Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 1 October 2024 – Wednesday 9 October 2024
Monday 6 January 2025 – Thursday 9 January 2025

Virtual Hearing

Name of Registrant:	Mr Sven Carey Rouse
NMC PIN	96D0869E
Part(s) of the register:	Nurses part of the register Sub part 1 RNMH: Mental health nurse, level 1 (26 April 1999)
Relevant Location:	Worcestershire
Type of case:	Misconduct
Panel members:	John Kelly (Chair, lay member) Vanessa Bailey (Registrant member) Alyson Young (Lay member)
Legal Assessor:	Hala Helmi (Tuesday 1 October 2024 – Wednesday 9 October 2024 and Monday 6 January 2025 – Thursday 9 October 2025) and Gillian Hawken (Thursday 9 January 2025)
Hearings Coordinator:	Eidvile Banionyte
Nursing and Midwifery Council:	Represented by Rebecca Butler (Tuesday 1 October 2024 – Friday 4 October 2024 and Thursday 9 January 2025) and Eilish Lindsay (Monday 6 January 2025 – Thursday 9 January 2025), Case Presenters
Mr Rouse:	Present and represented by Alex Lawson, instructed by the Royal College of Nursing ('RCN')

Facts proved by admission:	Charges 1a, 1c, 1e, 2 and 3
Facts proved:	Charges 1b, 1d and 1f
Facts not proved:	Charge 4
Fitness to practise:	Impaired
Sanction:	**Suspension Order (3 months)**
Interim order:	**Interim Conditions of Practice Order (18 months)**

Details of charge- as amended

That you, a Registered Nurse :

1) On 15 October 2022 during a physical restraint incident;

    a) Pulled and or grabbed Patient F by the arm on one or more occasions.

    b) Placed your hands on Patient F's neck.

    c) Pushed Patient F along the floor.

    d) Said to Patient F;

        i) 'Get the fuck up' or words to that effect.

        ii) 'I swear to God' or words to that effect.

        iii) 'I am warning you' or words to that effect.

    e) Pushed Patient C.

    f) Said to Patient C

        i) 'You shut the fuck up' or words to that effect.

        ii) 'Fucking move' or words to that effect.

2) On or about 15 October 2022 you failed to record an adequate and/or full account of your involvement in the physical intervention and bruising on Patient F in her clinical notes.

3) On or about 15 October 2022 you failed to record and adequate and/or full account of your involvement in the physical intervention and bruising on Patient F in the Datix.

4) Your actions in charges 2 and or 3 were dishonest in that you were seeking to conceal the extent of your actions during the physical restraint incident.

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

Decision and reasons on application to amend the charge

At the outset of the hearing, the panel heard an application made by Ms Butler, on behalf of the NMC, to amend the wording of charges numbers 2 and 3.

The proposed amendment was to remove words ‘any or’ and insert the word ‘of’ in both of those charges. It was submitted by Ms Butler that the proposed amendment would provide clarity and more accurately reflect the evidence.

> “That you, a registered nurse:
>
> 2) On or about 15 October 2022 you failed to record ~~any or~~ all <u>of</u> your actions in charge 1 in Patient F’s clinical records.
>
> 3) On or about 15 October 2022 you failed to record ~~any or~~ all <u>of</u> your actions in charge 1 in a DATX report.
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct.”

Mr Lawson did not object to these amendments.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

At the outset, both parties jointly informed the panel that they had made efforts in advance of the hearing to agree certain aspects of the evidence by redacting parts of the witness statements and exhibits. The parties pointed out however that it appears that the panel has been provided with unredacted versions of the documents. Ms Butler on behalf of the NMC and Mr Lawson on your behalf sought further time to redact the papers so that they could be provided in a form agreed between the parties, thereby minimising the need for submissions to and determinations by the panel itself.

The panel was duly provided with the papers in agreed redacted format and whilst no formal application was made by either party, the panel considered the need to ensure fairness to you and the NMC having regard to it having had sight of earlier unredacted versions. It considered that as a professional and experienced panel it was able to rely on the redacted papers, putting the earlier versions out of its minds and focussing on the allegations and evidence as presented. The panel removed early versions of the papers to ensure that the hearing proceeds solely on the new papers.

Consequently, the panel determined that it could continue to hear this matter without any unfairness towards or bias against yourself

Having agreed the redactions described above, Ms Butler told the panel that the witness statement of Witness 1 now simply serves as a production statement in relation to the CCTV evidence and the internal investigation report. Mr Lawson on your behalf acknowledged this point and made no objection to this evidence being introduced. On the basis of this agreement, the panel accepted the witness statement into evidence as a production vehicle for CCTV and other evidence.

Decision and reasons on application to admit written statements of Witness 2 and Witness 3 as hearsay evidence

The panel heard an application made by Ms Butler under Rule 31 to allow the written statements of Witness 2 and Witness 3 into evidence as hearsay.

Ms Butler told the panel that Witness 2 is not able to attend this hearing and whilst the NMC had made efforts to ensure that she was present, she was unable to attend today due to professional commitments. Ms Butler explained to the panel that this witness was warned and would have been available to attend last week, when this case was first listed.

Ms Butler submitted that the evidence of Witness 2 is not sole and decisive in support of the charges relating to the words allegedly used by you towards Patient F, but acknowledged that, with regards to the words allegedly used to Patient C, her evidence is sole and decisive.

With regards to the nature and extent of any likely challenge to Witness 2's evidence, Ms Butler submitted that you denied some of the allegations from the outset. She further submitted that, at an early stage, during the internal investigation, it was suggested by you that there may have been collusion between Witness 2 and Witness 3. She therefore acknowledged the possibility of some challenge to Witness 2's evidence.

Ms Butler submitted that, regarding the seriousness of the charge, taking into account any impact that an adverse finding could have on your career, the allegations regarding the

words allegedly used by you towards Patients C and F were less serious than the physical aspect of all the allegations. She further submitted that matters relating to your duty of candour, highlighted in Charges 2 and 3 and the dishonesty in Charge 4 are significantly more serious than the words used. Ms Butler submitted that the words said, in the context of this case and other charges, would only have an impact on misconduct and impairment, but not on any decision on sanction the panel makes.

Ms Butler further submitted that you had prior notice that the NMC would apply for the witness statement to be adduced as hearsay evidence, and that this was agreed by Mr Lawson on your behalf.

The panel heard a further application from Ms Butler under Rule 31 to allow the written statement of Witness 3 into evidence.

With regards to Witness 3, Ms Butler referred the panel to an email dated 27 August 2024, that Witness 3 sent to the NMC, confirming that the contents of her witness statement are true and correct.

Ms Butler submitted that Witness 3's evidence goes to, being present in the lounge area, and the corridor of Jubilee ward, and she gives evidence of the words allegedly used by you towards Patient F.

With regards to the nature and extent of any likely challenge to Witness 3's evidence, Ms Butler submitted that you denied some of the allegations from the outset. She further submitted that, at an early stage, during the internal investigation, it was suggested by you that there may have been collusion between Witness 2 and Witness 3. She therefore acknowledged the possibility of some challenge to Witness 3's evidence.

Ms Butler submitted that Witness 3 was an unwilling witness, as she declared she was not willing to come and give evidence. Ms Butler submitted that Witness 3 explained she had college commitments and that she did not wish to attend to face the registrant.

Ms Butler further submitted that you had prior notice that the NMC would apply for the witness statement to be adduced as hearsay evidence, and that this was agreed by Mr Lawson on your behalf.

Mr Lawson submitted that both applications are agreed between the parties and raised no objection but stated that he would make submissions on what weight to give to this evidence in due course.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is '*relevant and fair'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal accessor referred the panel to the cases of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and *NMC v Ogbonna* [2010] EWCA Civ 1216.

The panel noted the submissions by Ms Butler and the fact that this application is unopposed by Mr Lawson on your behalf.

The panel considered that the evidence of both witnesses, subject to the application, to be relevant in this case because it describes material events.

The panel noted that Witness 2's evidence is sole and decisive in relation to the words that you allegedly used towards Patient C. It also took into account that although neither Witness 2's nor Witness 3's evidence is individually sole and decisive in relation to the words alleged to have been used by you to Patient F, the only other evidence comes from the other witness and both witnesses are subject of a hearsay application in relation to their evidence.

The panel further noted that it had sight of the record of both witnesses' interviews conducted as part of the internal investigation and is therefore in a position to compare the

witness statements with each other and with earlier accounts and in this way, was able to triangulate in order to check points of detail. The panel determined that it was fair to admit this witness statement into evidence on this basis and having regard to the parties' mutual agreement.

In relation to Witness 3, the panel noted that her evidence is not sole and decisive in relation to the words allegedly used by you towards Patient F, but again noted the caveat expressed above, that the only other evidence is drawn from Witness 2's statement, which itself is subject of hearsay application. The panel determined that it was fair to admit this evidence as hearsay for the reasons set out in relation to Witness 2 above.

The panel was mindful that it would hear submissions about the weight to give such evidence in due course and would make a decision about that issue.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Lawson that there is no case to answer in respect of charges 1b, 1d, 1f, 2, 3 and 4. This application was made under Rule 24(7).

Mr Lawson submitted that with regards to charge 1b, the issue for the panel was whether from the CCTV evidence, it was the neck or the upper back of Patient F that was touched by you. Mr Lawson submitted that there was no evidence of bruising on Patient F's neck. In these circumstances, it was submitted that this charge should not be allowed to remain before the panel.

With regard to charges 1d and 1f and the words allegedly used by you towards Patients C and F, Mr Lawson submitted that you were wearing a mask and there is no sound to the CCTV footage and no live witnesses to be cross-examined on these points. Mr Lawson submitted that this incident took place in a space full of agitated people and there is evidence that Patient F was also shouting. Furthermore, Mr Lawson submitted that the earliest evidence from the Witnesses 2 and 3 was when they were interviewed a fortnight

after the incident and in her interview, Witness 3 did not articulate what words were said, she merely referred to swearing. Mr Lawson also stated that the witnesses' statements were written over a year later and any discussion between them would detract from the quality of the evidence. Mr Lawson submitted that there is very little evidence to actually support these charges beyond the recollections of Witnesses 2 and 3 and therefore it was submitted that these charges should not be allowed to remain before the panel.

With regards to charges 2 and 3, Mr Lawson submitted that these were not inadequate records and they were made on the day of the incident. Mr Lawson submitted that you acted with integrity and given constructive and honest information and did not act with delay. He submitted that there is no expectation that a nurse after an incident of this kind should sit and draft a '*blow by blow'* account. Mr Lawson further submitted that if there is no case to answer to charges 2 and 3, it flows from it, that there should be no case to answer to charge 4.

Ms Butler submitted that there is a case to answer in respect of all of the charges as when taken at its highest, the evidence could result in facts being found proved against you.

With regards to charge 1b, Ms Butler invited the panel to consider the CCTV footage again and submitted that there is evidence to show that it was the neck, rather than the upper back of Patient F that was touched by you and therefore there was a case to answer.

With regards to charges 1d and 1f, Ms Butler submitted that there are two witness statements, and it will be for the panel to decide how much weight to place on these, however, there is clearly a case to answer in respect of these charges as the panel needs to hear more from you, particularly during cross-examination.

Ms Butler submitted, with regards to charges 2 and 3, that there is also a case to answer. She submitted that the evidence suggests that you did not describe the bruising on Patient F in the clinical records and there were some omissions in the Datix and that the panel

needed to hear your evidence and your cross-examination to determine the facts in this regard.

With regards to charge 4, Ms Butler submitted that as it relies on charges 2 and 3 being found proved. And given that you the panel have to consider your state of mind, those are matters that the panel has to hear at the conclusion of the evidence.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor who referred to *R v Galbraith* [1981] 1 WLR 1039 and the relevant NMC Guidance.

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

With regards to charge 1b, the panel considered that there is CCTV evidence which it can consider in this case which shows a level of touching between yourself and Patient F to the extent that there is a case to answer in relation to this charge.
In relation to charge 1d, the panel saw the evidence of Witness 2 and Witness 3 about what they say you said to Patient F and consequently considered this sufficient to form the basis of a case to answer.

Turning to charge 1f, the panel determined that whilst there was no sound to the CCTV evidence, there is evidence from Witness 2 on this and therefore determined that there is also a case to answer.

With regards to charges 2 and 3, the panel noted that there is CCTV evidence and evidence from Witnesses 2 and 3 as to the events that took place. Considering the alleged omissions in charges 2 and 3 alongside the evidence provided by the NMC the panel concluded that there is a case to answer in relation to these charges.

Finally, regarding charge 4, the panel determined that having established that there is a case to answer regarding charges 2 and 3, there also is a case to answer regarding charge 4.

The panel determined that the application for a no case to answer is rejected regarding all the charges subject to the application.

Decision and reasons on application to amend the charge

At the conclusion of your case, the panel heard a further application made by Ms Butler, on behalf of the NMC, to amend the wording of charges 2 and 3.

The proposed amendments were to more accurately describe the allegations in both of these charges, specifying the alleged failures. It was submitted by Ms Butler that the proposed amendment would provide clarity and more accurately reflect the evidence.

"That you, a Registered nurse:

2. On or about 15 October 2022 you failed to record an adequate and/or full account of ~~all of~~ your involvement in the physical intervention and bruising on ~~actions in charge 1 in~~ Patient F~~'s~~ in her clinical notes ~~records.~~

3. On or about 15 October 2022 you failed to record an adequate and/or full account of ~~all of~~ your involvement in the physical intervention and bruising on Patient F ~~charge 1~~ in ~~a DATX report~~ the Datix.

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

The panel heard from Mr Lawson that the application is agreed between the parties and that you wished for the particulars to be put to you again should the amendments be granted by the panel.

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

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

The amended charges were put to you, and you admitted them. The panel therefore found them proved by a way of admission.

Background

The allegations relate to the period of time when you were employed by Priory Group as a charge nurse on Jubilee Ward at the Barnt Green Hospital (the Hospital). It is a psychiatric admission unit and some of the patients were detained under the Mental Health Act.

On 15 October 2022 you were the nurse in charge of Jubilee ward and were involved in a restraint incident with Patient F in the lounge and corridor area of Jubilee ward. The allegation is that you grabbed Patient F by the arm, pulled her arm several times while she was on the floor, pushed her along the floor and swore at her. In addition, it is alleged that you placed your hands on Patient F's neck.

It is further alleged that during the restraint incident, you pushed away Patient C and swore at her.

It is further alleged by the NMC that you did not comply with your duty of candour in that you did not fully explain what had happened during the incident in the records (nursing clinical records and Datix). It is not suggested that you delayed completing the records, because you had done it before the end of your shift. The NMC suggests that those account were not full accounts and therefore it was dishonest of you to have failed to fully account for your acts.

It is the NMC's position that this case raises both public protection and wider public interest concerns.

Decision and reasons on facts

At the outset of the hearing, you made full admissions to charges numbers 1a, 1c, 1e. Later in the hearing you made admissions to charges 2 and 3.

The panel therefore finds charges 1a, 1c, 1e, 2 and 3 proved in their entirety, by way of your admissions.

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 Ms Butler on behalf of the NMC and by Mr Lawson on your behalf.

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 also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, who referred the panel to the cases of *Ivey v Genting Casinos* [2017] UKSC 67, *Lavis v NMC* [2014] EWHC 4083 (Admin) and *Uddin v GMC* [2012] EWHC 2669 (Admin). The panel also considered the witness and documentary evidence provided by both the NMC and you. The legal assessor gave good character direction to the panel referring to your good character and that the panel must take this into account when considering your credibility and propensity to act as alleged in the charges which you denied.

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

Charge 1b)

> "That you, a registered nurse, on 15 October 2022 during a physical restraint incident;
> b) Placed your hands on Patient F's neck.

This charge is found proved.

In reaching this decision, the panel took into account the CCTV footage of the corridor in Jubilee ward where the alleged incident took place. The panel also heard your oral evidence regarding this charge.

The panel determined that the video evidence shows a brief contact between your right hand and the back of Patient F's neck whilst Patient F was sitting on the floor of the corridor. The panel found that this contact did not form part of any pushing of Patient F along the corridor floor which you admitted at the outset of the hearing. Therefore, the panel found this charge proved.

Charge 1d)

"That you, a registered nurse, on 15 October 2022 during a physical restraint incident;

d) Said to Patient F;

i) 'Get the fuck up' or words to that effect.

ii) 'I swear to God' or words to that effect.

iii) 'I am warning you' or words to that effect.

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and Witness 3 and your oral evidence.

The panel considered the weight that it would give to the witness statements that were accepted into the evidence through unopposed hearsay applications. The panel noted that the evidence of Witnesses 2 and 3 in their witness statements is consistent with the accounts given to Witness 1 as part of the internal investigation only nine or ten days after the incident subject of this hearing. The panel noted that both witnesses were consistent with each other and earlier accounts and was therefore able to triangulate the evidence to test its veracity. Consequently, the panel determined that the witnesses' evidence was reliable and there was no reason to believe it to have been fabricated. The panel therefore gave the evidence of Witnesses 2 and 3 significant weight in its consideration. The panel noted your suggestion to your employer of collusion between the witnesses but took into account that you did not provide any evidence to support this to your employer or in your oral evidence during this hearing.

The panel noted that you were the only male present at the scene and therefore a scope for mistaking your voice with anyone else's was little. It further accepted that the incident took place in a loud room whilst you were also wearing a mask.

The panel noted that you denied this allegation from the outset, suggesting that both of the witnesses were mistaken or had colluded.

However, on the balance of probabilities, the panel determined that it was more likely than not that you had said the words described in this charge. The panel determined that there was no evidence to suggest that both of the witnesses were untruthful or mistaken in their accounts as they remained consistent separately and in comparison, to each other. The panel therefore found these charges proved.

Charge 1f)

> "That you, a registered nurse, on 15 October 2022 during a physical restraint incident;
>
> f) Said to Patient C;
>
> i) 'You shut the fuck up' or words to that effect.
>
> ii) 'Fucking move' or words to that effect.

These charges are found proved.

In reaching this decision, the panel took into account the CCTV evidence and the evidence of Witness 2 and your own oral and written evidence.

The panel noted, from the CCTV evidence, your confrontational body language in what appeared to be a chaotic scene. The panel heard in your oral evidence that you were '*uptight'* and that it was a stressful situation that you were dealing with.

The panel noted Witness 2's evidence and determined that she was consistent throughout her accounts and no obvious reason why she would fabricate this evidence in relation to this charge.

The panel further noted that during cross-examination you were taken through the evidence of Witness 2 and agreed that her accounts of events, which made up the incident subject of this hearing are substantially accurate but could offer no explanation as to why she would introduce incorrect information into one aspect of the overall incident.

The panel therefore determined, that on the balance of probabilities, it is more likely than not that you said the words described in these charges and therefore finds the charges proved.

Charge 4

4) Your actions in charges 2 and or 3 were dishonest in that you were seeking to conceal the extent of your actions during the physical restraint incident.

This charge is found not proved.

In reaching this decision, the panel considered the test laid out in the case of *Ivey*.

The panel first considered the first limb of the test, determining the actual state of your knowledge or belief as to the facts.

The panel considered your oral and written evidence, CCTV evidence, the clinical records and Datix and took into account the overall context.

The panel noted that neither the Datix record nor clinical records represented a full and complete description of what had occurred during the incident subject of this hearing. In particular, it noted the absence of any reference to the extent of your physical contact with

Patient F nor any reference to consequent bruising suffered by Patient F. Neither do Datix or patient records completed by you on 15 October 2022 in relation to Patient F give any indication as to the severity, duration or intensity of the incident which flowed from a lounge area into the corridor and ultimately to Patient F's bedroom. You acknowledged in your evidence that you handled the whole situation badly and again, this was not reflected in the records that you made.

The panel heard evidence from you that on 15 October 2022, you were working a long day shift in excess of 12 hours, you were tired, stressed and the shift was busy as there were multiple incidents taking place. You told the panel that having initially assessed that you could operate during the shift with one member of staff less than the required staffing level, you realised that this was a mistake on your part as the day began to unfold. You accepted that your handling of the incident with Patients C and F was poor and that your decision making during the incident was not to your usual standard. All of this added to your desire to leave and go home as the end of the shift approached and you found yourself dealing with other issues with other patients and the required responsibilities which fall to the nurse in charge, such as preparing staff hand-over, which had an impact on your thought processes and available time.

The panel noted that you were working with two relatively inexperienced healthcare assistants and a newly qualified nurse.

The panel noted that you were candid during your evidence in relation to your record keeping and were open and frank about the extent of your failings on 15 October 2022 in handling the incident with Patients C and F, but also in the way that you subsequently managed the remainder of the shift. You articulated your thought processes and conduct highlighting that you had been '*slap dash*' and '*could have done a better job in all areas'*.

You acknowledged that you could and should have included more information in the patient and Datix records but denied that you were motivated by a desire to conceal the full extent of your actions.

The panel found your evidence in relation to this charge credible, having regard to the extent to which you acknowledged your failings, gave clear and frank evidence and made concessions when cross-examined and during panel questions.

The panel determined that your subjective state of mind as to the facts at the time that you made the Datix and patient records was impacted by the range of issues set out in your evidence and the overall context described in other evidence. It concluded that you were stressed as a result of a busy day combined with your self-acknowledged failings in handling the incident. You were also subject to other, wider demands upon your time from other patients who needed your attention and your responsibilities as the lead nurse on duty that day. The panel determined that your judgment at the time was more likely affected by the chaotic environment, you were trying to think ahead and your judgement was clouded.

The panel noted that there was nothing positively inaccurate or misleading in the patient notes or Datix that you made, though there were some omissions.

The panel rejected the suggestion that you made the notes only due to the bruising that Patient F suffered and accepted your explanation that you believed that the doctor who you called to see Patient F, would have noted the bruising.

The panel concluded on balance that your subjective state of mind was not focused on misleading potential recipients of the patient notes and Datix by reason of deliberate omission of facts. It determined that your mindset was significantly affected by the overall context and that the circumstances provide for a number of other more likely explanations for your failure to mention some aspects of the incident in the patient notes or Datix.

The panel determined, that by the standards of ordinary decent people, your conduct was not dishonest and therefore found this charge not proved.

Fitness to practise

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

In reaching its decision, the panel 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 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

Ms Lindsay provided the panel with written submissions on behalf of the NMC:

1. *Impairment is a matter for the Panel's judgment. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted. There is no burden or standard of proof. The submissions of each side are simply submissions, and the Panel must come to its own, independent decision on this issue.*

2. *Article 22 of the Nursing & Midwifery Order 2001 provides for a finding of impairment of fitness to practise via one or more of 5 routes.*

3. *In the 2009 case of Cheatle v GMC, Cranston J made clear that panels considering the question of impairment should engage in a two-step process: first, they should decide whether on the facts found proved, one or more of the 5 routes provided for has been established; only if they conclude that such a route has been established, should they go on to the second step and consider whether the registrant's fitness to practice is impaired by reason of that route.*

4. *The route by which you are asked to find impairment today is misconduct.*

Misconduct

5. *Misconduct has been defined in Roylance v General Medical Council (No. 2) [2000] 1 AC 311, as a "word of general effect, involving some act or omission which falls short of what would be proper in the circumstances".*

6. *One of the sources of these standards for the nursing profession can be found in The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code).*

7. *The NMC submits that Mr Rouse' conduct fell significantly short of the standards expected of a registered nurse when he grabbed Patient F by the arm; placed his hands on Patient's F's neck; pushed Patient F along the floor; and used profanities towards Patient F. In addition, his conduct also fell short of the standards expected when he pushed Patient C and used profanities towards Patient C. Mr Rouse's failure to record fully his actions in the clinical records for Patient F and in a DATIX report.*

8. *Specially, when considering the Code, the NMC would draw the Panel's attention to the following paragraphs as being relevant:*
    1. *Treat people as individuals and uphold their dignity*

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

10. Keep clear and accurate records relevant to your practice:

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

20. Uphold the reputation of your profession at all times

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

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

9. *Breaches of the code, of course, do not automatically amount to a finding of misconduct however the NMC submit that the facts proven by way of admission and determination are serious and consequently should be marked as such.*

10. *The Panel should have regard to R (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin) where it was stated that misconduct must be 'sufficiently serious that it can properly be described as misconduct going to fitness to practise'.*

11. *The NMC submit that the misconduct in this case is "sufficiently serious" that it can be properly described as misconduct both individually and cumulatively in respect of the charges found proven. In all the circumstances, it is submitted that the Panel should consider Registrant's conduct falls far below the standards which would be considered acceptable and that the facts found proved amount to misconduct.*

Mr Lawson, on your behalf, submitted that you accept globally within the charges proved or by way of admission that there is an element of misconduct.

Submissions on impairment

Ms Lindsay provided the panel with written submissions on behalf of the NMC:

'12. Should the panel find that the charges found proven do amount to misconduct, the panel should consider whether the registrant's fitness to practice is impaired, as of today.

13. Considering question of impairment, you must 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.

14. There is no definition of "impairment" provided by the NMC's legislative framework. However, the NMC defines "fitness to practise" as the suitability to remain on the register without restriction.

15. A general approach to what might lead to a finding of impairment was given by Dame Janet Smith in her Fifth Shipman Report. A summary is set out in Grant at paragraph 76 in the following terms:

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.

16. In this case, it is submitted that limbs a, b and c are engaged.

17. The NMC submit that the Panel should also consider the comments of Cox J in Grant at paragraph 101:

"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case."

Public Protection

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

18. In accordance with Article 3(4) of the Nursing and Midwifery Order 2001 ("the Order") the overarching objective of the NMC is the protection of the public.

19. The Order states:
The pursuit by the Council of its overarching objective involves the pursuit of the following objectives-
a) to protect, promote and maintain the health, safety and well being of the public;
b) to promote and maintain public confidence in the professions regulated under this Order; and
c) to promote and maintain proper professional standards and conduct for members of those professions.

20. The case of Grant makes it clear that the public protection must be considered paramount, and Cox J stated at para 71:

"It is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations … namely, the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession"

21. The NMC submit that Mr Rouse has acted in the past and/or is liable so as to put patients at unwarranted risk of harm. The NMC submit that Mr Rouse's misconduct placed patient C and patient F at unwarranted risk of harm and caused harm to two vulnerable individuals. As acknowledged himself, in his evidence before the Panel on impairment, the perception of psychiatric services has been a work in progress for a long time and actions like his do not assist with patient experience.

22. The public, quite rightly, expect nurses to provide safe and effective care. Mr Rouse's actions, as set out in the charges found proven, brought the profession into disrepute and had the potential to undermine trust and confidence in the profession. The Panel should consider that nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients must be able to trust nurses when they are at their most vulnerable. When considering the risk of harm to patients, the Panel should consider the possible consequences of the concerns, such as members of the public feeling reluctant to access health and care services, an issue which is acutely sensitive when dealing with those accessing psychiatric care. Nurses must make sure that their conduct at all times justifies their colleagues, patients' and public's trust in the profession. In the NMC's submission, Mr Rouse did not do that.

Public Interest

Has in the past brought and/or is liable in the future to bring the medical profession into disrepute

23. Registered professionals, such as Mr Rouse, occupy a position of trust in society to be responsible for the care of patients.

24. The NMC submit that the behaviour found proven in the charges not only brought Mr Rouse's reputation into disrepute, but also that of the wider profession. This in turn undermined the public's confidence in the profession as a whole. The facts, as set out in the charges, brought the profession into disrepute and had the potential to undermine trust and confidence in the profession.

Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession

25. The Code divides its guidance for nurses into four categories which can be considered as representative of the fundamental principles of nursing care. These are:

a. Prioritise people;
b. Practice effectively;
c. Preserve safety and
d. Promote professionalism and trust

26. It is submitted that the NMC have set out above, how, by identifying the relevant sections of the Code, Mr Rouse has breached fundamental tenets of the profession. Breaches of the Code, amount to a breach of the fundamental tenets of the profession, in the NMC's submission.

27. The public, quite rightly, expect nurses to prioritise patient care and attend to the needs of patients. Mr Rouse's actions, as set out in the charges, brought the profession into disrepute and had the potential to undermine trust and confidence in the profession.

Remediation, reflection, training, insight and remorse.

28. It is submitted that Silber J's guidance on remediation is also of assistance; that when deciding whether fitness to practise is impaired panels should take account of:

- *Whether the conduct which led to the charge is easily remediable;*
- *Whether it has been remedied; and*
- *Whether it is likely to be*

29. The first question is whether the concerns can be addressed. That is, are there steps that the nurse, midwife or nursing associate can take to address the identified problem in their practice?

30. It can often be very difficult, if not impossible, to put right the outcome of the clinical failing or behaviour, especially where it has resulted in harm to a patient. In the circmsatcnes [sic] *of this case, there has been harm to Patient C and Patient F. Mr Rouse stated in his evidence that he would offer an apology to them, but that does not put right his behaviour. However, rather than focusing on whether the outcome can be put right, the Panel should assess the conduct that led to the outcome, and consider whether the conduct itself, and the risks it could pose, can be addressed by taking steps, such as completing training courses or supervised practice.*

31. The NMC submit in this case the concerns are serious concerns, and it could be said extremely difficult, if not impossible to put right. The concerns fall into the category of conduct which falls so far short of the standards the public expect that public confidence could be undermined. The NMC would draw the Panel's attention to the guidance set out at FTP-15a where it is stated:

"Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:

- …

- incidents of violence towards, or neglect or abuse of people receiving care, children or vulnerable adults…."

32. In the NMC's submission, the behaviour of Mr Rouse's falls squarely within the conduct which has been identified at FTP 15a and, as such, cannot be addressed. Mr Rouse has been found to have ill-treated two patient's who could both be described as vulnerable in using excessive force towards Patient F.

Insight

33. The Panel are directed to the NMC guidance at FTP-13b where it states: A nurse, midwife or nursing associate who shows insight will usually be able to: step back from the situation and look at it objectively, recognise what went wrong, accept their role and responsibilities and how they are relevant to what happened, appreciate what could and should have been done differently and understand how to act differently in the future to avoid similar problems happening.

34. In the NMC's submission, Mr Rouse has shown some insight into his conduct. He made admissions to charges 1a, 1c, 1e, 2 and 3. In additional, Mr Rouse has provided a reflective piece dealing with the events of 15th October 2022, albeit he does not accept the language which was used towards both Patient C and Patient F in said reflective piece (his position on this has since altered during the course of his evidence). In addition, he has submitted various character references to the Panel, along with details of training courses.

35. Mr Rouse gave evidence to the Panel dealing with insight and his reflection on the charges. During the course of his evidence, he spoke of the difference in his present work environment and his own views on how he would have dealt with the situation differently. In the NMC's submission, however, it cannot be said that the steps taken by My Rouse thus far are sufficient to address the concerns raised in

this case. During the course of his evidence, Mr Rouse was not able to identify specifically what he would have done differently beyond managing his [PRIVATE]*. He has not highlighted specific steps which he has taken to address these areas of his working life, which he identified to be a contributing factor of his actions. In the NMC's submission, it cannot be said that generalities are sufficient. Despite Mr Rouse's evidence, in the NMC's submission, it cannot be said that is highly unlikely that the conduct will be repeated due to said insight.*

36. In all the circumstances, it is submitted that the misconduct demonstrated by Mr Rouse has not been remediated and a finding of current impairment needs to be proved in order to sufficiently protect the public, maintain the confidence in the NMC as a regulator and uphold the standard of the profession generally. The public interest calls for a finding of impairment to maintain trust and confidence in the profession and its regulator. A well-informed member of the public would be concerned to find that Mr Rouse was not found to be impaired given the nature of the charges.

37. Baring all factors in mind, it is the NMC's submission that the concerns have not been remediated and the NMC would therefore ask the Panel to find Mr Rouse's fitness to practise currently impaired by reason of his misconduct in respect of all charges.'

On your behalf Mr Lawson accepted that limbs A through C of *Grant* are engaged.

Mr Lawson submitted, with regards to the risk of repetition, that this was a one-off incident and that there are no other regulatory findings against you. He further submitted that you have expressed remorse and told that panel that you had very much learned your lesson. Mr Lawson told the panel that whilst it is accepted that your insight is still developing, you have already demonstrated a significant level of insight through your reflections and evidence. He further told that panel that going through the regulatory process has enabled you to fully understand the extent and impacts of the failings.

Mr Lawson reminded the panel that you made early admissions, and then made further admissions once the charges were reworded and thereby became clearer at a later stage of the hearing.

Mr Lawson told the panel that you now recognise the stress factors and what effectively contributed to the regulatory concerns in question, as well as how to avoid repeating this in the future. Mr Lawson further referred the panel to numerous references provided by you, and to relevant CPD training certificates.

Mr Lawson submitted that the risk of repetition in your case is very low. He told the panel that you have done everything you possibly can and continued working without any issue. He also reminded the panel of the good character direction.

Mr Lawson invited the panel to find that you are not currently impaired on either public protection or public interest grounds.

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

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council,* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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 your behaviour in each of the charges and sub charges found proved fell significantly short of the standards expected of a registered nurse. Your misconduct is serious and involved you using unnecessary and unsafe force on a vulnerable patient, pushing that patient along the floor in a way that caused your hand to come into contact with the patient's neck. You swore repeatedly at that patient and also swore at a second patient. All of these events took place between a sitting room in the hospital, moved into a corridor and finally into Patient F's room. This played out over a significant period of time and in front of less experienced and junior staff. You subsequently failed to make complete records of the incident in patient notes and Datix records. A significant part of the context to your behaviour was absence of proper communication with junior staff, before engaging with Patient F in order to ensure that everybody involved was aware of their role. Additionally, despite knowing that you did not have an experienced colleague to hand to assist you on that day, you also did not communicate with your management team to consider possible solutions.

The panel takes the view that fellow practitioners would be appalled by your conduct and that it amounted to several serious breaches 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

1.5 respect and uphold people's human rights.'

*'**2 Listen to people and respond to their preferences and concerns***

To achieve this, you must:

2.1. work in partnership with people to make sure you deliver care effectively

2.5 respect, support and document a person's right to accept or refuse care and treatment

2.6 recognise when people are anxious or in distress and respond compassionately and politely.'

*'**4 Listen to people and respond to their preferences and concerns***

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment.'

*'**8 Always practise in line with the best available evidence***

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

*'**10 Keep clear and accurate records relevant to your practice***

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

To achieve this, you must:

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

10.3 complete records accurately and …, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.'

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

To achieve this, you must:

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

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

To achieve this, you must:

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

’20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel appreciates that breaches of the Code do not automatically result in a finding of misconduct. However, it is of the view that each charge proved amounts to misconduct individually and cumulatively. The panel determined that these were serious breaches of the Code, as patients came to harm and were not treated with respect.

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 the following questions as the test of impairment:

'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 considered the first three limbs above in the context of your past actions and it is satisfied that these limbs are engaged in your case. The panel determined that through your misconduct you put patients at unwarranted risk of harm and in fact, harm was sustained. The panel determined that you brought the nursing profession as a whole into disrepute through your misconduct. Your actions breached fundamental tenets of nursing, relating to prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

The panel went on to consider whether your misconduct is capable of being remediated, the extent to which you have remediated it and whether, in all of the circumstances your misconduct is highly unlikely to be repeated.

The panel is satisfied that the misconduct in this case, whilst very serious, is capable of being remediated and, in coming to that conclusion, considered the context in which the events took place and the steps towards remediation that you have made since October 2022.

The panel determined that context is very important in this case. The panel noted that you were working long shifts at the time and, on the relevant date were engaged on the third of three scheduled 12-hour shifts. You gave evidence that you were [PRIVATE] and your

evidence was that you made errors such as not notifying on-call manager of being short staffed and not arranging for additional staff.

The panel is of the view that you were candid in recognising that you did not think sufficiently about the situation and that you should have done better. It noted and accepted the submission made on your behalf that this was a one-off incident, and it also accepted that you did not intend to cause harm though it was a likely consequence of your lapse in judgment and subsequent behaviour.

The panel noted that you have a good and settled work record with one employer since this incident, as a senior nurse with supervisory responsibilities. It noted the very favourable references from your colleagues, managers and junior staff. The panel determined that given the particular circumstances of your case and the context, your misconduct is capable of remediation.

In considering your level of insight, the panel notes that you made admissions at an early stage and expressed remorse and apologised for your actions throughout. Whilst for reasons beyond your control you were not able to offer apologies to those caught up in the events, you were able to articulate in evidence how such apologies would be framed. The panel notes that you identified your [PRIVATE] as contributing to the context and set out measures you have in place to reduce the likelihood of such effects in the future. These include a stronger commitment to talking annual leave time regularly, separating clinical work and management days, reducing personal caffeine intake and monitoring your own performance though regular supervisory meetings. The panel also took into account that your current role involves investigating complaints and service failures and this, on your account, has given you deeper insight into the adverse impact of practice that falls below acceptable standards.

The panel notes that you made a decision to move into a different area of nursing as part of your approach to reduce situations such as the one subject of this hearing. However, it considers that you may encounter any stressful situations in any area of the profession

and notes the submission made on your behalf, that you continue to reflect on how better to handle such situations.

The panel also notes your work to strengthen your practice through training, with some of your effort directed towards courses directly relevant to the regulatory failings in this case and others, as submitted by Mr Lawson, aimed at your broader nursing knowledge. The relevant courses that you have undertaken include: positive behaviour support, dignity in care and person centred care.

The panel considered the seriousness of your misconduct and balanced this with the steps that you have already taken to address the regulatory concerns along with the extent of your insight and reflection. The panel is satisfied that your conduct has not been repeated since the incident, and you continue to work with no concerns raised about your clinical practice by your employer. It considers your insight to be well developed.

Accordingly, the panel is of the view that there is a low risk of repetition of your misconduct sufficient for it to conclude that a finding of impairment is not necessary on the ground 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.

In considering the public interest in this case, the panel took into account the seriousness of your misconduct including using unnecessary force against one patient, swearing at that and another patient and failing to make complete records in medical notes and Datix records. You yourself were able, during evidence, to articulate the potential damage to the public interest from your actions. The panel concluded that a well-informed member of the public, who was aware of all your insight and remediation, would still be extremely

concerned if no finding of impairment was made, in light of the seriousness of your misconduct. The panel concluded that public confidence in the profession, and the NMC as its regulator, would be undermined if a finding of impairment were not made in this case and further that such a finding is necessary to declare and uphold proper standards amongst members of the profession. Accordingly, the panel was satisfied that your fitness to practise is impaired on the ground of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on public interest grounds only.

Sanction

The panel considered this case carefully and has decided to make a suspension order for a period of 3 months. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Ms Lindsay submitted that a strike off order would be the proportionate and appropriate sanction in this case. She referred the panel to the NMC Guidance on Sanction (SAN-3)

Ms Lindsay submitted that taking no action would not be appropriate in this case as there was a finding of current impairment and due to the seriousness of the misconduct. She further submitted that a caution order would also not mark the seriousness of the misconduct in this case and would not be an appropriate sanction in this case. She further submitted that a caution order would be insufficient to maintain the high standards in the profession or the trust the public place in the profession given the circumstances of this case.

Ms Lindsay submitted that the public interest cannot be addressed by way of conditions of practice in this case. She told the panel that you were subject to interim conditions of

practice order and those conditions were focused on a risk of repetition as opposed to public interest. Ms Lindsay submitted that condition of practice order would not be appropriate when considering the public interest in this matter and therefore would not be an appropriate sanction in the circumstances of this.

With regards to a suspension order, Ms Lindsay referred the panel to the NMC guidance and submitted that the seriousness of this case could justify an attempted removal from the register. She further submitted that a suspension order would not be sufficient for the protection of professional standards and that it would not be sufficient in addressing the public interest concerns arising in this case. Ms Lindsay further submitted that whilst the misconduct in this case does relate to a single incident, it is a serious misconduct, regarding you putting hands on a patient, swearing at patients and failing to keep proper records, and it is a conduct which is incompatible with you remaining on the register.

Ms Lindsay submitted that the regulatory concerns in this case raise fundamental questions about your professionalism. She further submitted that the public confidence in nurses cannot be maintained if you are not struck off from the register. Ms Lindsay submitted that striking off is the only sanction, given the seriousness of the misconduct, which will be sufficient to maintain the professional standards. She further submitted that the misconduct in this case was the abuse of vulnerable individuals in a psychiatric setting and therefore this would meet the criteria for seriousness to justify strike off.

The panel also bore in mind Mr Lawson’s submissions.

Mr Lawson submitted that a conditions of practice order would be appropriate in this case. He reminded the panel that impairment was found on public interest ground only. He told the panel that whilst it is accepted that this is a serious misconduct, it was serious within the context of that day, and it was a short incident on the ward.

Mr Lawson submitted that you have been successfully working under the interim conditions of practice for quite a period now and referred the panel to the references and

testimonials you have submitted for this hearing. He also referred the panel to your training and CPD certificates.

Mr Lawson submitted that there was only one aggravating factor in this case, harm caused to vulnerable patients.

With regards to mitigating features, Mr Lawson submitted that you had considerable insight, not just developing, early admissions, remorse, coping strategies and good previous character. Mr Lawson also reminded the panel about your personal mitigation regarding the circumstances and the context on the day of the incident.

Mr Lawson referred the panel to the NMC Guidance on Sanction and submitted that conditions of practice would be the appropriate sanction in this case and took the panel through the relevant factors. He submitted that it would be disproportionate and draconian, to go above conditions in this case.

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

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 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 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:

- Harm was caused to a vulnerable patient
- Distress was caused to junior members of staff
- The incident took place over several minutes in three areas of the hospital

- Your misconduct covered a number of nursing areas

The panel also took into account the following mitigating features:

- You have developed insight into your failings and have made substantial effort to remediate and ongoing reflection and continued learning from your misconduct
- You made early admissions at the outset and other admissions as the hearing progressed
- You were candid about your failings
- You offered apologies, expressed genuine remorse for your actions and expressed your willingness to offer apologies to the patients involved
- On your account, you were [PRIVATE] at the time, working long shifts and, on the day, with reduced staff on the shift in the unit
- You have a good work record since your misconduct

The panel had regard to NMC guidance SAN 2 on how seriousness is determined. This states:

> '*Sometimes we may need to take regulatory action against a nurse, midwife or nursing associate to promote and maintain professional standards and the public's trust and confidence in the professions we regulate*.'

The guidance continues:

> '*Safeguarding and protecting people from harm, abuse and neglect is an integral part of the standards and values set out in the Code, and any allegation involving the abuse … of …. vulnerable people will always be treated seriously*.'

In considering sanction in this case, the panel therefore determined that your misconduct is serious.

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, 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 took into account the NMC Guidance SAN-3c which sets out when conditions of practice may be more appropriate as follows:

'*The key consideration for the panel before making this order, is whether conditions can be put in place that will be sufficient to … address any concerns about public confidence or proper professional standards and conducts.'*

The guidance sets out a non-exhaustive list of factors that may indicate the appropriateness of conditions:

- *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;*
- *…*
- *…*
- *…*
- *Conditions can be created and can be monitored and assessed;*

Having regard to the seriousness of your misconduct and the panel's finding on impairment, it is of the view that a conditions of practice order will not be sufficient in the circumstances of this case to adequately address the significant concerns about public confidence or proper professional standards and conduct.

Additionally, 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.

Therefore, the panel concluded that placing conditions on your registration would not adequately address the seriousness of this case and would not satisfy the public interest concerns.

The panel then went on to consider whether a suspension order would be an appropriate sanction. Having regard to the guidance (SAN-3d), the panel's findings in this matter and the seriousness of your misconduct, the panel concluded that temporary removal from the register is required in this case. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel noted that each of these factors are present in your case. Whilst protracted in terms of timeframe, the events leading to this case took place during one shift. Your testimonials and candid approach to remediation suggest that there are no underlying attitudinal issues and there has been no repetition. The panel earlier concluded that you have insight and that there are no public protection concerns remaining.

Additionally, balancing your remediation and insight against the seriousness of your misconduct, the panel concluded that in the particular circumstances of this case, a period of suspension will be sufficient to protect confidence in the profession and underpin proper standards of conduct.

The panel is satisfied that in this case, your misconduct is not fundamentally incompatible with you remaining on the register.

The panel went on to consider whether a striking-off order would be proportionate. Taking account of all the information before it, and the mitigating factors, the panel concluded that in this case, a striking-off order would be disproportionate. 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 is the appropriate and proportionate sanction.

The panel noted the hardship such an order may 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.

Given your level of insight, continuing reflection and positive steps to remediate your misconduct along with the mitigating factors identified above, the panel determined that a suspension order for a period of 3 months is sufficient in this case to mark the seriousness of your misconduct and to address the public interest concerns identified.

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:

- Evidence of continuing reflection and professional development
- Information on how you have kept your nursing skills and knowledge up to date
- Any other information you consider relevant in helping a future review panel to consider your case

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 until the suspension sanction takes effect. 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. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Lindsay. She submitted that an interim suspension order for a period of 18 months would be an appropriate order in this case to cover the appeal period. She referred the panel to the NMC guidance SAN-5 and INT-4, on interim orders after a sanction is imposed.

The panel also took into account the submissions of Mr Lawson on your behalf.

Mr Lawson submitted that no interim order is necessary in this case.

Mr Lawson further submitted, that should the panel determine that an interim order is necessary, the current interim conditions of practice would be the appropriate one. He further submitted that you have been on an interim conditions of practice order for a period of time now and have successfully worked under it. Mr Lawson submitted that an immediate interim suspension would sour the current good relationship with your employer, bring potential harm to patients as immediate cover for your role would have to be found. He referred the panel to its earlier determination on sanction and submitted that the panel found that you do not pose a significant risk of repeating the misconduct.

Decision and reasons on interim order

The panel was satisfied that an interim order is 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 suitable interim order would be that of a conditions of practice order. It was mindful that there are no ongoing issues of public protection in your case and that it has found current impairment on public interest grounds only. It accepted Mr Lawson's submission that the proportionate interim order in your case is that of interim conditions of practice, noting that you are practising well with your employer under your current interim conditions of practice.

The conditions for the interim order will be the same as those currently in the interim conditions of practice order for a period of 18 months in order to cover the appeal period.

'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. Your nursing practice must be restricted to your current role as Clinical Lead at Severn Heights Nursing Home.

2. You must not take part in any hands-on restraint of patients.

3. You must have monthly meetings with your line manager/mentor/supervisor to discuss your clinical practice, leadership and behaviour.

4. You must provide a report to the NMC before any review from your manager/supervisor/mentor setting out your clinical practice, leadership and behaviour.

5. You must keep the NMC 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.

6. You must keep the NMC 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.

7. You must immediately give a copy of these conditions to:
    a) Severn Heights Nursing Home.
    b) Any employers you apply to for work (at the time of application).
    c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

8. 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.

9. 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) Severn Heights Nursing Home or any future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

If no appeal is made, then the interim conditions of practice 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.