Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
28 – 31 March 2023, 3 – 6 April 2023, 17 – 19 April 2023, 21 – 27 April 2023, 14 – 15 September 2023, 6 October 2023, and 30 October – 2 November 2023

Virtual Hearing

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

Name of Registrant:	Odette Benatar
NMC PIN	10K0812E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – April 2012
Relevant Location:	Lancashire
Type of case:	Misconduct
Panel members:	Philip Sayce (Chair, registrant member) Janine Ellul (Registrant member) Alan Greenwood (Lay member)
Legal Assessor:	John Moir
Hearings Coordinator:	Taymeka Brandy (27 – 31 March 2023) Tyrena Agyemang (28 – 31 March 2023) Ruth Bass (17 – 19, 21– 27 April 2023, 14 – 15 September 2023, 2 – 3 October 2023 and 5 – 6 October 2023) Monsur Ali (30 October – 2 November 2023)
Nursing and Midwifery Council:	Represented by Julian Norman, Counsel instructed by the NMC
Ms Benatar:	Present and represented by James Halliday, Counsel instructed by the RCN
Facts proved by admission:	Charges 1a, 1b, 2a, 2b, 2c, 3a, 3b, 5
Facts proved:	4 in the alternative in respect of charge 2a
Facts not proved:	None

Fitness to practise:	Impaired
Sanction:	Caution order (18 months)

Details of charge

'That you, a registered nurse:

1. *On 29 December 2016:*
    a. *did not carry out, or record that you had carried out, a full assessment of Patient A;*
    b. *did not refer Patient A to a GP.*

2. *On 7 January 2017:*
    a. *did not carry out, or record that you had carried out, a full assessment of Patient A;*
    b. *did not put in place measures to assess the effectiveness of pain relief given to Patient A;*
    c. *did not escalate Patient A's symptoms to a GP.*

3. *On 8 January 2017:*
    a. *did not carry out, or record that you had carried out, any clinical assessment of Patient A;*
    b. *did not arrange an urgent GP appointment for Patient A.*

4. *Your actions at one or more of charges 1 to 3 above contributed to the death of Patient A or in the alternative the loss of a chance of survival.*

5. *On 30 May 2017 you administered warfarin to Patient B in the absence of a valid prescription*

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Norman, on behalf of the Nursing and Midwifery Council (NMC), pursuant to Rule 31, to allow the expert witness report provided to the inquest from Mr 1 and Mr 2's local and NMC witness statement into evidence. She submitted that both Mr Halliday and Ms Chestnutt had had sight of these documents and had agreed that this evidence should be admitted.

In relation to Mr 1's report, Ms Norman explained that the NMC had made efforts for Mr 1 to attend the hearing and adduce this evidence himself. However, his secretary had confirmed in an email dated 13 March 2023 that he was unable to attend the hearing. In response to him being asked whether he would be happy to answer questions for the purpose of this hearing in writing, he stated:

> *'The report was made with a comprehensive view of all available information. I am not a nurse and hence it would be wholly inappropriate for me to comment on the specific actions of a nurse. The opinion of a nurse expert would be far more appropriate.'*

Ms Norman submitted that the NMC have sought this report as it is fair and relevant information and that goes into considerable detail of the events that led up to Patient A's death. She submitted that it also supports Mr 1's witness statement which can be read alongside his report.

In relation to Mr 2's witness statement, Ms Norman submitted that Mr 2 made a contemporaneous statement in which he also exhibits a reflective account and reflective statement from you dated 28 July and 7 June 2017. She submitted that both Mr Halliday and Ms Chestnutt had had sight of these documents and had agreed that this evidence should be admitted, subject to some small redactions agreed by all parties.

Ms Norman invited the panel to consider the relevant principles as set out in the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) (*Thorneycroft*) when considering this application:

‘

(i) whether the statements were the sole or decisive evidence in support of the charges;

(ii) the nature and extent of the challenge to the contents of the statements;

(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;

(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;

(v) whether there was a good reason for the non-attendance of the witnesses;

(vi) whether the Respondent had taken reasonable steps to secure their attendance; and

(vii) the fact that the Appellant did not have prior notice that the witness statements were to be read.’

Ms Norman addressed the panel on the relevant factors in *Thorneycroft*. She submitted that Mr 1’s report and Mr 2’s witness statements were not sole and decisive evidence in support of the charges and that there was no challenge by either Mr Halliday or Ms Chestnutt to the content of this evidence. She submitted that neither party had made any suggestion of fabrication.

Ms Norman submitted that Mr 1 had explained in his correspondence to the NMC contained within the hearsay bundle, why he was unable to attend this hearing. She submitted that within the bundle there was also evidence of attempts made to try and

secure Mr 2's attendance. She submitted that both Mr Halliday and Ms Chestnutt had prior notice of this material and this application.

Ms Norman invited the panel to adduce the evidence of Mr 1 and Mr 2 as hearsay for the reasons set out above.

In response to the panel's question Ms Norman confirmed that Mr 2's witness statements were signed and dated.

Mr Halliday submitted that he made no objection to this application providing that the panel received the relevant advice and legal directions given in respect of hearsay evidence. He submitted that the evidence was fair and relevant and spoke to the issues in this case.

Ms Chestnutt, on behalf of Colleague 3, submitted that she made no objection to this application providing that relevant legal advice was given in respect of admitting hearsay evidence, particularly how Mr 1's evidence should be treated in these circumstances. She also submitted that Mr 2 may be able to assist with providing clarity in respect of some charges.

The panel heard and accepted the advice of the legal assessor which included reference to the relevant cases of *Thorneycroft* and *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin). This included that Rule 31 provides that, subject only to the requirements of relevance and fairness, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

In reaching its decision, the panel took the factors as set out in *Thorneycroft* in turn. It did not consider Mr 1 and Mr 2's evidence to be sole and decisive. The panel concluded that there was no suggestion of fabrication of the evidence in this matter. The panel accepted that Mr Halliday and Ms Chestnutt did have prior notice of this hearsay application and that they did not oppose this. The panel determined that the hearsay evidence should be admitted into evidence.

Decision and reasons on application to admit hearsay evidence

Ms Chestnut made an application for the hearing to be held partly in private on the basis that there would be reference to Colleague 3's health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Norman, on behalf of the NMC, and Mr Halliday, on your behalf, both supported 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.

Having heard that there will be reference to your health, the panel determined to hold parts of the hearing relating to Colleague 3's health, and the health of any other participants in private, so as to protect Colleague 3's right to privacy and the rights of any other participants.

Application to Adjourn the Hearing Until 17 April 2023

The panel heard an application from Mr Howarth on behalf of Colleague 3 to adjourn the hearing, as her original representative Ms Chestnut's father had passed away suddenly on 5 April 2023. Mr Howarth informed the panel that Ms Chestnutt would be unavailable for the foreseeable future, and invited the panel to adjourn the hearing in fairness to Colleague 3.

Mr Howarth was unable to confirm whether the adjournment was for a short period, until 17 April 2023 or for later in the future.

Ms Norman on behalf of the NMC, did not oppose the application in light of the circumstances. She invited the panel to consider the timetabling of the hearing as Ms

Chestnutt was due to go on Maternity Leave soon and therefore would not be available to represent Colleague 3 if the hearing resumed later in the year.

Ms Norman submitted that she and Mr Halliday had looked at the remaining time allocated to the hearing and were of the view that if the hearing ran smoothly, then it could be possible to finish the facts stage before the hearing went part heard.

Mr Halliday on your behalf agreed with the submissions of Ms Norman and confirmed that he was also of the opinion that the facts stage could be concluded in the remaining time allocated for this hearing.

The panel heard and accepted the advice of the legal assessor, which included reference to Rule 32(2) of The Rules.

The panel considered fairness to all parties, specifically Colleague 3 in that she would not have the benefit of her original counsel, Ms Chestnutt, or consistent representation if the application was not granted. The panel also bore in mind the impact the adjournment could have on you. However, in light of the circumstances, the panel concluded that it was fair to allow the adjournment application.

Background

The charges arose whilst you were employed as a Band 5 Nurse by HMP Garth (the Prison).

On 24 August 2015, Patient A was taken into custody at HMP Durham. On 31 March 2016 Patient A was transferred from HMP Durham to the Prison. Patient A underwent a medical review upon his arrival at the Prison. During his health screen he was found to have no physical health conditions and there were no outstanding medical appointments.

Patient A made his first complaint to the health care team on 18 May 2016, where he complained of having sharp abdominal pains and headaches on opening his bowels. He was booked for blood tests and a GP review.

On 31 May 2016, the Prison GP Dr 6 reviewed Patient A.

On 12 June 2016 Patient A complained of abdominal pain, rectal bleeding and vomiting and was seen by Mr 2. Clinical observations were recorded and a GP appointment was requested for the following day. However, Patient A was not seen by the GP the following day.

On 23 July 2016 Patient A experienced rectal bleeding overnight. Colleague 7 performed a full blood test and referred Patient A to a GP. Dr 8, a prison GP, recorded that the blood test results were borderline and noted that a repeat test was required in a week or so. There was no record of a repeat test taking place.

On 24 July 2016 Patient A was examined by a GP who found nothing unusual but severe piles. Patient A was referred to a colorectal specialist at hospital. An appointment was made for 11 October 2016 but was later cancelled by the hospital. Two further dates were offered to Patient A which were declined by the Prison. No dates were subsequently set.

On 6 November 2016 Patient A complained again to Colleague 7 of vomiting and chest pains. He said that he had experienced vomiting every night over the last month. Colleague 7 recorded that clinical observations and ECG undertaken were normal. Colleague 7 advised Patient A to rest and take fluids and recorded that Patient A should be seen by the GP the next day. Patient A was not seen by the GP the next day.

It is alleged that Wing officers approached Colleague 3 four days later and expressed concern that Patient A was still being sick. Colleague 3 examined Patient A and it is alleged that she recorded that his clinical observations were normal. Colleague 3 noted *'he has now been seen 3 times in a week and nil acute presentation or findings on either of the 3 appts'* Colleague 3 declined to issue Patient A with a sick note and

advised him to apply for a GP appointment. Colleague 3 recorded that Patient A had become agitated and that she opened the door and indicated he should leave.

On 24 November 2016 Patient A called again complaining of vomiting and nausea. His complaint of persistent vomiting had reached its 18th day since he had been by Colleague 4. Colleague 3 spoke to Patient A on the phone and told him to stay in his cell for 48 hours and use his cell bell if he needed anything.

On 2 December 2016 Dr 6 reviewed Patient A and recorded that he suspected a duodenal ulcer caused by H pylori bacteria. A stool sample was requested, and medication prescribed to reduce acid and prevent sickness.

On 7 December 2016 test results confirmed that Patient A did have H Pylori. On 16 December 2016, Dr 6 saw Patient A and started him on a seven-day course of triple therapy treatment. Dr 6 noted that he would review Patient A two weeks later if it had not settled.

On 29 December 2016, Patient A had a triage assessment over the phone due to continued vomiting, with you. You advised Patient A to stay in his cell for 48 hours, and to fast or light diet with plenty of fluids. There was no record of a follow up but later in the day an officer opened an Assessment Care in Custody Teamwork (ACCT) for Patient A recording that his health problems were causing him to contemplate self-harm or suicide.

On 30 December 2016, Patient A was a part of the ACCT process. A care map was drawn up with a Mental Health Nurse and prison chaplain. The Mental Health Nurse booked Patient A into the GP clinic for that Sunday as it was urgent, but that appointment was cancelled and rebooked to a regular GP clinic for 6 January 2017.

On 5 January 2017 Colleague 3 spoke to the prison officer on the wing by telephone after Patient A complained of pain in his side which was so bad he could not get out of bed. It is alleged that Colleague 3 told the prison officer that Patient A's complaint did not warrant an immediate GP review nor a visit to healthcare. It is further alleged that

Colleague 3 told the prison office that Patient A was to wait for his GP appointment and use his cell bell if necessary, and declared him fit for work.

On 6 January 2017 at a GP review, it was noted that the hospital had cancelled the appointment, that Patient A had lost 11.6kg total over the last 24 months, a history of pain, *"coffee grounds"* vomit after eating and blood in his stool. Patient A was referred to the gastroenterology service at hospital.

On 7 January 2017, you recorded that you were called to see Patient A as a Code Blue emergency. A Code Blue emergency radio code indicated that someone was unconscious or not breathing, and immediately alerts healthcare staff and control room to call an ambulance.

It is alleged that you attended Patient A and recorded that he had vomited and had chest pain, and that his blood pressure and pulse were high, but his other observations were normal. You gave Patient A paracetamol and advised him to drink water. Later that day, you made an entry adding that you got the impression that Patient A was drug seeking. At the interview into Patient A's death you described Patient A as looking as though he was in pain, hunched up, and tachycardic but justified the belated entry regarding drug seeking on the basis that Patient A's reaction to being offered paracetamol was unexpected.

On 10 January 2017 Patient A told an officer that he was in a lot of pain. Witness 10 continued his duties but within 15 minutes returned as other prisoners were banging on their cell doors reporting that Patient A was dying. Witness 10 observed Patient A bent over and complaining of pain and called a code blue emergency. Colleague 3 arrived with a student nurse and two officers joined Colleague 3 shortly after. Colleague 3 stated in interview that Patient A was on all fours on his bed and swore at her when she asked him to sit up. It is alleged that Colleague 3 exited from the cell and said she would not treat him while he was being aggressive.

Prisoners continued to express concern about Patient A and within an hour were refusing to attend work until Patient A was seen. Witness 9 spoke to Colleague 3 on the

phone and it is alleged that Colleague 3 refused to see Patient A because of his earlier behaviour. Witness 9 remained very concerned about Patient A's condition. Patient A was unable to walk at this point, so the officer and several prisoners carried him up two flights of stairs in a wheelchair before the officer wheeled him into the GP.

Dr 6 saw Patient A at short notice. Colleague 3 provided Dr 6 with a summary prior to the consultation. Dr 6 noted abdominal, back and shoulder pain, also the anxiety and ACCT. Dr 6 diagnosed psychogenic hyperventilation and prescribed antacid. Patient A never collected this.

On 11 January 2017 officers unlocked Patient A's cell as part of the usual morning procedure. Patient A was observed to be gasping for breath. An officer remembered what Dr 6 had said and encouraged Patient A to breathe through his nose to prevent hyperventilation. The officer said it seemed to help so he left to complete his rounds.

At 09:10, during the routine check Witness 9 could not open Patient A's cell door and realised that Patient A was lying on the floor restricting the door from opening. Witness 9 called another officer for help, and they called a Code Blue emergency and squeezed through the gap in the doorway. These officers found Patient A collapsed on the floor unresponsive. They were unable to find a pulse and so started cardiopulmonary resuscitation (CPR). A supervising officer arrived having heard the Code Blue, and reiterated on the radio it was a Code Blue requiring an ambulance.

Colleague 3 said that she heard a call for assistance but did not realise it was a code blue. It is alleged that after being wary of the previous day's events Colleague 3 requested assistance from you. While waiting with you for an officer near the wing, a prisoner approached and said that Patient A was not breathing. You said that it was a Code Blue and you did not have the emergency bag. You and Colleague 3 then set off to Patient A's cell after asking an HCA to collect the Code Blue emergency bag.

On your arrival at Patient A's cell, you could not find any signs of breathing or a pulse, and so continued CPR. Other staff then arrived with the emergency bag. CPR continued until the paramedics arrived. The resuscitation attempt was unsuccessful and at 09:57 Patient A was pronounced dead.

The post-mortem concluded the cause of death was peritonitis caused by a perforated duodenal ulcer. Mr 1 said that Patient A had likely had a duodenal ulcer for some time which had likely perforated closer to the date of Patient A's death. Toxicological tests confirmed that the only substances present were prescribed drugs at a therapeutic level which had played no role in Patient A's death.

It is alleged by the NMC, that your omissions from 29 December 2016 to 8 January 2017 were failures, and that these inactions contributed to the death or a loss of a chance of survival.

It is alleged by the NMC, that although you were not responsible for every failing in Patient A's history, you are responsible for your own failings as set out in the charges above, and that one or more of your alleged failings contributed to Patient A's death, or alternatively, to the loss of chance of survival.

It is also alleged that you administered warfarin in May 2017 to Patient B in absence of a valid prescription.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Halliday, who informed the panel that you made full admissions to charges 1, 2, 3 and 5 in their entirety.

The panel therefore finds charges 1, 2, 3 and 5 proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Norman on behalf of the NMC and by Mr Halliday on your behalf.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact

will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Mr 2: Healthcare Manager at HMP Garth
- Colleague 3: Band 5 Registered Nurse
- Witness 4: Death in Custody Clinical Reviewer
- Witness 5: Fatal Incidents Investigator
- Witness 9: Prison officer at HP Garth at the time of incident
- Witness 10: Prison officer at HP Garth at the time of incident
- Witness 11: Nursing expert witness

The panel also heard evidence from you under affirmation.

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

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

Charge 4

Your actions at one or more of charges 1 to 3 above contributed to the death of Patient A or in the alternative the loss of a chance of survival.

This charge is found proved in respect of charge 2a, in the alternative that your actions contributed to a loss of chance of survival.

In considering this charge it is helpful to first set out the panel's approach to the alternatives in charge 4.

When considering whether your actions or inactions *'contributed to the death of Patient A'* the panel had regard to the consideration that issues of causation ordinarily require the NMC to prove, on the balance of probability, that, but for a registrant's actions or inactions, the patient would not have died. It recognised that the charge, as framed, referred to your contribution to the death. Nevertheless, it considered that it would be unfair to hold that your actions or inaction contributed to the death of Patient A if a) he would have died even without your actions or inactions or b) that actions or inactions by other clinicians, for which you were not responsible, broke the chain of causation.

The panel was satisfied that the interventions of more senior clinicians, namely Dr 8 on 6 January 2017 and Dr 6 on 10 January 2017, were likely sufficient to break the chain of causation in relation to your prior actions and inactions. In any event the panel was not satisfied that an unbroken chain of causation had been proved. Accordingly, the panel was not satisfied that the first alternative in charge 4 had been proved.

When considering whether your actions or inactions *'contributed to the loss of a chance of survival'* in respect of Patient A*,* the panel considered that it had to be satisfied firstly that, at any point in time they were considering, there was a real and substantial chance that Patient A would have survived, and secondly the NMC has to show, on the balance of probabilities, that your actions or inactions contributed to the loss of that chance of survival.

The panel was aware that there were numerous potential factors which may have contributed to the loss of a chance of Patient A's survival, not least the lack of resources and health care staff at the prison in addition to the actions or inactions of other sometimes more senior healthcare providers. The panel considered that it would be unfair to hold that your actions or inactions contributed to the loss of chance of survival unless there was a sufficiently clear nexus in time and connection, between your actions or inactions and Patient A's death.

The panel accepted the hearsay evidence of Mr 1, which was not challenged by any party, that the fatal stage of septic shock was likely to have occurred overnight on 10 January/early hours of 11 January 2017. Accordingly, the panel was satisfied that, by that point, Patient A did not have a real and substantial chance of survival.

With regard to charges 1a and 1b, the panel noted that the relevant consultation had taken place at least two weeks before the death of Patient A, and the focus of the consultation was in relation to Patient A's complaint concerning piles. The panel therefore was not satisfied that there was a sufficient nexus between the time and the connection to Patient A's death to satisfy that your inactions contributed to the loss of a chance of survival. The panel was also satisfied that there was insufficient connection between the presenting symptoms at that consultation and the eventual cause of death of Patient A.

With regard to charge 2a, the panel found that there was a contribution to a loss of chance of survival as a result of your inactions on 7 January 2017. The panel decided that you had a duty as the nurse to carry out a full assessment. You told the panel that you had carried out observations of Patient's A's heart rate and blood pressure and the results were outside of the normal limits. In your evidence you stated that you noted there were abnormalities with regard to Patient A being tachycardic (high pulse rate). You attributed this to him being in distress as a result of his pain despite noting in his records that he had pain across his chest and a recent code blue call out to his cell. The panel determined that you had a duty to go back and check whether your assumption was correct for Patient A's abnormal observations and chest pain. You were now aware of Patient A's ulcer issues and should have called on Patient A for a fuller assessment.

The panel also noted that, at the time of inputting your note you had access to Patient A's medical records which included reference to the history of *"coffee ground"* vomit and that his pain appeared to have objectively worsened in that he was squatting on the bed whereas the day before he had some generalised discomfort. The panel found that there was a duty on you at this stage to undertake a full assessment of Patient A which you failed to do. It found that by you not carrying out a full assessment at this stage contributed to a loss of chance of survival for Patient A. By not measuring or fully assessing Patient A, there was no objective measure for Patient A's condition against which previous or future readings could be compared. Due to the absence of a full assessment being undertaken or recorded by you, there was no way of accurately assessing Patient A's deterioration.

With regard to charge 2b the panel was of the view that the omission by you to not put in a place measures to assess the effectiveness of pain relief given to Patient A did not capture the mischief of what may have led to a loss of chance of survival of Patient A. The panel determined there was insufficient connection between effectiveness and pain relief and the cause of Patient A's eventual death. The panel concluded that the mischief was captured within charge 2a, and not by charge 2b.

With regard to charge 2c the panel was of the view that the symptoms observed by you namely, the one time recording of pulse and blood pressure without a full assessment, would not have led to an effective escalation, and as such did not contribute to the potential loss of Patient A's chance of survival.

With regard to charges 3a and 3b, the panel accepted that Patient A's presentation of symptoms on 8 January 2017 was three days before his death. However, the panel accepted that Patient A was consulting with another clinician, who had simply asked you to administer pain relief to Patient A. The panel accepted your evidence that you were engaged in another clinic and determined that, having not conducted the consultation of Patient A, it would not be fair to place the burden of undertaking a clinical assessment and escalating Patient A for an urgent GP appointment on you.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

Ms Norman reminded the panel that the question of impairment involves a two-stage test and the panel first has to be satisfied that the facts proved amount to serious professional misconduct. Only if the panel is satisfied of that, can it go on to consider whether your fitness to practise is currently impaired.

With regard to the question of misconduct, Ms Norman reminded the panel of the decision of the High Court in *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a: *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Norman drew the panel's attention to the following provisions of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the

Code). She submitted that that the following provisions of the Code have been breached:

> ***'1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> *1.1 treat people with kindness, respect and compassion*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***2 Listen to people and respond to their preferences and concerns***
>
> ***4 Act in the best interests of people at all times***
>
> ***7 Communicate clearly***
>
> ***10 Keep clear and accurate records relevant to your practice***
>
> ***13 Recognise and work within the limits of your competence***
>
> *To achieve this, you must:*
>
> *13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care'*

Ms Norman submitted that the facts found proved amount to misconduct on the grounds of public protection and also otherwise in the wider public interest.

Mr Halliday submitted that you accept that your behaviour amounted to misconduct.

Submissions on impairment

Ms Norman moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of

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

Ms Norman submitted that your fitness to practise is currently impaired on the grounds of public protection and also otherwise in the wider public interest. She said, in terms of public interest, the panel has found that your conduct had contributed to the loss of a chance of survival, which is a serious charge which could damage public confidence in the profession were it not to find impairment.

Ms Norman said, in terms of public protection, you did accept the charges against you but she submitted that there is a risk of repetition of your misconduct. She said that in your own evidence as provided to the panel, you said you could not think you would do anything differently which reflects a failure to appreciate the seriousness of the charges and very limited, if any, insight into the care you provided to Patient A. She said that your care fell short of what is reasonably expected of a registered nurse.

Ms Norman invited the panel to consider whether your conduct fell below the standards expected of a registered nurse. She said that despite the fact that you have been practising for over six years since the incidents in question without issue, part of that delay was due to the inquest in this case. She submitted that the inquest is the reflection of the seriousness of the charges rather than delay in the proceedings. Ms Norman said that the panel may take into account that someone who is facing these ongoing proceedings may be on their best behaviour. She submitted that the evidence before the panel demonstrates that there were repeated failures in your care and unreasonable risks were taken. Ms Norman submitted that the evidence shows that there remains a risk of repetition and invited the panel to find impairment on the grounds of public protection.

Mr Halliday submitted that you are not currently impaired in your fitness to practise and that you are currently fit and safe to work as a nurse. He said that although a patient had tragically died in government facilities and there was a subsequent inquest, this itself does not indicate seriousness of your action in this case. Mr Halliday submitted

that it is clear from the evidence that there were numerous opportunities for senior clinicians to step in and avoid Patient A's death.

Mr Halliday submitted that although there are failings on your part, there is context which is extremely important when assessing if someone is impaired. He submitted that this is a case where there is a serious outcome, but your fitness is not impaired because you have reflected on the situation at length. He reminded the panel that you said during your evidence that if you could do anything differently you would have done it. He said that this incident has had a serious effect on you. He further submitted that you are still conscious of the outcome for Patient A seven years on and your role in the eventual outcome, and this shows you have reflected deeply and that you are an exemplary nurse.

Mr Halliday told the panel that you have undertaken numerous training courses to strengthen your practise and you accept that there were shortcomings in your care of Patient A, which you have addressed through deep reflection, undergoing training and your continued awareness of the errors you made.

Mr Halliday submitted that the most recent testimonials before the panel show that you have been practising well for nearly seven years without restrictions and there have been no concerns raised. He said this adds weight to his submission that your fitness to practise is not currently impaired.

Mr Halliday submitted that the public would not be concerned if a panel returned a finding of no impairment on public interest ground for a nurse who has been practising for seven years since the incidents in question, has reflected deeply on the shortcomings in your practice, taken steps to remediate the concerns and expressed genuine remorse for what happened. Further, he said that it will be a loss to the nursing profession if your fitness to practise was found to be impaired, and as a result, restricted from practising and serving the public. He therefore invited the panel to find you not currently impairment on the ground of public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin) , and Cohen v GMC [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that 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:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

10 Keep clear and accurate records relevant to your practice

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

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

20 Uphold the reputation of your profession at all times

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel noted that your actions in charges 1, 2, 3b and 4b did fall below the standards expected of a registered nurse but are not so serious in the circumstances of this particular case as to amount to misconduct. However, it was of the view that charges 2a and 4 are so serious that they individually amounted to professional misconduct.

The panel, therefore, determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, 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. To justify that trust, 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 judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

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

The panel finds limbs a-c are engaged. Your misconduct had breached the fundamental tenets of the nursing profession and had brought the reputation of the profession into disrepute. The panel finds that a patient was put at risk of unwarranted harm as result of your misconduct.

Regarding insight, the panel took into account the training you have undergone and it is of the view that the training demonstrates you have strengthened your practice. Further, the panel considered your reflective piece and determined that you have developed a deep insight into your failures and are able to apply it to both the charges that have been found proved. The panel considered the following paragraphs from your reflective piece in relation to your insight:

‘I have since considered the barriers to communication there can be and the lack of trust or feelings of frustration of talking but not being 'heard' and I have endeavoured in my subsequent practice to bring all this to my care to make me a more rounded practitioner, I hope. Certainly, it is an ongoing process and my memory of patient A continues to inform and loom large in that process along with everything else.’

‘Over the years since patient A's death and particularly since I was first made aware of issues of this fitness to practice hearing and the inquiry into the death of patient A which was some 18 months after his death, I have thought long and hard about my actions and reflected on it. I have particularly focussed on my documentation which I realise was far short of ideal. But I have realised that whilst I thought I was doing the right thing in regards to what or how I documented…’

Having taken all of the above into consideration, the panel determined that your fitness to practise had been strengthened as a result of your reflection and training. It determined that the risk of repetition of your misconduct was extremely low. Accordingly, the panel determined that your fitness to practise was not currently impaired on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest ground is required because it considered that your misconduct in charges 2a and 4 to be very serious. The panel determined that the public would be concerned if there were no finding of impairment on the ground public interest. The panel concluded that it is important to mark the seriousness of your misconduct, and to send out a clear message to other professionals and to the public that this type of behaviour is unacceptable.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired only on the ground of public interest.

Sanction

The panel considered this case very carefully and decided to make a caution order for a period of 18 months. The effect of this order is that your name on the NMC register will show that you are subject to a caution order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Ms Norman informed the panel that in the Notice of Hearing, dated 27 February 2023, the NMC had advised you that that it would seek the imposition of a suspension order if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that a caution order is more appropriate in light of the panel's findings.

Ms Norman submitted that the aggravating features in this case are: the serious nature of the misconduct and that the conduct increased the risk of harm to the patient. She said the mitigating features are that: you seem to have a deep understanding of your failures; and you have developed insight into your misconduct.

Ms Norman submitted that the loss of chance of survival allegation that the panel found proved, is a very serious charge and does have the potential to damage public confidence and the trust in the nursing profession. She submitted that the appropriate sanction in this case would be a caution order with a period reflecting the damage to

public confidence and trust in the profession. She said that the appropriate period would be five years.

Mr Halliday asked the panel to consider reasonableness and proportionality when it comes to assessment of this case. He said that the panel should bear in mind that the protection of the public is the primary concern when it comes to sanction.

Mr Halliday reminded the panel that it had determined that your fitness to practise is impaired solely on the ground of public interest. He stated that he acknowledged the aggravating and mitigating features outlined by Ms Norman, and added that the panel should consider the impact of delay when determining any sanction and this is a key mitigating feature.

Mr Halliday stated that when considering proportionality in this case, if a caution order is imposed for five years, as proposed by the NMC, then it would mean that the case concluded 12 years after the event, which would be unduly punitive. He said that what happened in relation to Patient A plays a part in your daily practice and you continue to apply the lessons learnt in your nursing role.

Mr Halliday submitted that any sanction, even a caution order, would have an impact on your current role and it is not clear whether you could keep your job in light of a caution. However, you work 60 hours a week and a cover could not be found for the work you provide. He asked the panel to consider the harm that could come to the public if you were to be restricted in your practice.

Mr Halliday submitted that it is clear that you are not a risk to the public and you have remediated and strengthened your practice, therefore the panel could make a decision to take no further action. He said, if the panel does determine that an order is necessary then, it should consider the imposition of a caution order for a period of one year or close to a year, rather than five years as proposed by the NMC.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Serious nature of misconduct
- Actual harm caused to a patient

The panel also took into account the following mitigating features:

- Developed sufficient insight
- Strenghtened your practice
- No repetition of the misconduct

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 SG, 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 determined that you have shown sufficient insight into your misconduct. The panel noted that you acknowledged your failures, expressed remorse and deeply reflected on your shortcomings. The panel heard that you are doing well in your current role and have been doing so for nearly seven years without any concerns about your practice being raised.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. The panel concluded that no useful purpose would be served by a conditions of practice order. It is not necessary to protect the public and would not assist your return to nursing practice. The panel further considered that a suspension order would be wholly disproportionate in this case.

The panel has decided that a caution order would adequately address the wider public interest. For the next 18 months your employer - or any prospective employer - will be on notice that your fitness to practise had been found to be impaired and that your practice is subject to this sanction. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of 18 months would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered nurse.

The panel took into account the delay in these proceedings since the events in question amounted to over seven years. These proceedings have been hanging over you for this entire period. The panel considered that it was appropriate to mark the punitive effect of that delay in modifying the length of the order that it has imposed.

At the end of this period the note on your entry in the register will be removed. However, the NMC will keep a record of the panel’s finding that your fitness to practise had been found impaired. If the NMC receives a further allegation that your fitness to practise is impaired, the record of this panel’s finding and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to you in writing.

The panel considered that it was important for a proper understanding of the circumstances that led to the death of Patient A, to note that he had been subjected to

systemic failings by the prison health service and that your failings were only a part of the much wider picture.

That concludes this determination.