Section 29 Case Meeting

14 December 2021

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Jason Jaw Obeng

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny & Quality (Performance), Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority

In attendance
Fenella Morris, Counsel, 39 Essex Street Chambers

Observers
Louise Appleby, Accreditation Officer, Professional Standards Authority
Collette Bryne, Scrutiny Officer, Professional Standards Authority
David Martin, Concerns & Appointments Officer, Professional Standards Authority
Rachael Martin, Scrutiny Team Coordinator, Professional Standards Authority
Richard West, Scrutiny Officer, Professional Standards Authority

This meeting was held remotely due to the ongoing pandemic.

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public

- to maintain public confidence in the profession concerned, and
- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of Justice of England and Wales and the statutory time limit for an appeal would expire on 23 December 2021.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 22 October 2021.

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the panel dated 22 October 2021
- The Authority's Detailed Case Review
- Transcripts of the hearing dated 19 – 22 October 2022
- Final witness statement bundle
- Final exhibit bundle
- Proof of Service bundle
- Registrant bundle
- Completed case management form
- My path entry document

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

- Restraint and Violence Reduction Policy
- Hearing Decision Letter
- Notice of hearing to registrant
- The NMC's Indicative Sanctions Guidance
- The Authority's Section 29 Case Meeting Manual

7.2 The Members and the Legal Advisor were provided with a copy of a response from the NMC to the Authority's Notification of s.29 Meeting. The Members considered the response having received legal advice and after they reached a conclusion on the sufficiency on the outcome.

8. Background

8.1 The registrant was employed as a Bank Nurse at the time of the incident and worked within the Low Secure Women's Mental Health Unit (the Unit) of Cygnet Hospital in Bradford, where he had been employed since September 2013.

8.2 The allegations considered by the panel concerned the registrant's conduct during a night shift on 23 May 2020, when he was working with two Healthcare Assistants.

8.3 During this shift, it is alleged that Patient A requested to go for a cigarette break, but the registrant informed Patient A that the ward could not permit this at the time due to staff shortages. It is alleged that this resulted in an altercation between him and Patient A. During this altercation the registrant allegedly pointed and/or shook his finger in Patient A's face, raised his hand towards the patient, and made physical contact with the patient's face. The incident was captured on CCTV.

8.4 The registrant documented Patient A's presentation during his shift and handed this over in the morning to incoming staff. However, it was further alleged that the registrant failed to record that he had made physical contact with Patient A or escalate the incident captured on CCTV. This omission was alleged as dishonest.

8.5 On 28 May 2020, Patient A's sister telephoned the Unit to enquire about what had transpired between the registrant and Patient A.

8.6 An investigatory meeting was held on 23 June 2020 with the registrant and the Unit's General Manager. A disciplinary hearing was subsequently held on 10 July 2020, which resulted in the registrant's dismissal on the grounds of gross misconduct. The registrant made an appeal against his dismissal on the basis that his dismissal was unfair, harsh and biased. The appeal hearing was held on 27 July 2020, and the outcome was that his dismissal was upheld.

8.7 The registrant made partial admissions to the allegations at the hearing. He did not admit that he made aggressive contact with Patient A's face or that his conduct was dishonest in that he knew he was required to note and/or report the incident or that he deliberately sought to mislead any subsequent reader by omitting the incident.

8.8 The panel found that the registrant must have realised that he made physical contact with Patient A during the incident and that he had failed to accurately record the details of the incident. The panel was, however, mindful of the registrant's previous unblemished career and was satisfied that he had demonstrated insight. A finding of impairment was made solely on public interest grounds.

8.9 The panel deemed this to be a rare case where a caution order appropriately and proportionately addressed the serious concerns. It found that the registrant had demonstrated insight and remediation to the point that it would not be in the public interest to prevent the registrant from continuing unrestricted practice. A caution order was imposed for three years.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members discussed the following concerns about the decision:

Insight

9.3 The Members considered whether the panel had fully grappled with the matter of insight given that the registrant continued to deny being aware that he had made physical contact with Patient A during the incident and denied acting dishonestly.

9.4 The Members felt that the registrant had not fully engaged with his dishonesty although he had completed appropriate and relevant courses to the misconduct found proved, which indicated that he was aware that the incident should not have happened and was inappropriate. The panel was also clearly satisfied having considered the evidence that repetition was unlikely.

9.5 The Members were mindful that deference was to be given to the panel since it had the benefit of hearing evidence from the registrant when coming to its decisions. The Members also noted that there was significant evidence to confirm that the registrant was a good practitioner working in a difficult field of practice and that the misconduct was an isolated incident.

9.6 The registrant's continuing denial that he was aware that he had made physical contact with Patient A was, however, a cause of concern for the Members. Particularly since the incident involved a detained and vulnerable patient and there was an element of power within the relationship with the registrant and Patient A. Furthermore, the panel's thinking and decision making in how it determined the registrant to have insight given his denial of dishonesty was not clear to the Members and for that reason they could not be sure the panel had fully grappled with the level of insight displayed by the registrant.

9.7 While the panel did engage with the case and weigh the mitigating and aggravating factors its reasons were poor in how it came to find that the registrant had insight. The Members recognised however, that there was strong mitigation

Aggravating and mitigating features

9.8 The Members considered whether the panel had come to the correct conclusion on impairment having only found the registrant impaired on public interest grounds. The Members acknowledged that the registrant did have significant mitigation, but the panel's reasoning did not engage with the lack of candour shown by the registrant about an action that was central to the case.

9.9 The Members also considered the aggravating and mitigating factors identified by the panel with which they largely agreed. However, the Members had difficulty agreeing with the panel's assessment that the incident involved a difficult encounter. This was true, but the registrant had experience working with vulnerable patients and the encounter had not been abnormally difficult. The Members also had difficulty agreeing with the panel's assessment that the dishonesty carried out by the registrant was not for personal gain when clearly the motivation was to conceal the truth and protect himself. The Members considered whether this indicated that the panel's assessment on dishonesty was flawed.

9.10 In relation to aggravating factors, the Members considered that the panel failed to note the fact that Patient A was detained and how this further created a power relationship with the registrant.

9.11 The Members concluded that the seriousness of the misconduct appeared to be under-played throughout the decision, leading to a lighter sanction. The Members felt that the panel failed to adequately deal with the registrant's partial insight which led them to come to a potentially incorrect conclusion on impairment.

Sanction

9.12 The Members considered whether the panel's assessment that this was a rare case where a caution appropriately and proportionately addresses the serious concerns was appropriate.

9.13 The Members felt that the panel did not give adequate reference to the SG in relation to a suspension order. This outlines a non-exhaustive list of factors, many of which applied to in this case. Furthermore, the SG on dishonesty referred to many of the factors present in this case, including vulnerable victims, misuse of power, deliberately breaching the professional duty of candour to cover up when things have gone wrong and premeditated conduct. The Members considered that this suggested this was a serious case of dishonesty which the panel did not appear to have properly considered. Instead, the panel appears to have focused on the fact that this was an isolated incident which occurred in difficult working circumstances and that the registrant has an otherwise unblemished record without weighing this against the very serious aspects of the case.

9.14 The Members noted that this was an isolated incident and that there was significant remediation undertaken since the incident and there has been no suggestion of repetition. The remediation undertaken by the registrant appeared enough to indicate that he was aware the incident should not have happened and what he should have done following the incident. The Members concluded that it was difficult to go behind the panel's assessment given that it has seen the registrant and made its assessment on risk of repetition and public protection

concerns. However, the fact that this was a serious incident involving a detained vulnerable patient and exacerbated by the registrant's denial and dishonesty was of concern to the Members.

9.15 Against this, the Members noted particularly that the panel, in considering suspension, had referred to the public interest in competent members of the profession being able to provide care to members of the public. They noted that this was a very challenging area of practice and it had no basis to question the registrant's competence and safety.

Conclusion on insufficiency for public protection

9.16 The Members concluded that the panel's decision to impose a three-year caution was insufficient for public protection.

9.17 This was a serious case of misconduct, exacerbated by the registrant's dishonesty to cover up his conduct concerning a detained vulnerable patient. The Members were particularly concerned by the registrant's ongoing dishonesty and by the panel's failure to consider that appropriately in its reasoning. However, they also accepted the strong mitigation, and the view that repetition was unlikely. The Members also acknowledged the public interest in competent practitioners being able to continue to practice without restriction. The decision was finely balanced but, given the poor reasoning and seriousness of the conduct, the Members felt that the sanction was insufficient to protect the public.

Referral to court

9.18 Having reached this decision, the Members considered whether the matter should be referred to the Court. In doing so, they took advice on the prospects of success, whether alternative means could be found to address their concerns and the public interest.

9.19 The Members noted that their main concern had been over the adequacy of the panel's reasons and determined that it was possible to address those concerns by way of learning points sent to the NMC. The Members also noted that they had no reason to believe that the registrant was an unsafe practitioner or that there was a risk of repetition. They bore in mind that there was a public interest in a competent practitioner being able to practise in a difficult area of work. The Members therefore determined it was not proportionate in this matter to refer the case to court.

9.20 For these reasons, the Panel agreed that the Authority should not exercise its power under Section 29 and refer this case to the High Court of Justice of England and Wales.

10. Learning points

10.1 The Members agreed that the learning points set out at Appendix C should be communicated to the Regulator.

Alan Clamp (Chair)

04/01/22

Dated

11. Annex A – Definitions

11.1 In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	A Fitness to Practise Panel of the Nursing & Midwifery Council
The Registrant	Jason Jaw Obeng
The Regulator	Nursing & Midwifery Council
NMC	Nursing & Midwifery Council
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on 22 October 2021
The Court	The High Court of Justice of England and Wales
The SG	Regulator's Indicative Sanctions Guidance