Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

27 November – 10 December 2018

Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Maxwell Nyamukapa
NMC PIN:	07C0182E
Part(s) of the register:	RNLD, Registered Nurse – Learning Disabilities (March 2007)
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Jill Wells (Chair, Lay member) Jacqueline Nicholson (Registrant member) Peter Swain (Lay member)
Legal Assessor:	Nigel Ingram
Panel Secretary:	Caroline Pringle
Mr Nyamukapa:	Present but not represented
Nursing and Midwifery Council:	Represented by Helen Fleck, Case Presenter
Facts proved:	1.1 (in relation to “dislodged”), 1.2, 1.3 (in relation to “punched”), 1.4, 2.1 and 2.2 (in relation to “restrain”)
Facts not proved:	1.3 (in relation to “hit”), 2.2 (in relation to “move”)
No case to answer:	1.1 (in relation to “and or fall out”)
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim Order:	Interim suspension order (18 months)

Details of charge (as amended)

That you, a registered nurse whilst employed by Castlebeck Care Ltd:

1. On 20 August 2009
   1.1. Caused Patient S's two front teeth ~~out~~ to become dislodged and or fall out
   [Found proved in relation to "dislodged". No case to answer in relation to "and or fall out"]
   1.2. Caused an alveolar fracture to Patient S.
   [Found proved]
   1.3. Punched or hit Patient S in the face
   [Found proved in relation to "punched". Found not proved in relation to "hit"]
   1.4. Used excessive force on Patient S
   [Found proved]

2. On 7 March 2011 participated in and / or failed to intervene to prevent the restraint and removal of Patient F
   2.1. Which was unnecessary and / or disproportionate to the risks posed
   [Found proved]
   2.2. Which was inappropriate in that a duvet was used to restrain and / or move Patient F
   [Found proved in relation to "restrain". Not proved in relation to "move".]

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

Background

Winterbourne View was a hospital for adults with learning disabilities, owned and operated by Castlebeck Care (Teesdale) Limited ("Castlebeck"). It was a specialist hospital to support highly vulnerable adults with learning disabilities and mental health needs, including those detained under the Mental Health Act (1983). The nature of the work and the hospital patient profile meant that staff were trained in behaviour management techniques including restraint and were required to use these skills on a regular basis. Staff at all times were expected to use restraint techniques within national and local policy guidance. All of the patients were vulnerable. Patients had learning disabilities and mental health conditions and some were detained under the Mental Health Act. Patient S was separated at a considerable distance from family members. There was no background information available about the family circumstances of Patient F.

You were employed by Castlebeck from the time you qualified as a nurse, in 2007, until the closure of Winterbourne View in June 2011.

In 2011 BBC undercover reporter, Mr 2, was employed by Castlebeck as a support worker. He covertly filmed footage at Winterbourne View. Some of the footage filmed by Mr 2 was broadcast on 31 May 2011 as part of a BBC Panorama documentary "Undercover Care: The Abuse Exposed" (the Panorama documentary). This documentary revealed sustained neglect and repeated abuse towards patients by some Winterbourne View staff.

As a result of the Panorama documentary, 11 members of staff including care workers and nurses were convicted of a total of 38 charges of abuse and neglect. In his sentencing remarks the Judge who sentenced the care workers commented on a "culture of cruelty" at Winterbourne View and stated that it had been "run with a scandalous lack of regard to patients and staff".

You did not feature in the Panorama documentary. Nor were you charged with any criminal offences. However, it is alleged that you were involved in two discrete incidents at Winterbourne View.

The first incident involved Patient S, who was 18 years old at the time. Patient S has autism and learning disabilities, and was admitted to Winterbourne View on 10 July 2009. Patient S was subject to compulsory detention under s.3 of the Mental Health Act 1983.

Charge 1 concerns an incident on 20 August 2009 where you allegedly punched or hit Patient S. As a result of this alleged incident, Patient S sustained a serious dental injury which included two dislodged teeth and an alveolar fracture (the bone which contains the tooth sockets). He was taken to the University of Bristol Dental Hospital where he was treated by Dr 1. Attempts were made to save Patient S's teeth but this was not successful. Patient S lost his two upper front teeth at some point and now has dentures. You were also injured and required minor surgery on your hand. You say that this was as a result of Patient S biting you.

There was a Safeguarding meeting on 25 August 2009. The conclusion of this meeting was that the police 'take no action criminally'. The Detective Sergeant at that meeting said 'it seems clear that Maxwell punched Patient S in the face, but seems understandable given the circumstances, but goes against any training.' The agreement was for Castlebeck to carry out an internal investigation.

You were interviewed on 26 August 2009 as part of the internal investigation during which you are recorded as saying: 'I most probably did hit him in the mouth at some point since he has sustained injuries but I do not remember consciously punching him because I was in a lot of pain and really struggling to pull my hand out'. On 23 April 2013 you gave a written statement to the police in which you confirmed that the notes of the meeting on 26 August 2009 were accurate. However since this point you have

denied that you punched Patient S and state that you sought to remove your hand from Patient S's mouth using a recognised disengagement technique.

Castlebeck's internal investigation report contained actions and recommendations including additional training required and a decision was made that the safeguarding case could be closed.

The incident was raised again on 28 June 2011 by a safeguarding alert received from Patient S's family via the Care Quality Commission. You were questioned by the police.

Charge 2 concerns an alleged incident which took place on 7 March 2011, involving a restraint of Patient F. Although it did not feature in the Panorama documentary which was broadcast in 2011, Mr 2 filmed footage of you and other staff restraining Patient F. This involved using a duvet and then removing Patient F out of the lounge and into her bedroom, with each staff member carrying a limb.

It is alleged that this restraint and removal from the room of Patient F was unnecessary and disproportionate to the risks posed.

The allegations against you were originally heard by a panel of the NMC's Fitness to Practise Committee in October 2017 and the panel was provided with some transcripts from this hearing, although the panel was not aware of the outcome of that hearing.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Fleck, on behalf of the NMC, to amend the wording of charge 1.1.

She proposed that the word "out" should be removed from charge 1.1 as follows:

Original wording:

"Caused Patient S's two front teeth out to become dislodged and or fall out"

Proposed wording:

"Caused Patient S's two front teeth ~~out~~ to become dislodged and or fall out"

Ms Fleck said that this was clearly an error in the charge and that the amendment could be made without prejudice to you.

You did not object to the proposed amendment.

The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

> 28.— (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—
>
> (a) the charge set out in the notice of hearing; or
>
> (b) the facts set out in the charge, on which the allegation is based,
>
> unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.
>
> (2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.

The panel allowed the application. It decided that this was clearly an error in the charge. It was therefore satisfied that there would be no prejudice to you and no injustice would be caused to either party by allowing the proposed amendment.

Decision and reasons on application to hear evidence from Ms 7 and Ms 8 via WebEx pursuant to Rule 31

At the start of the hearing Ms Fleck made an application for two witnesses, Ms 7 and Ms 8, to give evidence via WebEx.

Ms Fleck told the panel that both of these witnesses were unable to attend this hearing due to personal difficulties. [PRIVATE].

Ms Fleck submitted that both witnesses are senior safeguarding practitioners who mainly provide documents and give background to the investigations into Winterbourne View. Neither give direct evidence to either of the charges. She submitted that giving evidence by WebEx would allow you and the panel to see the witnesses and assess their demeanour. She further submitted that the NMC had informed you, in advance of this hearing, that the NMC intended to call both of these witnesses by WebEx and you did not object to this.

In these circumstances, Ms Fleck submitted that it would be in the interests of justice and the public interest for Ms 7 and Ms 8 to give evidence by WebEx.

You confirmed that you did not object to either witness giving evidence via WebEx.

The panel accepted the advice of the legal assessor.

The panel decided to allow the application in respect of both witnesses. It decided that there were good reasons for both Ms 7 and Ms 8's non-attendance at this hearing in person. It noted that the evidence of these witnesses was neither controversial, nor decisive to the charges. It also considered that allowing Ms 7 and Ms 8 to give evidence via WebEx would not cause prejudice or unfairness to any of the parties, as the witnesses can be cross-examined and the panel will be able to assess their demeanours. This will assist the panel in testing their evidence and assessing their credibility.

Decision and reasons on application under Rule 19

At the start of the hearing Ms Fleck made an application that parts of the hearing be held in private. This application was made under Rule 19 of the Rules. She specifically requested that the following parts of the hearing be held in private:

- The viewing of the video footage showing Patient S' police interview;
- The viewing of the video footage, recorded by Mr 2, showing the restraint of Patient F;
- Mr 2's evidence.

Ms Fleck said that the dignity of Patient S and Patient F had been compromised and it would not be right for the video footage of them to be viewed in a public hearing.

You did not object to the application.

The legal assessor reminded the panel that while Rule 19 (1) provides, as a starting point, that hearings shall be conducted in public, Rule 19 (3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel noted that it could be possible to identify Patient S and Patient F from the video footage of them. It was therefore satisfied that it was appropriate that this video footage should be viewed in private, in order to protect the anonymity of Patient S and Patient F.

In respect of Mr 2's evidence, the panel was mindful that the Rules create a presumption that hearings should be held in public, unless there is a good reason to do otherwise. The panel was mindful that there is a public interest in justice being conducted in public. There is also a high public interest in this case, given the wider concerns about Winterbourne View. The panel was of the view that there was no good reason to hear Mr 2's evidence in private. Patient F has been anonymised and therefore

cannot be identified from Mr 2's oral evidence. The events which took place at Winterbourne View are already in the public domain.

The panel therefore decided that Mr 2's evidence should be heard in public, apart from any viewing of the video footage which may be necessary as part of his evidence.

Ms Fleck indicated that she may make an application to hear Patient S's mother's evidence in private. However she later told the panel that Patient S's mother had asked to give her evidence in public. The panel accepted Patient S's mother's decision; it noted that, should any transcripts be requested, both her name and that of Patient S would need to be anonymised.

Decision and reasons on application to hear evidence from Ms 8 via telephone pursuant to Rule 31

On day 4 of the hearing Ms Fleck made an application to hear evidence from Ms 8 by telephone.

Although the panel had agreed that Ms 8 could give evidence by WebEx, and this had been tested with her prior to the hearing, on the day it was not possible to establish a video link with her.

Ms Fleck submitted that hearing evidence from Ms 8 by telephone was the best option in the circumstances and would not prejudice you. She submitted that Ms 8's evidence goes only to the safeguarding interventions which took place at Winterbourne View; she does not give direct evidence to any of the charges and her credibility is not in dispute.

You indicated that you were content for the witness to give evidence by phone.

The panel accepted the advice of the legal assessor.

The panel decided to allow the application. It noted that Ms 8's witness statement mainly exhibits documents related to the safeguarding investigations. It took account of the fact that her evidence was not in dispute and her credibility was not an issue. In these circumstances, the panel decided it was fair to allow the unopposed application.

Decision and reasons on application of no case to answer

The panel considered an application from you that there is no case to answer in respect of all of the charges. This application was made under Rule 24 (7) of the Rules. This rule states:

> 24 (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –
>
> (i) … upon the application of the registrant …
>
> the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.

You made submissions in relation to all of the charges.

In relation to charge 1.1 you submitted that there was evidence from Dr 1, the dentist who treated Patient S on 20 August 2009, that his teeth were still in situ. You submitted that the technique you say you used to disengage from his bite may have weakened Patient S's teeth and caused the injuries. Other staff using a similar technique on a number of occasions prior to this incident may have also weakened Patient S's teeth. You also submitted that there was a possibility that Patient S may have subsequently aggravated his injuries.

In relation to charges 1.3 and 1.4, you submitted that Patient S had a well-documented history of aggressive behaviour, which included biting, and the force you used to disengage from the bite was proportionate and reasonable. You submitted that Dr 6, an expert in clinical psychology and intellectual disability, could not give evidence about how much force would be required to release a hand from a bite.

In relation to charge 2, you submitted that the evidence from Mr 2 and Dr 6 that Patient F presented no risk to herself or others was opinion. You referred the panel to risk assessments which documented Patient F's history of physical aggression. You submitted that it therefore was necessary to restrain Patient F in order to protect her and others. You submitted that although Mr 2 said he could not recall a fire blanket being used, Dr 6 gave evidence that there were exceptional circumstances in which accepted restraint techniques could be modified.

Ms Fleck responded to the application on behalf of the NMC. She submitted that sufficient evidence had been presented, at this stage, on which a reasonable panel, properly directed, could find the charges proved.

In relation to charge 1, Ms Fleck referred to the evidence of Dr 1 and Dr 3, an expert in general dental practice. She submitted that Dr 1 gave clear evidence that Patient S's teeth were dislodged when she treated Patient S on 20 August 2009. Both of these witnesses were adamant that the injuries sustained by Patient S could only be caused by a significant impact, and were consistent with a punch. Ms Fleck further submitted that Patient S has consistently maintained that you punched him; he said this to Dr 1, during the police interview, and repeatedly to his mother since the incident. Ms Fleck also referred to the evidence of Dr 6, specifically in relation to charge 1.4, that punching a patient in the face would never be acceptable because it is never the least restrictive means of dealing with a situation.

In relation to charge 2, Ms Fleck submitted that the panel had seen video evidence of the incident and was entitled to make its own assessment as to whether restraining and

removing Patient F was necessary and/or proportionate. She submitted that Dr 6, as an expert, was entitled to give an opinion and it had been his clear evidence after viewing the video that Patient F had not presented a risk to herself or others which would justify the restraint depicted in the video footage.

The panel took account of the submissions made and accepted the advice of the legal assessor, who referred the panel to Rule 24(7) and R v Galbraith 1 WLR 1039.

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.

The panel considered each charge in turn.

Charge 1.1 – Case to answer EXCEPT in relation to "and or fall out"

The panel considered that there had been sufficient evidence at this stage to support the charge that you "caused Patient S's two front teeth to become dislodged". The panel had clear oral evidence from Dr 1 that when she examined Patient S at the dental hospital on 20 August 2009 she found his teeth to be "displaced palately". This was supported by the records she made at the time. It was therefore satisfied that there was a case to answer in relation to this charge.

However, the panel was mindful that the charge brought by the NMC was also phrased in the alternative, namely: "dislodged and/or fall out". The panel noted that it was clear from the evidence that Patient S lost two teeth at some point, as he now has dentures. However, the panel had no evidence from the witnesses or the papers as to whether Patient S's teeth fell out, or whether they were removed by dental staff as part of a treatment plan. None of the witnesses could assist on this point.

The panel therefore decided that, adopting a literal and straightforward interpretation of "fall out", there was no evidence presented to support the part of the charge that you caused Patient S's teeth to fall out.

The panel acknowledged that it was within its power to amend the charge at this stage to a broader wording which would be supported by the evidence. However, it considered that it would be unfair to you to make such an amendment at this stage, when the NMC has already called all of its witnesses. The panel also considered that it would not be failing in its overarching duty to protect the public by not amending the charge, as it has found that there is a case to answer in relation to the alternative charge.

Accordingly, there is a case to answer in relation to "Caused Patient S's two front teeth to become dislodged" but no case to answer in relation to "Caused Patient S's two front teeth to fall out".

Charge 1.2 – Case to answer

The panel considered that there had been sufficient evidence at this stage to support this charge. It is not disputed by you that there was dental contact between you and Patient S. The panel had clear oral evidence from Dr 1 that when she examined Patient S at the dental hospital on 20 August 2009 she found that his alveolar bone had been fractured. This was supported by the records she made at the time. It was therefore satisfied that there was a case to answer in relation to this charge.

Charge 1.3 – Case to answer

The panel considered that there had been sufficient evidence at this stage to support this charge. The panel had evidence from both Dr 1 and Dr 3 that, in their professional opinions, the type of injuries sustained by Patient S were consistent with a "significant impact". Examples were given of a punch, blow to the face with a hockey stick, or the impact of a steering wheel during a road traffic accident. Both witnesses stated that the injuries sustained by Patient S could not be caused by the type of disengagement

technique that you put to them. It was therefore satisfied that there was a case to answer in relation to this charge.

Charge 1.4 – Case to answer

The panel considered that there had been sufficient evidence at this stage to support this charge. The panel had evidence from both Dr 1 and Dr 3 that the injuries sustained by Patient S were consistent with a "significant impact" and such force could not be explained by the methods put forward by you. The panel was therefore satisfied that there was a case to answer in relation to this charge.

Charge 2.1 – Case to answer

The panel considered that there had been sufficient evidence at this stage to support this charge. The panel had seen the video evidence and you had been identified and accept that you were one of the staff involved in the restraint and removal of Patient F. It had the expert evidence of Dr 6 who, having seen the video footage of the incident involving Patient F, gave the opinion that her restraint was unnecessary and disproportionate in the circumstances. The panel was therefore satisfied that there was a case to answer in relation to this charge.

Charge 2.2 – Case to answer

The panel considered that there had been sufficient evidence at this stage to support this charge. The panel had seen the video evidence and you had been identified and accept that you were one of the staff involved in the restraint and removal of Patient F. As with charge 2.1, it had the expert evidence of Dr 6 who told the panel that using a duvet to restrain or move a patient was never appropriate. Although he gave evidence that there were exceptional circumstances in which approved restraint techniques could be modified, it was his evidence that the circumstances he viewed in relation to Patient F were not exceptional. The panel was therefore satisfied that there was a case to answer in relation to this charge.

The panel was of the view that there had been sufficient evidence to support all of the charges at this stage, with the exception of "and or fall out" in charge 1.1. As such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Fleck, on behalf of the NMC, and those made by you.

The panel accepted the advice of the legal assessor.

The panel was aware that the burden of proof rests on the NMC. The standard of proof is the civil standard, namely the balance of probabilities. This means that the facts will be proved if the panel was satisfied that it was more likely than not that the incidents occurred as alleged.

The panel heard oral evidence from nine witnesses called on behalf of the NMC:

- Dr 1 – Dentist at the University of Bristol Dental Hospital;
- Mr 2 – BBC reporter;
- Dr 3 – Expert in General Dental Practice;
- Ms 4 – Director of Legal Services and General Counsel to the Chief Constable at Avon and Somerset Police;
- Ms 5 – Head of Governance at Danshell (formerly Castlebeck Care (Teesdale) Limited);
- Dr 6 – Expert in Clinical Psychology and Intellectual Disability
- Ms 7 – Senior Practitioner in South Gloucestershire Council Safeguarding Team;
- Ms 8 – Senior Practitioner in South Gloucestershire Council Safeguarding Team;
- Patient S's mother.

The panel also had the written witness statement of Mr 10, Deputy Manager of the Hawthorns Care Centre, where you worked following the closure of Winterbourne View.

It also had video footage of the police interview carried out with Patient S on 29 November 2012 and the undercover footage, filmed by Mr 2, of the restraint of Patient F on 7 March 2011.

Dr 1 was the dentist who treated Patient S at the University of Bristol Dental Hospital on 20 August 2009, following the incidents alleged in charge 1. The panel found her to be a professional, credible and reliable witness. She did not speculate and readily accepted if a matter was beyond her expertise.

Mr 2 was the BBC reporter who went undercover as a support worker at Winterbourne View and recorded the footage included in the Panorama documentary. The panel found him to be a clear and helpful witness, particularly in relation to explaining the video footage he had filmed on 7 March 2011. The panel considered that he tried to be balanced. He did present as an advocate for the patients on occasions and at times his evidence went beyond the questions asked of him. The panel therefore focused on the parts of his evidence which went directly to the facts of the events he witnessed.

Dr 3 was the dental expert, instructed by the NMC to review Patient S's dental records and give an opinion on the injuries he sustained on 20 August 2009. The panel found him to be a helpful, professional and reliable witness who was very clear about the parameters of his expertise and evidence.

Neither Ms 4 nor Ms 5 were direct witnesses to the charges, nor were they involved with Winterbourne View at the relevant time. As such, they were of limited assistance to the panel as their evidence did not go beyond the documents exhibited by their written witness statements. However, they were as helpful as their limited involvement in the events allowed and the panel had no reason to doubt their credibility or reliability.

Dr 6 was an expert in clinical psychology and intellectual disability. He was instructed by the NMC to review and comment on the video footage of Patient F's restraint and on the incident relating to Patient S. The panel found him to be a helpful, professional, clear and credible witness who did not speculate and was clear about the boundaries of his knowledge.

Ms 7 and Ms 8 both sought to assist the panel as much as they could but had limited involvement in the relevant events.

Patient S's mother provided the panel with helpful background information regarding Patient S and was able to explain her experience of his behaviour. Her evidence was clear and measured and she accepted the limits of her knowledge about the incident which this panel is considering. The panel found her to be a credible and reliable witness.

You also gave evidence and were open to cross-examination. You were unclear in your recollection about some details of events. You made a number of concessions, for example that Patient F's behaviour in the video footage did not show any immediate risks to her or anyone else. Your oral evidence was at times inconsistent with the accounts that you had provided to others closer to the time of the events.

The panel considered each charge and made the following findings:

Charge 1.1

1. On 20 August 2009

1.1. Caused Patient S's two front teeth to become dislodged

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and Dr 3. Dr 1 told the panel that when she examined Patient S on 20 August 2009 she found that two of his teeth on the upper left side were dislodged and could be moved about 2mm in their sockets (classed as grade II mobile). In addition to this, she also identified that the alveolar bone was fractured and mobile, there was bruising to the area of the lip over the dislodged teeth, and also a degloving injury (where the gum is stripped away revealing the bone underneath). Her oral evidence was supported by the notes she made at the time in Patient S's dental records.

The panel was therefore satisfied that Patient S sustained the injury specified in charge 1.1.

The panel noted that you did not appear to dispute that the injuries had arisen as a result of this incident with Patient S (although you do dispute the way in which the injury was caused). You did suggest that Patient S's teeth may have already been weakened, either by staff repeatedly having to disengage from his biting or from other dental issues. Dr 1 told the panel that, aside from the injuries she identified arising from the incident, Patient S's teeth were in a good condition. Dr 3 also confirmed in his evidence that he had examined Patient S's dental records and could find no evidence of gum disease or other dental problems which may have weakened Patient S's teeth. Patient S's mother also confirmed that his teeth were in good condition prior to this incident. Consequently, the panel rejected your explanation.

Taking the above into account, the panel was satisfied on the balance of probabilities that on 20 August 2009 you caused Patient S's two front teeth to become dislodged.

Accordingly, charge 1.1 is found proved.

Charge 1.2

1. On 20 August 2009

1.1. …

1.2. Caused an alveolar fracture to Patient S.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and Dr 3. As discussed above in relation to charge 1.1, Dr 1 told the panel that when she examined Patient S on 20 August 2009 she found that his alveolar bone was fractured, amongst other dental injuries. Her oral evidence was supported by the notes she made at the time in Patient S's dental records.

The panel was therefore satisfied that Patient S sustained the injury specified in charge 1.2.

As in charge 1.1, you did not appear to dispute that the injuries had arisen as a result of the incident with Patient S earlier that day and Dr 1 and Dr 3 both gave evidence that there was nothing to suggest that Patient S's teeth or bones were already weak from some other cause. Patient S's mother also confirmed that his teeth were in good condition prior to this incident. Consequently, the panel rejected your explanation.

Taking the above into account, the panel was satisfied on the balance of probabilities that on 20 August 2009 you caused an alveolar fracture to Patient S.

Accordingly, charge 1.2 is found proved.

Charge 1.3

1. On 20 August 2009

1.1. …

1.2. …

1.3. Punched or hit Patient S in the face

This charge is found proved in that the panel finds you punched Patient S in the face.

In reaching this decision the panel took into account the evidence of Dr 1, Dr 3, the video of Patient S being interviewed about his time at Winterbourne View, and your evidence.

Dr 1 told the panel that when she examined Patient S on 20 August 2009 and asked him what had happened he told her that the staff at Winterbourne View had touched him without asking and he made a punching gesture towards his mouth with a clenched fist. The panel also had the benefit of watching a recording of a police interview with Patient S, held on 29 November 2012, about his experiences at Winterbourne View. During this interview, Patient S says "Max punched me on the teeth". The footage shows Patient S making a punching gesture towards his mouth. According to the evidence of Patient S's mother, Patient S has also repeatedly told her this. She told the panel that she speaks to Patient S on the phone about five times a week and he will normally talk about the incident during about three of those phone calls.

You deny punching or hitting Patient S. In your evidence, you told the panel that you were in the quiet room with Patient S, who was colouring. Patient S suddenly got up, grabbed your right arm and bit your right hand. The panel was aware that during the course of the police and NMC investigations, you have given differing accounts as to how the injuries to Patient S were caused. However, at this hearing, you told the panel that when you were being bitten by Patient S you placed your hand on the back of Patient S's head and were pushing in. You told the panel that this was a technique that you had been trained in at Winterbourne View. However you then stopped using this technique and attempted to free yourself by pushing and pulling your hand in and out of his mouth. You told the panel that the back and forth motion you used must have caused his injuries.

However, when your explanation was put to Dr 1 and Dr 3, both were of the opinion that this would not have caused Patient S's injuries. Both witnesses were clear that Patient S's injuries could only be caused by a high impact blow to the face. Dr 1 said that she sought a second opinion at the time of treating Patient S. The senior colleague confirmed her view. Examples were given of what could cause such an injury. These were: a punch, blow to the face with a hockey stick, or the impact of a steering wheel during a road traffic accident. Both Dr 1 and Dr 3 were clear that the action of pushing and pulling your hand in and out of Patient S's mouth would have been insufficient to have caused Patient S's injuries. Dr 3 conceded in his oral evidence that your version of events may have loosened Patient S's teeth, but he was adamant that it would not have fractured the alveolus or caused the degloving injury.

Taking account of all of the above, the panel was satisfied on the balance of probabilities that on 20 August 2009 you punched Patient S in the face.

Accordingly, charge 1.3 is found proved.

Charge 1.4

1. On 20 August 2009

1.1. …

1.2. …

1.3. …

1.4. Used excessive force on Patient S

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 6, as well as its earlier findings that you punched Patient S.

You told the panel in your evidence that you were in significant pain after being bitten by Patient S. You state that you did not use excessive force to disengage from the bite and your actions were proportionate in the circumstances.

However, the panel had regard to its earlier decision in charge 1.3 that you had punched Patient S. It had regard to the conclusions of Dr 6's report, which he confirmed in his oral evidence, that:

> 'Given the severe nature of the injuries sustained by Patient S I can only conclude that excessive force was used here, irrespective of whether Mr Nyamukapa actually punched Patient S. Whilst it is accepted that Mr Nyamukapa had every right to defend himself he also had a duty of care toward Patient S in spite of the fact that he was attempting to assault him.
>
> I would argue that it would never be appropriate for a nurse in this situation to hit or punch a patient. This would be a dereliction of their duty of care and I cannot envisage that this would ever be considered to be the least restrictive alternative.'

In his oral evidence Dr 6 said excessive force was used and he had never come across force like this in 30 years' experience. He told the panel that hitting a patient is never appropriate and that there are always other less restrictive options. He emphasised that this was not a "street brawl", but a professional care situation.

Having regard to Dr 6's evidence, the severity of Patient S's injuries and the degree of force required to cause them, as described by Dr 1 and Dr 3, the panel was satisfied on the balance of probabilities that on 20 August 2009 you used excessive force on Patient S.

Accordingly, charge 1.4 is found proved.

Charge 2.1

2. On 7 March 2011 participated in and / or failed to intervene to prevent the restraint and removal of Patient F

2.1. Which was unnecessary and / or disproportionate to the risks posed

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 2 and Dr 6, as well as your evidence. It also had regard to the video footage of the restraint, filmed by Mr 2.

The panel noted that it is clear from the video footage that you participated in the restraint and removal of Patient F on 7 March 2011. It therefore finds this part of the charge proved.

It therefore moved on to consider whether this was unnecessary or disproportionate. The video footage only starts at the point where the restraint begins, and therefore provided no assistance as to the build-up of events beforehand.

You told the panel that Patient F had a history of violent and aggressive behaviour which could escalate, and it was therefore necessary to restrain her and remove her from the lounge. There were other patients present and removal was required in order to maintain everyone's safety. You referred the panel to risk assessments regarding Patient F which recorded that Patient F's behaviours can become 'aggressive and destructive' and require 'physical intervention for her own safety and that of others'. You did accept when questioned that there did seem to be no risk from the point of the video recording starting. You told the panel that this was approximately the point that you entered the room. You said that you made an assumption that staff had tried other less restrictive methods prior to calling for assistance. You therefore followed what the other

staff were doing, which was being led by a support worker. You did this without challenging anyone's actions.

The panel noted that the risk assessment regarding Patient F post-dates the events of charge 2 (7 March 2011). The risk assessment states 'do not manually move Patient F' and that physical intervention should only be used if distraction and de-escalation techniques have already been tried unsuccessfully. It was the evidence of Mr 2, who was present in the room before filming started, that Patient F presented no risk to others in the room at that time and that no de-escalation or distraction techniques were used before staff began to restrain her.

The panel also considered the evidence of Dr 6. In his expert report, which he confirmed in his oral evidence, he stated:

> "The footage gives no indication whatsoever of an incident that would ordinarily necessitate removing a patient by force. The only behaviour that might be considered of concern was a verbal utterance of 'you bitch' and on all occasions this appeared to be precipitated by staff trying to restrain her. The footage provides no evidence of Patient F hitting out and there would appear to be no risk of physical harm to herself, other patients or staff. There is no apparent reason why she could not have been handled in situ i.e. not removed from the lounge, as there was no indication of any risk to herself, staff or other patients."

Dr 6 described alternatives that could have been used, for example, getting down to the patient's level, talking to her, giving her space and suggesting an activity as a distraction.

The panel had the benefit of viewing the footage of Patient F and agreed with the evidence of Mr 2 and Dr 6 that Patient F did not appear to be presenting any significant or immediate risk which would justify restraining and/or removing her.

It was therefore satisfied that, on the balance of probabilities, on 7 March 2011 you participated in and failed to intervene to prevent the restraint and removal of Patient F, and that this was both unnecessary and disproportionate to the risks posed.

Accordingly, charge 2.1 is found proved.

Charge 2

2. **On 7 March 2011 participated in and / or failed to intervene to prevent the restraint and removal of Patient F**
   - **2.1. …**
   - **2.2. Which was inappropriate in that a duvet was used to restrain and / or move Patient F**

This charge is found proved with the exception of "or move".

In reaching this decision, the panel took into account the evidence of Mr 2 and Dr 6. It also took account of your evidence and the video footage of Patient F's restraint.

It was clear from the video footage that you actively used a duvet to wrap around Patient F's legs and you accepted this. In your evidence you told the panel that you tried to wrap it around her legs to stop her from kicking. However the panel noted from the video that other staff used the duvet to wrap around other parts of Patient F. She then disengaged from the duvet and was then lifted by her limbs and carried by you and other staff out of the lounge.

The panel was therefore satisfied that you used a duvet to restrain Patient F, but that you did not use it to move her.

The panel then went on to consider whether using a duvet to restrain Patient F was inappropriate.

You told the panel in your evidence that you had been taught to use a blanket to restrain patients as part of your training at Winterbourne View. The training was the Maybo programme, delivered by an in-house trainer. You acknowledged that this technique was not included in the Maybo course workbook, but you were adamant that you had been taught this. You described it as an alternative taught from a "fire blanket" technique. However the Maybo workbook describes the fire blanket technique with no use of any form of blanket.

Mr 2, who had undergone the same Maybo training as you (albeit at a different time) told the panel that he had not been trained to use a blanket to restrain or move patients.

Dr 6 told the panel that there is a Maybo taught technique in the Safer PI Physical Intervention in the Assault Reduction, Disengagement and Holding course workbook known as the "fire blanket" technique but this does not involve the use of a blanket or duvet. He told the panel that there are no approved restraint techniques which use blankets or duvets. His expert report stated that using a duvet 'would have prevented observation of the patient's vital signs and was degrading for the patient'.

He concluded his analysis of the restraint incident by stating:

> 'In summary the incident in question should have been handled in situ and there is no evidence that the risks around this incident necessitated the removal of the patient from the area. The actions of the staff in removing the patient would appear to have exacerbated the situation rather than resolve it. The technique employed would not be considered good practice, it was not part of the curriculum taught and had risks associated with it including its questionable effectiveness and the extent to which it enabled the vital signs of the patient to be monitored as well

as negative psychological impact on the patient. I have to conclude that the removal of Patient F was both unnecessary and improper.'

The panel noted that there were no techniques in the Maybo workbook which involved using a blanket or duvet to restrain a patient. It also viewed the video footage and agreed with Dr 6's opinion that the use of the duvet was inappropriate.

The panel was therefore satisfied, on the balance of probabilities, that on 7 March 2011, you participated in and failed to intervene to prevent the restraint and removal of Patient F which was inappropriate in that a duvet was used to restrain Patient F.

Accordingly, charge 2.2 is found proved.

Submission on misconduct and impairment

Having announced its finding on all the facts, 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 has defined it as a registrant's suitability to remain on the register unrestricted.

You gave evidence on oath. You told the panel that you have continued to practise as a registered nurse since leaving Winterbourne View in 2011, doing agency work. You have been employed by your current agency since 2015 and mainly work in two private hospitals. You care for patients with learning difficulties and mental health conditions, some of whom are detained under the Mental Health Act. You told the panel that you work night shifts and usually work about two shifts per week.

You told the panel that there have been no further complaints or concerns about your practice since you left Winterbourne View. You told the panel that Winterbourne View was your first job after qualifying and neither the organisation nor the staff were

equipped to manage the challenging behaviours presented by some of the patients. You told the panel that since leaving Winterbourne View you have had the opportunity to observe and learn from other nurses.

You maintained that you did not punch Patient S, but apologised for your actions and the harm that you caused. When asked what you would do if you found yourself in a similar environment to Winterbourne View again, you said that you would initially raise concerns with management and, if that was unsuccessful, you would go to the media.

Ms Fleck provided the panel with written submissions. In these submissions she invited the panel to take the view that your actions amounted to a breach of The Code: Standards of conduct, performance and ethics for nurses and midwives 2008 (the Code). She then directed the panel to specific paragraphs and identified where, in the NMC's view, your actions amounted to misconduct.

Ms Fleck referred the panel to the case of Roylance v GMC (No. 2) [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances'.

She then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Ms Fleck referred the panel to the cases of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).

You accepted that the panel's findings of fact amounted to misconduct. You said that you have continued to work since the incidents with no further concerns about your practice. You said that you have reflected on your past actions and realise where you went wrong. You said that you know you are accountable for your own actions and that nothing like this would ever happen again. You provided the panel with a testimonial,

dated 7 December 2018, from the Office Manager and Senior Recruitment Officer at DNA Care Services (the agency you have worked for since 2015). This testimonial confirmed that they had not received any complaints regarding your work. However, when questioned, you confirmed that the author of the testimonial is unaware of the charges and findings against you, or that your fitness to practise is currently being considered by the NMC.

The panel accepted the advice of the legal assessor who referred the panel to the cases of Roylance and Grant.

The panel adopted a two-stage process in its consideration, as advised. 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 your fitness to practise is currently impaired as a result of that misconduct.

Decision on misconduct

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of the Code.

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

> **The people in your care must be able to trust you with their health and wellbeing**
>
> **To justify that trust, you must:**

- make the care of people your first concern, treating them as individuals and respecting their dignity
- work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community
- provide a high standard of practice and care at all times
- …act with integrity and uphold the reputation of your profession.

As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions.

Treat people as individuals

1 You must treat people as individuals and respect their dignity.

3 You must treat people kindly and considerately.

4 You must act as an advocate for those in your care...

Provide a high standard of practice and care at all times

35 You must deliver care based on the best available evidence or best practice.

Be open and honest, act with integrity and uphold the reputation of your profession

54 You must act immediately to put matters right if someone in your care has suffered harm for any reason.

Uphold the reputation of your profession

61 You must uphold the reputation of your profession at all times.

The panel accepted that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your actions fell seriously short of what would be proper in the circumstances.

Both Patient S and Patient F were highly vulnerable patients. You were in a position of trust and had a responsibility, as a qualified Registered Learning Disabilities Nurse, to ensure their safety and well-being.

The panel accepts that you were bitten by Patient S. However, you had a duty of care towards Patient S and, as a registered professional working within a specialist unit, were expected to be able to manage and respond to challenging behaviour professionally and appropriately. The panel agreed with Dr 6's evidence that punching a patient would never be appropriate. Not only did you punch Patient S, but you did so with enough force to dislodge his teeth and cause an alveolar fracture. As a result, Patient S now has dentures. The panel considered that such actions fundamentally conflict with the values of the nursing profession, fell seriously short of the standards expected of a registered nurse, and amounted to misconduct.

In relation to Patient F, the panel had regard to the evidence of Dr 6 that it would never be acceptable to restrain a patient using a duvet or remove them in the way that you and other staff did. There was no evidence of there being any immediate risk to justify restraint being used on Patient F, and you failed to challenge this when you arrived on the scene. You then participated in the restraint using a duvet and removed her from the room by her limbs. The restraint and removal was unnecessary and inappropriate. It was not a recognised technique, had a risk of physical and psychological harm, and compromised Patient F's dignity. The panel accepted that when you arrived in the room the decision had already been made to restrain and remove Patient F and was being led by a support worker. However, you followed the decision that had already been made, took an active role, and failed to question this decision or intervene. The panel considered that in doing so you failed in your professional responsibilities and duty of

care towards Patient F. It considered that your failures fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

The panel therefore found that your actions in respect of both charges 1 and 2 fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision on impairment

The panel next went on to decide if as a result of this misconduct your fitness to practise is currently 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. Nurses 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 judgement of Mrs Justice Cox in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) 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."

Mrs Justice Cox went on to say in Paragraph 76:

"I would also add the following observations in this case…as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

> 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 found that limbs (a), (b) and (c) were engaged in this case. Your actions put patients at a risk of harm and, in the case of Patient S, caused actual significant harm. You breached fundamental tenets of the nursing profession. This, in turn, brought the profession into disrepute.

The panel then moved on to consider whether you were likely to act in such a way in the future.

The panel noted that you have continued to work since these incidents. It had no evidence that there have been any further concerns about your practice. The agency you have been working for since 2015 confirms that that they have had no complaints. However, the panel also considered that there was very little evidence of how you have learned from the incidents, or how you have changed your practice as a result.

You provided training certificates to the panel, but these were mandatory training sessions from 2014 and 2015 relating to Basic First Aid and Moving and Handling, organised by your employer. It appears your Maybo training expired in January 2018. You did provide evidence that you had been invited to attend Prevention Management of Violence and Aggression training, but you were unable to attend due to the dates coinciding with this hearing. The panel considered that although you demonstrated some understanding that further training may help you better manage challenging situations in the future, and would be prepared to do this, it had no evidence that you had proactively tried to remediate your practice.

The panel did bear in mind that you are not represented. However, in the absence of any reflective piece or any testimonial from an author who was fully aware of these allegations, and preferably a professional colleague who has directly observed your practice, the panel could not be satisfied that you have in fact addressed the concerns arising from these two incidents.

In your submissions you told the panel that you have reflected on events and recognise where you went wrong. However, during your evidence you were unable to satisfactorily explain what you would do differently, if faced with similar situations. You spoke about the challenges and lack of support at Winterbourne View. The panel recognised that Winterbourne View was a dysfunctional and failing organisation with a culture of neglect and abuse. It also considered that it was unfortunate that this was your first experience of nursing after qualification. However, when you were asked what you would do if you found yourself in a similar environment, the panel was concerned by your answers. You

said you would whistleblow, but could not explain what this would involve or identify the relevant people or organisations that you would turn to.

The panel considered that you remain in a state of denial about your role and responsibilities as a registered nurse. The panel acknowledged the challenging culture and lack of support at Winterbourne View. However, it considered that this only increased your own individual responsibility. As a registered nurse you have a duty to protect and advocate for patients, for example, by intervening to prevent abuse of patients.

The panel considered that your oral evidence showed a profound lack of insight into your obligations as a member of the nursing profession. It was not satisfied that you had fully understood your professional responsibility to ensure you are equipped with the skills and knowledge you need for safe and effective practice.

Having regard to the above, the panel could not be satisfied that if you found yourself in a similar situation to charges 1 and 2, or in a poor and/or unsafe working environment, that you would not repeat the same mistakes again. You have been working unrestricted without incident for several years as an agency nurse. However, the panel had no evidence that you have developed full insight, learned from the incidents, and changed your practice as a result. It therefore considered that there remained a risk that in the future you may act in such a way as to put patients at unwarranted risk of harm, breach fundamental tenets of the profession, and bring the profession into disrepute.

It therefore concluded that a finding of current impairment is required on the ground of public protection.

The panel also bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining

public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The public must be able to trust that highly vulnerable patients who, by virtue of their conditions, may sometimes be challenging, will be safe and cared for by nurses who will keep their interests at the centre of decisions about their care. Furthermore, where organisations fail, or poor and abusive cultures are found, nurses have a vital individual professional responsibility to take action to ensure that the safety and care of patients is protected. The panel therefore considered that a finding of current impairment is required to uphold public confidence in the profession. To not make a finding of impairment would seriously undermine public confidence in both the profession and the regulator. It would also send a poor message to the profession about the standards expected of them.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Determination on sanction

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

In reaching this decision, the panel had regard to all the evidence that has been adduced in this case, together with the submissions of Ms Fleck, on behalf of the NMC, and those made by you.

Ms Fleck provided the panel with written submissions. In these submissions she outlined a number of aggravating factors. She submitted that your actions in respect of Patient S and Patient F were contrary to the duty of care held by registered nurses and raise fundamental questions about your suitability to remain on the register. She

therefore submitted that a striking-off order is the only sanction which would protect the public and satisfy the public interest in this case.

You addressed the panel. You said that nursing is a career that you have known for your entire adult life, and one which you find very fulfilling. You said that there have been no complaints about your practice since these incidents and, if the panel gave you the chance, you would continue to work to the standards that are expected of you.

The panel accepted the advice of the legal assessor, which included the cases of Langford v The Law Society [2002] EWHC 2802 (Admin) and Salvarajan v GMC [2008] EWHC 182 (Admin) in regard to the issue of delay. The panel bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel considered that the mitigating factors in this case were:

- Winterbourne View was your first job after qualifying and, in 2009 when the incident occurred with Patient S, you lacked experience;
- You were bitten by Patient S, who caused you pain and injury;
- There is some evidence that the in-house training you received may have been delivered inadequately;
- You have continued to work since the incidents without repetition;
- You have no previous disciplinary findings and these incidents are the first time you have been before your regulator.

The panel considered that the aggravating factors in this case were:

- The charges found proved relate to more than one incident;
- Both patients were particularly vulnerable;
- You were entrusted to carry out your role effectively and you had responsibility to ensure that you had the skills to do so;

- Your failure to intervene to prevent Patient F's mistreatment and abuse was a fundamental disregard of your professional responsibility to make the care and safety of Patient F your first concern;
- Your actions risked physical and psychological harm to Patient F, as well as a loss of her dignity;
- You used an excessive level of force which caused serious and long-lasting harm to Patient S;
- You have demonstrated a lack of insight and personal accountability into your actions and role in respect of both Patient S and Patient F;
- Despite the passage of time there is minimal evidence of ongoing training or meaningful attempts to address the particular deficiencies in your practice;
- You remain in denial against very clear expert evidence;
- You continued to work at Winterbourne View for four years when you say that you knew that management and staff were not equipped with the knowledge and skills to provide good and safe care;
- You have provided no evidence that you challenged the attitude and culture and poor care at Winterbourne View;
- You have not kept the agency that you currently work for fully informed about these NMC proceedings.

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.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the Sanctions Guidance, which 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 entirely inappropriate in

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. However the panel was of the view that a conditions of practice order would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The Sanctions Guidance indicates that a suspension order would be appropriate where (but not limited to):

- 'does the seriousness of the case require temporary removal from the register?
- will a period of suspension be sufficient to protect patients and the public interest?

This sanction may be appropriate where the misconduct is not fundamentally incompatible with continuing to be a registered nurse or midwife in that the public interest can be satisfied by a less severe outcome than permanent removal from the register. This is more likely to be the case when some or all of the following factors are apparent (this list is not exhaustive):

- 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 was mindful that you have continued to work as a registered nurse since these incidents. In this time, no further complaints have been made regarding your practice. Ordinarily at this stage, a registrant having worked safely for several years after an incident would be a factor weighing in their favour.

However, although you say that you have worked well as a nurse since these incidents, you have produced very little evidence of this. The only evidence was produced at a late stage from the Agency’s Office Manager, who is not aware of the charges or the panel’s findings of fact. You have not provided any evidence about your practice from a fellow registered nurse, or from anyone who is aware of these proceedings and the charges against you. You have completed very little training and no training relevant to the incidents involving Patient S and Patient F. After a number of years of opportunity for reflection and relevant training you remain unclear how you would manage the situations you were in if they occurred in the future. You remain in denial about the cause of Patient S’s injuries against very clear expert evidence from multiple witnesses.

The panel has had regard to its findings of fact in relation to Patient S and Patient F. Patient S suffered severe injuries which included dislodged teeth and an alveolar fracture. He now wears dentures as a result. The panel bore in mind the evidence it heard regarding the significant force required to cause such injuries. The panel considered that for a registered nurse to use such force on a patient, whatever the circumstances, was entirely unacceptable and ran directly contrary to the values of the nursing profession.

The panel also considered that your actions and omissions in relation to Patient F demonstrated a fundamental disregard for your professional responsibilities as a registered nurse. When you arrived in the lounge, you failed to challenge the decisions that had been made by your colleagues and continued to participate in an inappropriate

restraint and removal of Patient F. You did not make the safety or dignity of Patient F your first concern.

Taking all of the above into account, the panel decided that a suspension order would be insufficient to protect the public and would not satisfy the public interest. A suspension order, even for the maximum period of 12 months, would not reflect the seriousness of the force used on Patients S, nor the abdication of your responsibilities as a registered nurse to advocate for Patient F.

The panel considered that your actions were fundamentally incompatible with remaining on the NMC register. It therefore decided that the only sanction which would protect the public and satisfy the public interest is a striking-off order. Your actions were a serious departure from the expected standards and caused serious and long-lasting harm to Patient S. You also put Patient F at a risk of harm, compromised her dignity and violated her rights. Despite the significant passage of time, you have not demonstrated any real insight or remediation.

The panel also decided that this was necessary, not only to protect patients, but also to send a clear message to the nursing profession about the standards expected of them. Nurses are expected at all times to do no harm, act as advocates for their patients, and ensure that the interests of their patients are put first. This is never more important than in environments where cultures of abuse or neglect are found. In these situations, the safety net for safe and effective patient care is the professional responsibility held by all registered nurses to advocate for their patients and challenge poor practice. Poor culture can never outweigh or absolve a registered nurse's responsibility for their patients.

In all the circumstances, the panel decided that to allow you to continue to practise would seriously undermine public confidence in the profession and in the NMC as a regulatory body. It therefore decided that a striking-off order is the appropriate,

proportionate and necessary sanction. Nothing short of this would be sufficient in this case.

Determination on interim order

The panel considered the submissions made by Ms Fleck that an 18 month interim suspension order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

You made no submissions at this stage.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by the striking-off order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.