident.
- Witness 3: Health Care Assistant at the Home at the time of the incident.
- Witness 4: Health Care Assistant at the Home.

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

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

Charge 1a

"*That you, a registered nurse,*

1. *On 19 July 2022, in relation to resident MM,*

a. *Manually lifted her back into bed."*

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness evidence of all 4 witnesses as well as the documentary evidence. It concluded that the NMC had failed to prove that it was more likely than not that Mr Flynn had manually lifted Resident MM back into bed.

The NMC case, based on the evidence of Witness 1, is that Mr Flynn and Witness 1 manually lifted Resident MM into bed after finding her on the floor of her room at around 2.20 am. The panel found that it was inherently improbable that a fall was sustained at this time as, according to the NMC witnesses, Resident MM was checked at 3 am and was found to be sleeping.

The panel found it likely that, had Resident MM sustained a fractured femur at this time, the act of lifting her back into bed would have caused her considerable pain. However, according to Witness 1's account, Resident MM was showing no signs of

pain. Witnesses 3 and 4 also described checking on Resident MM at 3am and finding her peacefully asleep. Furthermore, none of the witnesses reported hearing any signs of distress from Resident MM between the 3am and 7am checks.

Whilst the panel accepted that it was more likely than not that at some point during the night Resident MM sustained a fall, it considered that it was more likely to have occurred closer to 7:20 am, when she was found to be in pain. There was insufficient evidence to show that Mr Flynn was responsible for lifting her back into bed at this time and it could equally have been the health care assistants. Indeed, the text messages sent by Witness 3 to Mr Flynn provide some support for this possibility. (See below)

The panel did not find Witness 1's account of this incident to be credible in light of the inherent unlikelihood of it having occurred as she described and there were no other direct witnesses to support the allegation that Mr Flynn had lifted Resident MM back into bed.

The only other witness to the alleged incident at 2:20am was Resident MM. The panel considered the hearsay evidence from Witness 4, that Resident MM reported that a man and a woman had lifted her back to bed. It did not find this to be reliable, as Witnesses 3, who was also present at the time Resident MM is alleged to have reported this, did not corroborate this account. Witness 3 stated that Resident MM did not say anything but was just screaming in pain. Due to the inconsistencies between the NMC witnesses the panel gave no weight to this hearsay evidence.

The panel therefore concluded that the NMC had failed to discharge the burden of proof in relation to this charge.

Charge 1b)

"That you, a registered nurse, On 19 July 2022, in relation to resident MM;

b. Did not call an ambulance and/ or seek medical assistance"

This charge is found proved.

The panel took account of the witness statements and oral evidence as well as Mr Flynn's documentary evidence.

In a handwritten statement (undated) provided for the Home's internal investigation Mr Flynn stated;

> *"I had no other help at the time… it was my intent to get Resident MM some analgesia and then make a call to NHS 24 with regard to getting some advice and the possibility of getting an ambulance as I thought the resident would require a scan or x-ray"*

In an email to the NMC dated 24 August 2023 Mr Flynn also states,

> *"At this time the dayshift nurse had came on duty, I briefly outlined the events that had unfolded, we both went to see the resident and jointly decided that indeed some painkillers and then contact NHS 24 with regards to getting an ambulance as we agreed the resident required an X-Ray or Scan. My shift then finished"*

The panel found that, as a matter of fact and by his own admission, Mr Flynn did not call an ambulance and did not seek medical assistance and therefore charge 1b is found proved.

Charge 1c)

"That you, a registered nurse, On 19 July 2022, in relation to resident MM,

c. Colluded with colleague 1 to cover up a fall sustained"

This charge is found proved.

The Panel reached its decision on this charge based on the contemporaneous documentary evidence of text messages between Mr Flynn and Witness 3 (Colleague 1) dated 19 and 20 July 2022. These were exhibited by Witness 2, who told the panel that he had been informed by Mr Flynn that some messages had been deleted. The panel accepted that these messages did not, therefore, provide a full picture. However, it was clear from the messages that had not been deleted that Witness 3 referred to a fall that had occurred, that Mr Flynn was aware of this by the time of the text messages, and that he and Witness 3 had attempted to cover it up.

Witness 3 in her oral evidence, was asked about the messages. She told the panel that she had engaged in the exchange of texts in order to try to get Mr Flynn to incriminate himself, as she believed he would deny any part in the incident involving Resident MM.

The Panel did not find her explanation to be credible as it appeared from her messages that she herself was involved with the fall. In particular it noted a message sent by Witness 3 sent at 22:13 on 19 July 2022.

> *"I think we are fucked for this dunno how can cover up a broken leg …simple accident we out her back to bed which we knew was wrong but not staffed to monitor her laying on the floor where more damage could. Have been done"[SIC]*

A further message sent by Witness 3 at 23:12 states

> *"…have to be as truthful as we can to keep us all out the shite but 3 of us still to put statement in no idea what to do other than do state found at 7:20 on the floor and 3 of us put her back to bed and we know never has moved her but no staff to watch over her so safest op." [SIC]*

The panel also noted text messages which appear to show that Mr Flynn and Witness 3 were sharing statements which they would later submit for the Home's internal investigation. At 14:57 on 19 July 2022 Witness 3 sent a text message which said;

" Ohh we haven't put our statements in have you got your statement to show me"[SIC]

Mr Flynn replied at 14:59

"send me your email address and ill forward it to you. I've kept it nice and simple" [SIC]

In a later exchange Witness 3 sent a message at 22:13;

"Simple accident but we out her back to bed which we knew was wrong but not staffed to monitor her laying on the floor where more damage could. Have been done"[SIC]

At 22:52 Mr Flynn replied;

"no problem (Witness 3) hear what you are saying…"[SIC]

The following day at 16:59 Witness 3 sent a text to Mr Flynn saying;

" Hi I've sent my statement to your wife's email if you could have a look when you get a minute before I send it to (Witness 2) thanks"[SIC]

At 17:53 on 20 July 2022 Mr Flynn replied;

"right saw the email (Witness 3) that statement sounds absolutely fine to me"[SIC]

In light of the above the panel was satisfied that Resident MM did at some point sustain a fall. Whilst the panel was not satisfied that Mr Flynn was involved in the fall himself, it was satisfied that on the 19 July 2022 he knew from the text exchange that a fall had taken place, and he colluded with Witness 3 (Colleague 1) to cover it up.

Therefore, charge 1c is found proved.

Charge 1d(i) – 1d(iii)

"That you, a registered nurse,

1. *On 19 July 2022, in relation to resident MM,*
d. *Did not record:*

    i. *Details of the examination you carried out.*
    ii. *Any fall having occurred.*
    iii. *Your clinical findings at 7.20am."*

This charge is found proved in its entirety.

The panel noted that this charge was purely factual. It had regard to Resident MM's care notes. There is no record of an examination, a fall or clinical findings at 7:20am. It further had regard to Mr Flynn's written account in which he states

> *"I did however let myself down by failing to record anything in the residents notes, a mistake and genuine oversight."[SIC]*

Furthermore, in his email to the NMC dated 24 August 2023 Mr Flynn stated;

> *"I did accept from the start that I failed to write details in the residents careplan"[SIC]*

On the basis of both the care notes and Mr Flynn's own admission the panel finds this charge proved in its entirety.

Charge 1e)

"That you, a registered nurse, On 19 July 2022, in relation to resident MM;

e. Upon being told one leg appeared shorter than the other, laughed and said, "did it get shorter overnight?" or words to that effect"

This charge is found proved.

The panel took into account the minutes of the investigation meetings conducted by Witness 2 on the 27 – 28 July 2022, as well as the oral evidence of Witnesses 3 and 4.

In Witness 4's investigation meeting she stated;

"Went in just before 21:00, then just after midnight, just after 03:00 then at 07:00. She was sound asleep on all occasions apart from 07:00. She was being sick and holding her left leg. I went to get the nurse in charge PF. He arrived and checked over and said he couldn't find anything broken. CH told PF that she thought leg looked swollen and shorter than the other one. He laughed and responded "did it happened overnight"[SIC]

In Witness 3's investigation meeting she stated;

"He laughed and said "did it get shorter overnight". He told us to do personal care"[SIC]

Both witnesses confirmed their accounts in their oral evidence.

Therefore, the panel found charge 1e proved.

Charge 2

"That you, a registered nurse, your actions as set out at charge 1(c) were dishonest in that you were aware resident MM had suffered a fall but colluded with colleague 1 to mislead other colleagues to believe no fall had taken place."

This charge is found proved.

In reaching its decision the panel had regard to its findings at charge 1(c). It found that, by the time of the text messages, Mr Flynn was aware that Resident MM had sustained a fall. He colluded with Witness 3 to cover it up. This was evident from the text exchange between Mr Flynn and Witness 3. It was further satisfied that his purpose in covering up the fall was to mislead other colleagues to believe it had not occurred, as there was no other plausible explanation. Having regard to his knowledge that a fall had occurred and his actions to cover it up, the panel had no doubt that this would be regarded as dishonest by ordinary decent people.

The Panel therefore found charge 2 proved.

Charge 3

> *"That you, a registered nurse, your actions as set out at charge 1(d)(ii) were dishonest in that you intentionally made no record of resident MM's fall to conceal that you manually lifted her back to bed and did not seek medical assistance."*

This charge is found NOT proved.

The panel found Charge 1a not proved. It could not be satisfied that Mr Flynn was aware that a fall had taken place before he left the Home on the morning of 19 July 2022.

Therefore, the panel could not find that Mr Flynn's failure to record a fall in Resident MM's notes was dishonest.

Therefore Charge 3 is found not proved.

Fitness to practise

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

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

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

Submissions on misconduct

Mr Anson Jones 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 cases of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Calheam v GMC [2007]* EWHC 2606 (Admin)

Mr Anson Jones invited the panel to take the view that the facts found proved amount to misconduct. Mr Anson Jones referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015'

(the Code) and he identified the specific, relevant standards which, he submitted Mr Flynn had breached and which, he submitted, amounted to misconduct.
Mr Anson Jones submitted that Resident MM suffered a serious injury and was put at further risk of harm as a result of Mr Flynn's decision to not seek medical assistance or call an ambulance. Mr Anson Jones submitted that Mr Flynn, did not admit to this at the earliest opportunity to Witness 2 during the investigation meeting, but instead tried to cover up the fall of Resident MM and attempted to control the narrative by colluding with Witness 3.

Mr Anson Jones submitted that that Mr Flynn's actions amounted to conduct that falls short of what would be expected of a registered practitioner and would be regarded as deplorable.

Mr Anson Jones concluded that Mr Flynn's behaviour is clearly concerning, and it breaches the NMC's code and, collectively, the charges amount to misconduct in this case.

Submissions on impairment

Mr Anson Jones 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).

Mr Anson Jones submitted that the question to help the panel decide on whether Mr Flynn's fitness to practise is impaired is whether he can practice kindly, safely and professionally.

Mr Anson Jones submitted that limbs a, b, c and d of the test set out in the case of *Grant* are engaged.

Mr Anson Jones submitted that Mr Flynn has shown limited insight and has instead attempted to deflect any blame onto his colleagues and the management of the Home. Other than his admission and apology for failing to record events in resident MM's notes, Mr Flynn has shown no remorse. Mr Anson Jones submitted that there is a clear risk of repetition of Mr Flynn's misconduct and that a finding of impairment is required for the protection of the public.

Mr Anson Jones submitted that the dishonesty that has been found proved indicates an attitudinal issue that would be difficult to remedy. Therefore, he submitted a finding of impairment is also required in the public interest to uphold proper professional standards and to maintain public confidence in the profession.

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), *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (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 Flynn's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Flynn's actions amounted to a breach of the Code. Specifically:

> ***"1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

8 Work co-operatively

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

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

To achieve this, you must:

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

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.1 take measures to reduce as far as possible… the effect of harm if it takes place

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times…"

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

However, the panel was satisfied that Mr Flynn's conduct, as found proved in relation to charges 1b, 1c, 1d(i) and (iii), 1e and 2, was so serious as to amount to misconduct.

Mr Flynn was made aware at around 7.20 am that Resident MM, who was an elderly and vulnerable patient, was in pain and distress. Regardless of whether he was aware at that point that she had fallen, he should have sought immediate medical assistance and should have treated her with care and compassion. His response to being told that Resident MM appeared to have one leg shorter than the other was inappropriate and unprofessional. Mr Flynn's care of Resident MM fell far below the standards to be expected of a registered nurse.

With regard to Charge 1d, the panel noted its previous findings that it could not be satisfied that Mr Flynn was aware of Resident MM having sustained a fall by the time

he left the Home. It therefore it did not find misconduct in relation to 1d(ii). However, he was aware that Resident MM was in severe pain and required further attention. In the circumstances, the panel considered that he had a duty to remain at the home and to complete a record of events, his assessments and any clinical findings he had made. His failure to do so was sufficiently serious to amount to misconduct.

In relation to charges 1c and 2, the panel was of the view that colluding to cover up the true picture of an incident that had severe consequences for Resident MM and hampered the Home's internal investigation, was extremely serious and would be considered deplorable by fellow practitioners.

The panel found that Mr Flynn'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 Flynn'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 and to maintain professional boundaries. 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.

The panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* (No 2) [2000] 1 A.C. 311 in reaching its decision.

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds limbs a – d engaged. Resident MM was put at risk of further harm by Mr Flynn's failure to seek medical attention and his failure to make contemporaneous records. The panel was satisfied that the breaches of the code it had identified showed that Mr Flynn's misconduct had breached fundamental tenets of the nursing profession and brought its reputation into disrepute. He also acted dishonestly in colluding to cover up the fall.

The panel next considered whether Mr Flynn was liable to repeat his misconduct in the future. It concluded that he was liable to do so because of his lack of insight, reflection, remorse and remediation. There is no evidence before the panel of any reflection on the impact of his actions on Resident MM and her family, nor the impact on his colleagues or the wider nursing profession. The panel had no evidence of any training that Mr Flynn might have undertaken or any efforts he has made to strengthen his practice.

The panel therefore decided that there was a risk of repetition and as such a finding of impairment was necessary for the protection of the public.

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 also required, particularly in light of Mr Flynn's dishonesty. It determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case. Therefore, the panel finds Mr Flynn's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Submissions on sanction

Mr Anson Jones invited the panel to impose a striking off order as it found Mr Flynn's fitness to practise currently impaired. He provided the panel with submissions on the aggravating and mitigating factors of the case. Mr Anson Jones provided the panel with submissions on the sanctions available to the panel, going through the appropriateness and proportionality of each sanction. He submitted that a striking off order is the only order that would be sufficient to protect patients, address the public interest and maintain professional standards.

Decision and reasons on sanction

Having found Mr Flynn'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 Flynn's lack of insight into his failings
- Mr Flynn's conduct put Resident MM at risk of suffering further harm as he did not immediately seek medical assistance or call an ambulance.

- Mr Flynn's dishonesty and collusion with Witness 3 demonstrate a serious attitudinal concern.

The panel next went on to consider if there were any mitigating features in this case. It had regard to a handwritten testimonial contained in Mr Flynn's documentary evidence. The panel noted that the testimonial was not recent nor was it on headed paper and it was unclear which care home the testimonial referred to. It was also unclear whether the author of the testimonial knew the exact details of this case. The panel therefore concluded that it was not able to attach significant weight to the testimonial. The panel concluded that there are no mitigating features in this case.

The panel took into account the NMCs guidance on "Considering sanctions for serious cases", SAN-2, dated 27 February 2024. The panel reminded itself that Mr Flynn's dishonest conduct arose from a single incident from a night shift involving one resident. However, his dishonesty was maintained throughout the time of the Home's investigation. Furthermore, Mr Flynn has not provided any evidence or information to the NMC to demonstrate that he has developed any further insight into the concerns identified in this matter. The panel concluded that Mr Flynn's actions were a deliberate breach of the professional duty of candour and a direct risk to people receiving care.

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 Flynn'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 Flynn's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case.

The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Flynn's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel noted that there was no engagement from Mr Flynn during this hearing, which persuaded the panel that he would be unlikely to comply with a conditions of practice order. The panel was of the view that Mr Flynn's misconduct was not something that could be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Flynn's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate and proportionate sanction. The panel took into consideration that the SG states some of the factors where a suspension order may be appropriate. The panel took into consideration that this was a single instance of misconduct with Resident MM however, it bore in mind that Mr Flynn colluded with Witness 3 to cover up the fall following the initial incident. The panel was of the view that Mr Flynn has demonstrated an attitudinal problem given the apparent ease with which he was able to lapse into dishonest conduct. The panel bore in mind that Mr Flynn took no real responsibility for his actions. The panel noted its previous findings that there is an absence of insight from Mr Flynn and that there is a risk of repetition of the behaviour found proved.

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

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

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

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

Mr Flynn's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. To allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mr Flynn in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Flynn's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Anson Jones. He submitted that the panel should impose an interim suspension order for a period of 18 months to cover any potential period of appeal.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any potential period of appeal.

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

That concludes this determination.