AC-2023-LON-003355

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

AC-2023-LON-003355

BETWEEN:

THE PROFESSIONAL STANDARDS AUTHORITY
FOR HEALTH AND SOCIAL CARE

Appellant

- and –

(1) NURSING AND MIDWIFERY COUNCIL
(2) CHRISTINA CAREY

Respondents

ORDER BY CONSENT

UPON the Appellant and the First Respondent having agreed to the terms of this Order, in particular that it is just and convenient for the Court to make the Order set out below

AND UPON no party being a child or protected party and the appeal not being an appeal from a decision of the Court of Protection

AND UPON the Second Respondent being a nurse on the register established and maintained by the First Respondent ('the Register')

AND UPON the First Respondent's Fitness to Practise Committee ("the Panel") having decided that the fitness to practise of the Second Respondent was impaired by reason of misconduct and having imposed a twelve month suspension with review ('the Decision')

AND UPON the Appellant having lodged an appeal on 13 November 2023 against the Decision pursuant to Section 29 of the National Health Service Reform and Health Care Professions Act 2002 (as amended)

AND UPON the First Respondent conceding that the appeal should be allowed on the basis of the reasons set out in the schedule

AND UPON the Second Respondent having failed to engage with the fitness to practise proceedings or this appeal

IT IS ORDERED THAT: -

1. The appeal is allowed.

2. The Decision is quashed and substituted with an order that the Second Respondent's name be struck off the Register.

3. The First Respondent is to pay the Appellant's reasonable costs of the appeal, to be assessed if not agreed.

4. The Second Respondent has permission to apply to the Court to vary or discharge the order within 28 days of the order being sealed and upon giving 14 days' notice to the parties.

Ros Foster
For the Appellant

Matthew Cassels, Senior Lawyer
For the First Respondent

Dated: May 2024

BY THE COURT 04/09/2024

Approved by Ms. Clare Ambrose DHCJ

Order approved by Claire Ambrose sitting as a Deputy High Court Judge

Date 3rd September 2024

Schedule – statement of reasons

Ground 1: The case was under-prosecuted. There was relevant evidence which should have been before the Panel and made the subject of a specific allegation.

1. The First Respondent was in possession of clear evidence (from Witness 4) that the Second Respondent had mocked a vulnerable, confused and agitated patient by pulling faces, making growling noises, and "making the situation worse". This was evidence of behaviour fundamentally incompatible with the role of nurse and represented a clear breach of professional standards.
2. This behaviour was particularly serious given that it related to deliberate conduct towards a vulnerable patient, with the obvious potential to cause harm, and to damage the reputation of the profession.
3. There was a serious prima facie case for the Second Respondent to answer in respect of this evidence. Had the Panel found an allegation based on this evidence proved, such a finding might have made a significant difference to the Panel's overall conclusions about the seriousness of the misconduct and thus led to the imposition of a striking off order.
4. The failure by the First Respondent to place this information before the Panel, and to include a charge reflecting this conduct was a serious procedural irregularity.

Ground 2: The Panel's finding that charge 2(d) did not amount to misconduct was wrong, and the reasoning provided was insufficient.

5. The Panel found that that, on 13 December 2018, the Second Respondent did not allocate a patient with severe diarrhoea to a room with a toilet. This was based on the evidence before the Panel from Witness 6 who was clear that it

6. was “not appropriate or dignified for this patient to be nursed in this room, particularly as the room doesn’t have a bathroom.”
7. The Panel accepted Witness 6’s version of events, which was:
“[A colleague] informed me that the patient had been allocated to bed 14 [which had a toilet]. At this point [the Second Respondent] came out of the office and immediately said that the patient couldn't be allocated to this side room, however, couldn't give a reason for this.”
8. Witness 6 was also clear that “there were several empty beds on the ward”.
9. On the basis of Witness 6’s evidence, which the Panel accepted entirely, it is clear that the Second Respondent’s conduct, on proper assessment, amounted to a departure from the Code of Conduct, and misconduct. There was no innocent or indeed any explanation for her behaviour.
10. In terms of reasoning, the Panel’s finding was: “The panel found that 2d [the charge that related to this incident] did not amount to misconduct.” It is not possible to understand why, or on what basis the Panel made this decision.

Ground 3: The Panel’s decision sanction on sanction was wrong.

11. The Panel erred in its approach to sanction in three material ways: (i) it relied upon irrelevant factors as mitigating against a striking-off order; (ii) it failed to have proper regard to the First Respondent’s Sanction Guidance (‘the Guidance’); and (iii) it came to an irrational conclusion that a suspension order was appropriate.

(i) Irrelevant factors

12. The Panel’s reasons for imposing a suspension order included: “this is the first time [the Second Respondent] has come before [the First Respondent]”; that the Second Respondent “had not specifically been asked to provide the panel with a reflective piece or demonstrate any remediation or insight”; and that “there had been no fundamental clinical concerns”.
13. These factors were not relevant. The section of the Guidance entitled “Factors to consider before deciding on sanctions” states that: “If the allegations relate to deep-seated attitudinal concerns…the absence of a fitness to practise history is unlikely to be relevant to a panel when considering sanction.” The

Panel had already determined that there were deep seated attitudinal concerns. The Panel was not referred to this aspect of the Guidance, nor did the Panel make any reference to it. There was nothing about this case which meant that the absence of previous fitness to practise concerns was relevant.

14. That the Second Respondent had not specifically been asked to provide a reflective piece or demonstrate remediation was also irrelevant and nevertheless, wrong. The First Respondent's guidance, "Engaging with your case" makes clear the importance of the Second Respondent providing a Panel with evidence of insight and repetition, and the implication of not doing so. Further, the letter inviting the Second Respondent to the hearing, dated 3 July 2023, stated:

"If the panel do not have any information from you (for example, evidence of your insight or strengthened practice) they will not be able to take this into account. This could lead to a more adverse decision than if they had this information. You have a duty to cooperate with us, as we are your regulator. This is part of The Code which you agree to follow when you register with us."

15. The Second Respondent was aware of the hearing, aware of the obligation to co-operate with her regulator, and aware of the implications of not providing any evidence of insight or remediation. She chose not to engage at all with the hearing and did not seek any adjournment.

16. There was no evidence whatsoever to suggest that the Second Respondent might show insight into her actions in the future.

17. In respect of the absence of clinical concerns, the Panel had previously found that the Second Respondent's actions caused patients "physical and emotional harm" and "significant distress to patients, their families and her colleagues". The findings were all related to: the way in which the Second Respondent carried out her role; her failure to provide appropriate levels of care for patients; and the detrimental impact upon her colleagues' ability to provide care. As such, the issues found proved were centrally linked to the Second Respondent's clinical performance as a nurse. This factor should not have been afforded any weight.

(ii) Failure to follow the Guidance

18. The Guidance makes clear that a striking off order was, prima facie, the appropriate order in this case. The Panel described such an order as being "entirely appropriate". The Panel correctly identified the factors from the Guidance that might mean suspension order might be appropriate, namely:
    a. A single instance of misconduct but where a lesser sanction is not sufficient.
    b. No evidence of harmful deep-seated personality or attitudinal problems.
    c. No evidence of repetition of behaviour since the incident.
    d. The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.
19. The only factor which potentially applied was "No evidence of repetition of behaviour since the incident", though there was no evidence before the Panel that the Second Respondent had been in nursing practice since her dismissal on 4 June 2019. Accordingly, this should not have been afforded any weight.
20. In contrast, all of the "key considerations" that the Panel were required to take into account for a striking-off order to be appropriate were engaged. The Panel's finding that a striking-off order would not be "proportionate" is not explained nor apparent from its reasoning.

(iii) Irrational sanction

21. On proper assessment, the nature and seriousness of the repeated and persistent misconduct towards multiple patients and colleagues, and the harm caused, combined with the lack of engagement, insight, remediation or remorse on the part of the Second Respondent, meant that striking-off was the only appropriate sanction in this case. This was behaviour that was fundamentally incompatible with continued registration as a nurse.
22. The suggestion that a suspension might allow the Second Respondent "time to engage and show remediation and insight" was unsupported wishful thinking. No remediation or insight had been shown in more than 4.5 years since the misconduct, and there was nothing to suggest that it would emerge.
23. The decision to impose a suspension rather than make a striking off order was irrational and wrong.

BY THE COURT

04/09/2024