Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 6 August 2024 – Wednesday, 14 August 2024

Virtual Hearing

Name of Registrant:	**Lorna Dale Willis**	
NMC PIN	08G1287E	
Part(s) of the register:	RNC: Children's nurse, level 1 (5 March 2009)	
Relevant Location:	Kent	
Type of case:	Misconduct	
Panel members:	Rachel Onikosi	(Chair, lay member)
	Rashmika Shah	(Registrant member)
	Gill Mullen	(Lay member)
Legal Assessor:	Alain Gogarty	
Hearings Coordinator:	Max Buadi	
Nursing and Midwifery Council:	Represented by James Edenborough, Case Presenter	
Mrs Willis:	Not present and not represented	
Facts proved:	Charges 1, 2, 3, 4, 5, 6, 7, 8 and 9	
Facts not proved:	None	
Fitness to practise:	Impaired	
Sanction:	Suspension order with a review (12 months)	
Interim order:	Interim suspension order (18 months)	

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Willis was not in attendance and that the Notice of Hearing letter had been sent to Mrs Willis's registered email address by secure email on 3 July 2024.

Mr Edenborough, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Willis's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In light of the information available, the panel was satisfied that Mrs Willis has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Willis

The panel next considered whether it should proceed in the absence of Mrs Willis. It had regard to Rule 21 and heard the submissions of Mr Edenborough. He drew the panel's attention to an email Mrs Willis sent to the NMC, dated 30 July 2024, which stated:

> *"…Unfortunately I will not attend the hearing and I would like the hearing to proceed in my absence. I will send a document to present to the hearing panel shortly. Please let me know when you receive it."*

Mr Edenborough informed the panel that the email was the response to the concerns from Mrs Willis which they had received in addition to another document entitled "Registrant Response Bundle".

Mr Edenborough submitted that there had been no request for an adjournment today as Mrs Willis had requested the hearing proceed in her absence. He therefore invited the panel to continue in the absence of Mrs Willis.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Willis. In reaching this decision, the panel has considered the submissions of Mr Edenborough, the representations from Mrs Willis, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Willis sent an email to the NMC, dated 30 July 2024, stating that she would like the hearing to proceed in her absence;
- No application for an adjournment has been made by Mrs Willis;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Mrs Willis had sent written representations responding to the charges for the panel's consideration;
- Two witnesses have attended today to give live evidence;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Willis in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Mrs Willis at her registered email address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies or weaknesses in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Willis's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide live evidence.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Willis. The panel will draw no adverse inference from Mrs Willis's absence in its findings of fact.

Details of charge (as amended)

That you, a registered nurse, during a night shift on 1-2 August 2022:

1. Slept on duty, which was not permitted.
2. Between 12 midnight and 6am did not reposition Patient A.
3. Failed to check patient A's tracheostomy site and/or tapes.
4. Between 10pm and 6:20am failed to reposition patient A's saturation probe.
5. Failed to maintain visual observation of Patient A.
6. Failed to check on patient A's continence.

7. Left patient A in soiled clothing/bedding and/or a wet towel when they had soiled themselves.
8. Documented that you had repositioned Patient A's saturation probe when you had not.
9. Your conduct in charge 8 above was dishonest in that you represented that you had repositioned Patient A's saturation probe when you knew you had not.

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

Background

Mrs Willis was working a waking nightshift on the night of 1 and 2 August 2022. Mrs Willis had worked numerous shifts at the home of Patient A – a child with complex health needs who communicated using sign language. These needs included 24 hour ventilation, tracheostomy care, suction via artificial airway, repositioning, enteral feeding, cough assistance and full personal care.

Unity Care Solutions ("the Agency"), the agency through whom Mrs Willis was booked for the shift in question, received a complaint from Patient A's father. This prompted Witness 1, the Coordination Team Leader at the agency, to review the footage from the CCTV positioned in Patient A's bedroom. She is alleged to have observed Mrs Willis sleeping with a mask over her eyes, leaving Patient A unmonitored, failing to respond to Patient A being incontinent of urine and failing to reposition the saturation probe. Witness 1 is also alleged to have seen that Mrs Willis had failed to reposition Patient A throughout the shift. It had also been alleged that Mrs Willis had documented that she had repositioned Patient A's saturation probe, however it is the NMC's position that this was not the case.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Edenborough, on behalf of the NMC, to amend the wording of charge 4.

Mr Edenborough submitted that the proposed amendment was to accurately state the time within the charge.

<u>Proposed amendment</u>

That you, a registered nurse, during a night shift on 1-2 August 2022:

4. Between 10pm and ~~620am~~ **06:20am** failed to reposition patient A's saturation probe.

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

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

Decision and reasons on facts

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 Mr Edenborough on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mrs Willis.

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:

- Witness 1: Coordination Team Leader at Unity Care Solutions;
- Witness 2: Nurse Case Manager at Unity Care Solutions.

Before making any findings on the facts, the panel heard closing submissions from Mr Edenborough. It also heard and accepted the advice of the legal assessor.

The panel took account of the NMC guidance entitled “Evidence” (reference: DMA-6) and the guidance entitled "Making decisions on dishonesty charges and the professional duty of candour” (reference: DMA-8).

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

Charge 1

That you, a registered nurse, during a night shift on 1-2 August 2022:

1. Slept on duty, which was not permitted.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and written representations from Mrs Willis.

The panel decided to first establish whether sleeping on duty was permitted. Witness 1 in her witness statement stated that the Integrated Care Board (ICB), who commissions service from the Agency, had:

> *"…assessed the patient's care needs and concluded that they needed their carer to be awake for the duration of the night shift."*

The panel also bore in mind that Mrs Willis was working a "waking night shift" which Witness 1, in her witness statement, defined as:

> *"A waking nightshift means that the nurse stays awake the whole night. The staff member has to be awake with their eyes open for the duration of that shift…"*

Witness 1, in her witness statement, also confirmed that all nurses would have known that they would have been working a night shift because they would "*sign a document setting out the client's needs prior to beginning a care package with a new patient…"*

The panel took account of the "Staff Working Nights Policy" referred to in Witness 1's witness statement. Under the sub-heading entitled "Safeguarding" it stated:

> *"In order to promote the safeguarding and protection of the service user, the holder of this post is subject to summary dismissal if found to be absent, or for waking night staff, asleep whilst on duty…"*

In light of the above, the panel was satisfied that sleeping on duty was not permitted.

The panel then went on to consider if Mrs Willis had in fact fallen asleep whilst on duty on the night shift on 1 to 2 August 2022.

The panel took account of the meeting minutes from Witness 1's investigation with Mrs Willis undertaken on 16 September 2022. It bore in mind that Witness 1 stated that she could not determine whether Mrs Willis was asleep or awake.

Mrs Willis, in an undated written response to this charge, stated:

> *"I was not asleep although my eyes were covered by my face mask or when my back was turned to the child. I had explained to the agency when they had their internal interview that I had my ear bud in one ear listening to my ipad. However, from this action and further reflections I fully understand that I was wrong and why it gave them cause to be concerned although at the time I felt I did nothing wrong and I did not consider how my behaviour and lapse of judment could be seen by others at the time as unprofessional." [sic]*

The panel bore in mind that Witness 1, in her oral evidence, stated that having an ear bud and listening to an iPad was allowed, however the nurse on shift had to stay awake.

The panel took account of the CCTV footage (10 hours) which the panel watched in its entirety of the night shift on 1 to 2 August 2022. It noted that at certain points in the CCTV footage, Mrs Willis appears to be sitting calmly on a chair next to Patient A while wearing a mask covering her eyes. It also noted that at numerous times, Mrs Willis' head drops and then appears to suddenly jerk upright. It also noted that at times, Mrs Willis was not in control of the chair she was sitting on as it appeared to be moving around.

The panel considered that Mrs Willis would have known she was not permitted to sleep while on duty. It also noted that Mrs Willis in her written response denied that she was asleep. However, the panel was of the view that if Mrs Willis was awake, she would be able to keep her head upright, have her eyes open and be in control of the chair she was sitting on. It concluded that this was because Mrs Willis was not fully alert.

The panel was satisfied that it could infer from the CCTV footage that at times during a night shift on 1 to 2 August 2022, Mrs Willis was in a light sleep.

In light of the above, the panel was satisfied that, on the balance of probabilities, during a night shift on 1 to 2 August 2022, Mrs Willis slept on duty, which was not permitted.

The panel therefore found this charge proved.

Charge 2

That you, a registered nurse, during a night shift on 1-2 August 2022:

2. Between 12 midnight and 6am did not reposition Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and written representations from Mrs Willis.

Witness 1, in her witness statement, stated:

> *"Mrs Willis didn't change the patient's position. For the patient's airway and breathing, Mrs Willis was required to maintain a visual of the patient at all times. As her face was away and/or covered by a mask, she would not have seen the signs that the patient makes when he needs his position to be changed."*

Witness 2 in her witness statement stated

> *"Patient A does not have any independent mobility. He is dependent on those caring for him to reposition him regularly and in accordance with his wishes. Mrs Willis would have had to reposition Patient A at his request regularly overnight to*

aid his comfort, reduce the risk of skin pressure damage and to ensure that his positioning does not compromise his airway or ventilation tubing."

Witness 2 in her oral evidence stated that she would have expected Patient A to be repositioned every two to three hours, even if he had not requested it.

Mrs Willis, in an undated written response to this charge, stated that Patient A had been repositioned at the start of the shift, which the panel noted would have been sometime between 22:00 and 00:00. However, it noted that Mrs Willis, within her written response, did not appear to have addressed the charge directly.

The panel took account of the CCTV footage of the night shift on 1 to 2 August 2022. It noted that between 00:00 and 06:00 Mrs Willis could not see Patient A because she was facing the wall for a significant period of time. It also bore in mind that it had already determined in charge 1 that at periods during the shift, Mrs Willis had an eye mask on and did not appear to have sight of Patient A.

The panel also noted that the CCTV appeared to support Witness 1's witness statement as Mrs Willis was not able to see any signs by Patient A that could indicate that his position needed to be changed.

The panel was satisfied from its viewing of the CCTV footage that at no point between 00:00 and 06:00 had Mrs Willis repositioned Patient A.

The panel therefore found this charge proved.

Charge 3

That you, a registered nurse, during a night shift on 1-2 August 2022:

3. Failed to check patient A's tracheostomy site and/or tapes.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and written representations from Mrs Willis.

In order to find this charge proved, the panel had to be satisfied that Mrs Willis had a duty to check Patient A's tracheostomy site and/or tapes during the shift on 1 to 2 August 2022. The panel took account of Patient A's care plan. It noted that in various parts of the care plan, under the sub-heading "Plan of Care" in relation to the tracheostomy site, the following are stated:

> *"Staff are to ensure my skin around my tracheostomy site and under my tapes are clean, dry and to help treat any redness or sore areas."*
>
> *"Staff should watch me closely for difficulty in breathing or other signs that my tracheostomy tube could be blocked or has come out."*
>
> *"I sometimes need tape changes more regularly than daily due to excessive secretions."*

Additionally, under the sub-heading "Problem/Need", in the section entitled "Airway/Breathing", it stated *"It is not uncommon for my tubing to disconnect from my tracheostomy."*

Witness 2 in her witness statement stated:

> *"Tracheostomy care – Staff should check the tracheostomy to ensure that it is in situ, patent and secure. Staff are to ensure that the expiratory port (otherwise known as an exhalation valve) is not covered. If this was covered it could pose a risk of harm to Patient A as expiratory gases would remain in the ventilator circuit."*

In light of the above, the panel was satisfied that Mrs Willis had a duty to check Patient A's tracheostomy site and/or tapes during the shift on 1 to 2 August 2022. In light of this, the panel then went on to consider whether Mrs Willis had failed in her duty check Patient A's tracheostomy site and/or tapes.

Witness 1, in her written record of her review of the CCTV footage dated 15 August 2022, highlighted the following as an "Area of concern". She stated:

> *"Tracheostomy- the tapes on this appear not to have been checked, they need to be checked to ensure that they are of a correct tension to reduce risk of decannulation. His tracheostomy site was not visible to the staff member during the shift as she had her back to him therefore, she was not able to visually monitor the client to ensure that his airway stayed patent and in situ. It appears that she only responds to the client when his equipment alarms."*

The panel bore in mind that Witness 2, in her oral evidence, stated that tracheostomy tapes should be checked for the correct tension and explained that there should be a "finger sized space" between the tape and the patient's neck.

The panel took account of the CCTV footage of the night shift on 1 to 2 August 2022. It could not determine whether Mrs Willis checked the Patient A's tracheostomy site and/or tapes.

The panel noted that Mrs Willis acknowledged that she did not follow the correct procedure as stated by Witness 2. In an undated written response to this charge, Mrs Willis stated:

> *"Tracheotomy tapes were visually checked although I did not use my fingers to determine that on this occasion. I could clearly see that they were secured and had the right tention on… I understand and fully accept that I did not use my fingers to*

determine the tention of the tracheotomy tapes and I apologise for not adhering to the right procedures” [sic]

The panel determined that because Mrs Willis did not adhere to the correct procedure pertaining to check patient A’s tracheostomy site and/or tapes, she had failed in her duty to do so.

The panel therefore found this charge proved.

Charge 4

That you, a registered nurse, during a night shift on 1-2 August 2022:

4. Between 10pm and 06:20am failed to reposition patient A’s saturation probe.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and written representations from Mrs Willis.

In order to find this charge proved, the panel had to be satisfied that Mrs Willis had a duty to reposition patient A’s saturation probe during the shift on 1 to 2 August 2022. The panel noted that Patient A’s care plan did not appear to specifically mention repositioning Patient A’s saturation probe. However, witness 2 in her witness statement stated:

> *“Moving the saturation probe every 4 hours is standard practice and staff are reminded of this in training. Detrimental results from this not being completed depend on the individual patient’s skin integrity – it could result in anything from minor redness to blisters. No damage was reportedly caused in this case.”*

In light of the above, the panel was satisfied that Mrs Willis had a duty to reposition patient A's saturation probe during the shift on 1 to 2 August 2022. In light of this, the panel then went on to consider whether Mrs Willis had failed in her duty to reposition patient A's saturation probe between 22:00 and 06:20.

Witness 1, in her written record of her review of the CCTV footage dated 15 August 2022, highlighted the following as an "Area of concern". She stated:

> *"Saturation probe not moved for the duration of shift- this should be repositioned ever 4 hours as the sensor can cause burns to skin, staff member has written that this had been repositioned, but this was not observed on the CCTV."*

The panel took account of the CCTV footage of the night shift on 1 to 2 August 2022. It noted that at no point between 22:00 and 06:20 did Mrs Willis reposition patient A's saturation probe.

The panel noted that Mrs Willis appeared to accept the charge. In an undated written response to this charge, Mrs Willis stated:

> *"Saturation Probe, I had fully admitted that I thought I had repositioned the child saturation probe but unfortunately I did not do so."*

In light of all the above, and the CCTV footage, the panel concluded that Mrs Willis had failed in her duty to reposition Patient A's saturation probe.

The panel therefore found this charge proved.

Charge 5

That you, a registered nurse, during a night shift on 1-2 August 2022:

5. Failed to maintain visual observation of Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and written representations from Mrs Willis.

In order to find this charge proved, the panel had to be satisfied that Mrs Willis had a duty to maintain visual observation of Patient A during the shift on 1 to 2 August 2022.
The panel took account of Patient A's care plan. It noted that in various parts of the care plan, under the sub-heading "Plan of Care" in relation to the tracheostomy site, the following is stated:

> *"Please ensure you always have a visual and reconnect tubing immediately as needed."*

Witness 2 in her witness statement stated:

> *"Patient A generally communicates through signing therefore it is important that staff can see him at all times to ensure that they are able to respond appropriately to his wishes."*

In light of the above, the panel was satisfied that Mrs Willis had a duty to maintain visual observation of Patient A during the shift on 1 to 2 August 2022. In light of this, the panel then went on to consider whether Mrs Willis had failed in her duty to maintain visual observation of Patient A.

Witness 1, in her written record of her review of the CCTV footage dated 15 August 2022, highlighted the following as an "Area of concern". She stated:

"[Mrs Willis] had her back to the client for a significant amount of time during the shift, appears to be asleep, mask positioned over eyes and on one occasion also puts on dark glasses.

The client uses signing as his form of communication so therefore you need to be able to always see him visually to enable him to communicate his needs."

The panel took account of the CCTV footage of the night shift on 1 to 2 August 2022. It was of the view that it supported the notes Witness 1 had made. It noted that Mrs Willis did have her back to Patient A for a significant period of time during the shift.

The panel noted that Mrs Willis appeared to accept the charge. In an undated written response to this charge, Mrs Willis stated:

"Maintaining observation of patient at all time. I fully understand and I took responsibility of having my back to the child… I also stated that I was not aware that my eyes should be constantly on the child. Which after further relections I looked at my behaviour and saw that it was wrong of me and I should have have followed his care plan more closely." [sic]

The panel also reminded itself that when considering charge 1, it had noted during the shift, the CCTV footage showed that Mrs Willis appeared to be asleep with an eye mask on.

In light of the above, the panel determined that at times Mrs Willis did not maintain visual observation of Patient A. The panel therefore concluded that she had therefore failed in her duty to do so.

The panel therefore found this charge proved.

Charge 6

That you, a registered nurse, during a night shift on 1-2 August 2022:

6. Failed to check on patient A's continence.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and written representations from Mrs Willis.

In order to find this charge proved, the panel had to be satisfied that Mrs Willis had a duty to check on patient A's continence during the shift on 1 to 2 August 2022. The panel took account of Patient A's care plan. It noted that one of the aims of the care plan was for Patient A to be *"comfortable and dry".* Under the sub-heading "Plan of Care" it stated:

> *"Staff should check my nappy regularly overnight BUT only if absolutely necessary as it disturbs him. If I do not need changing my parents would prefer it if I was left asleep."* [sic]

Witness 2 in her witness statement stated:

> *"Patient A may need his pad changed overnight if he has passed urine or opened his bowels. Patient A's pad requires checking regularly overnight."*

In light of the above, the panel was satisfied that Mrs Willis had a duty to check on Patient A's continence during the shift on 1 to 2 August 2022. In light of this, the panel then went on to consider whether Mrs Willis had failed in her duty to check on Patient A's continence.

Witness 1, in her written record of her review of the CCTV footage dated 15 August 2022, highlighted the following as an "Area of concern". She stated:

"Pad area- this area was not checked during the night and it was only noted around 6.20am that his bed sheets were wet as he did not have a pad on during the night, he first urinated around 1.20am then again at 1.40am, therefore he had been laying in on wet bedding and wet clothing for a significant length of time, this can cause a breakdown in his skin, moisture associated skin damage, as there was a fan on in his room he could also be at risk of him getting a chill."

The panel took account of the CCTV footage of the night shift on 1 to 2 August 2022. It noted that during the early hours of the morning, a dark wet patch can be seen on the bedding of Patient A. It was clear to the panel that Mrs Willis only became aware that Patient A had become incontinent until much later towards the end of her shift. The panel particularly noted when Mrs Willis removed the bed covers, she raises her hands which appeared to suggest that she was surprised at what she had seen.

The panel noted that Mrs Willis appeared to accept the charge. In an undated written response to this charge, Mrs Willis stated:

"Then a few hours later the child alerted me that he needed me to repositioned him unto his left side, and just as I lift his bed cover I saw that he was wet and I promptly put him unto his big bath sheet and change his clothing… Again this is no excuse I was wrong to assume that he was wearing his pad, I should have checked regardless." [sic]

The panel bore in mind that it had already determined that Mrs Willis had not maintained visual observation on Patient A and appeared to have fallen asleep. It also noted that Mrs Willis stated that she did not know that Patient A did not have his pad on. However, it was of the view that had she undertaken initial checks on Patient A before her shift started, she would have been aware of this.

In light of the above, the panel concluded that Mrs Willis did not check on Patient A's continence. The panel therefore concluded that she had therefore failed in her duty to do so.

The panel therefore found this charge proved.

Charge 7

That you, a registered nurse, during a night shift on 1-2 August 2022:

7. Left patient A in soiled clothing/bedding and/or a wet towel when they had soiled themselves.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and written representations from Mrs Willis.

Witness 1 in her witness statement stated

> *"When Mrs Willis said that she left the patient on the wet towel, she explained that she didn't have time or assistance to move him. However, there was an hour and a half left of her shift, leaving her enough time to change the bed. It was also usual to wake parents to help with things like that, and these parents had communicated that they were okay with being woken up for this type of thing. As Mrs Willis had worked with the family many times before, she would have been aware of this."*

The panel also took account of Witness 1's written record of her review of the CCTV footage as quoted in charge 6.

The panel took account of the CCTV footage of the night shift on 1 to 2 August 2022. It was clear to the panel that Patient A had been left in soiled clothing/bedding when he had soiled himself. It also noted that Mrs Willis, upon discovering that Patient A had soiled himself, placed a towel under him.

The panel noted that Mrs Willis appeared to accept the charge. In an undated written response to this charge, Mrs Willis stated:

> *"I would never knowingly leave a child in wet clothing because it is uncomfortable and its not showing dignity to the child. And to be honest when I saw that the child was wet I was very upset because I have never encountered him not wearing his night pad on any of the occasion I have looked after him but on this occasion his dad had forgotten to put his night pad on."*

In light of all the above, the panel determined that Mrs Willis had left Patient A in soiled clothing/bedding and/or a wet towel when they had soiled themselves.

The panel therefore found this charge proved.

Charge 8

That you, a registered nurse, during a night shift on 1-2 August 2022:

8. Documented that you had repositioned Patient A's saturation probe when you had not.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and written representations from Mrs Willis.

The panel reminded itself that it had already determined, upon viewing the CCTV footage, that Mrs Willis had not repositioned Patient A’s saturation probe between 22:00 and 06:20. It therefore considered whether Mrs Willis had documented that she had repositioned Patient A’s saturation probe.

The panel took account of Patient A’s observation chart. It took account of the dates entries made on 1 and 2 August 2022. It noted that on 1 August 2022, at 22:00, Mrs Willis had placed her signature indicating that the saturation probe site was on Patient A’s right toe. On 2 August 2022, at 01:00, she had signed and made a record on the chart indicating that the saturation probe site was on Patient A's right toe. At 04:00 and 07:00, Mrs Willis had signed the chart and recorded that the saturation probe site was now on Patient A’s left toe.

However, the panel was satisfied on viewing the CCTV footage that there was no evidence to show that Mrs Willis had repositioned the saturation probe. Additionally, it had also noted that at 06:20 the saturation probe was in fact still on Patient A’s right toe.

The panel noted that Mrs Willis appeared to accept the charge. In an undated written response to this charge, Mrs Willis stated:

> *“Saturation Probe, I had fully admitted that I thought I had repositioned the child saturation probe but unfortunately I did not do so. And when I saw from the documentation that I had documented that I did I took full resposibilty for my actions, because I should not have documented care that was not given as given.”* [sic]

In light of all the above, the panel determined that Mrs Willis had documented that she had repositioned Patient A’s saturation probe when she had not.

The panel therefore found this charge proved.

Charge 9

That you, a registered nurse, during a night shift on 1-2 August 2022:

9. Your conduct in charge 8 above was dishonest in that you represented that you had repositioned Patient A’s saturation probe when you knew you had not.

This charge is found proved.

In reaching this decision, the panel bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67.* It had to now ascertain (subjectively) what Mrs Willis’ actual state of knowledge or belief was to the facts and decide whether her conduct with that state of mind would be considered dishonest by the standards of ordinary decent people.

The panel bore in mind that it had already determined that Mrs Willis had documented that she had repositioned Patient A’s saturation probe when she had not.

The panel bore in mind that Mrs Willis had documented that she had repositioned Patient A’s saturation probe. It noted that she had recorded the position of the saturation probe four times at 22:00 on 1 August 2022, and at 01:00, 04:00 and 07:00 on 2 August 2022.

Before drawing the inference that she had documented repositioning Patient A’s saturation probe when she knew she had not, the panel bore in mind that it had to safely exclude other possible explanations for her conduct.

The panel considered whether there was evidence of alternative explanations. It took account of the contemporaneous meeting minutes from Witness 1’s investigation with Mrs Willis undertaken on 16 September 2022. Witness 1, in the interview, put to Mrs Willis that she did not reposition the saturation probe the whole night. Mrs Willis’ response was that the humidifier went off and she disconnected the saturation probe and then reconnected it.

The panel also noted that within the meeting minutes, she stated that she could not fully remember what she did.

The panel then considered whether Mrs Willis had made a mistake or failed to recollect her actions, but determined that a mistake was less than probable and was not supported by the CCTV footage.

Mrs Willis, in an undated written response to this charge, stated:

> *"Poor record keeping. Most definitely my record keeping on the night was unacceptable and due care and attention was not given. Even if I thought that a particular care was given I should have made sure before documenting it.*
>
> *I had no intention of being dishonest or was I trying to mislead anyone."*

However, within the same undated response, Mrs Willis appeared to accept that she had documented care that was not given:

> *"Saturation Probe, I had fully admitted that I thought I had repositioned the child saturation probe but unfortunately I did not do so. And when I saw from the documentation that I had documented that I did I took full resposibilty for my actions, because I should not have documented care that was not given as given."*

The panel was of the view that Mrs Willis did know that she had not repositioned Patient A's saturation probe as she had documented. By doing so, the panel was satisfied that her actions amounted to dishonesty. Ordinary decent people would regard her conduct as dishonest.

The panel concluded that on the balance of probabilities Mrs Willis' actions in relation to charge 8, based on the test in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67,* were dishonest.

The panel therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Willis's 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 ability to practise kindly, safely and professionally.

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.

Submissions on misconduct and impairment

In coming to its decision, the panel had regard to the case of *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.'*

Mr Edenborough submitted that the panel may consider that where there had been one to one care for a highly vulnerable patient, and a registrant had slept on duty, acted dishonestly and care was not completely undertaken, then this could be considered to be indicative of an attitudinal concern.

Mr Edenborough submitted that the panel may consider the care carried out was a result of unfortunate or understandable reasons, or because of a lax attitude towards

professional responsibility towards the care of a child. He submitted that the NMC's position was the latter and that it would be viewed as misconduct by a fellow professional.

Mr Edenborough invited the panel to take the view that the facts found proved amount to misconduct as Ms Willis' actions fell below the standards expected of a registered nurse. He directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015 (the Code) and identified where, in the NMC's view, Ms Willis' actions amounted to misconduct.

Mr Edenborough 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).

Mr Edenborough submitted that there are, to an extent, some admissions from Mrs Willis and there appears to be remorse for an "appalling" work shift. He submitted that if the panel find that there are attitudinal concerns underlying these matters, even in part, then that goes to the risk of repetition.

Mr Edenborough submitted that the panel may consider that, in broader terms, there isn't sufficient evidence of insight to avert a risk of repetition.

Mr Edenborough submitted that this was an instance of one to one care with significant failings in professionalism involving a vulnerable patient. He submitted that the panel may consider that a finding of impairment was necessary to mark the misconduct and maintain confidence in the profession.

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

Decision and reasons on misconduct

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, Mrs Willis's fitness to practise is currently impaired as a result of that 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 Mrs Willis's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Willis's actions amounted to a breach of the Code. Specifically:

> *'Prioritise people*
>
> *You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.*
>
> ***1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.2 act with honesty and integrity at all times…'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

With regards to charge 1, the panel bore in mind that Mrs Willis was working a waking night shift which required her to be awake at all times. It also bore in mind that for safeguarding reasons, nurses working a waking night shift could be subject to dismissal if they are found to be asleep whilst duty.

The panel found that Mrs Willis was asleep at times during the night shift and the panel was of the view that her conduct put Patient A at a significant risk of harm. Additionally, whilst being asleep at times, and because her back was facing Patient A for significant periods of the shift, she would have not been able to see if Patient A's condition had deteriorated or his tracheostomy tube became dislodged. It bore in mind that due to being asleep at times, she could have missed any signs that could have meant that Patient A was requesting assistance.

In light of the above, the panel therefore determined that Mrs Willis' actions in charge 1 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

With regards to charge 2, the panel bore in mind that Mrs Willis would have known that Patient A was vulnerable. Additionally, Patient A's care plan made it clear that he was dependent on others to reposition him. The panel also bore in mind that Witness 2, in her witness statement stated that Patient A needed to be repositioned *"to aid his comfort, reduce the risk of skin pressure damage and to ensure that his positioning does not compromise his airway or ventilation tubing*".

The panel noted that Mrs Willis did not reposition Patient A and therefore could have placed him at a significant risk of harm. It therefore determined that Mrs Willis' actions in

charge 2 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

With regards to charge 3, the panel bore in mind that Mrs Willis had cared for Patient A before and would have known that checking his tracheostomy site and/or tapes was in his care plan. It bore in mind that it had heard evidence that Patient A required mechanical ventilation at all times and by not following the correct procedure of checking Patient A's tracheostomy site and/or tapes, Mrs Willis had placed Patient A at a significant risk of harm.

The panel therefore determined that Mrs Willis' actions in charge 3 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

With regards to charge 4, the panel bore in mind that Witness 2 in her witness statement stated that failure to move Patient A's saturation probe could potentially cause skin damage such as burning or blisters. While there was no harm caused, Mrs Willis' conduct placed Patient A at significant risk of harm. The panel therefore determined that Mrs Willis' actions in charge 4 fell short of the conduct and standards expected of a nurse and amounted to misconduct.

Similarly with charge 1, with regards to charge 5 Mrs Willis falling asleep, having her back to Patient A and at times wearing an eye mask meant that she could not maintain a visual observation of Patient A. As a result, she could have missed signs made by Patient A who may have been requesting assistance and therefore she was unable to provide any pertinent care that may have been required to a vulnerable patient. The panel therefore determined that Mrs Willis' actions in charge 5 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

With regards to charge 6 and 7, the panel bore in mind that Mrs Willis did not check to see if Patient A was wearing a pad. It was of the view that it was important for Mrs Willis to undertake a full assessment of Patient A before her shift. It also considered that Patient A

could not verbalise any requests and had to use sign language but Mrs Willis did not have visual observations of Patient A to pick up any of these signs.

Consequently, her failure to check on the continence of Patient A led to him becoming incontinent and being left in soiled clothing and bedding. It bore in mind that Witness 2 in her witness statement stated that this could have resulted in an adverse effect on the skin integrity, body temperature and hygiene of Patient A. Additionally, Patient A's dignity was not maintained. The panel also bore in mind that if Mrs Willis had changed the wet bed sheets and left Patient A comfortable, his parents would not have raised a concern. Patient A was left in soiled clothing and bedding, and his parents discovered him like this.

In light of the above, the panel therefore determined that Mrs Willis' actions in charge 6 and 7 individually fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

With regards to charges 8 and 9, the panel was of the view that Mrs Willis would have been aware of the NMC code and her duty of candour. By documenting that she had repositioned Patient A's saturation probe when she had not, gave a misleading impression. It considered that any colleagues looking at the records would think that Patients A would have had his saturation probe repositioned.

The panel had earlier determined that Mrs Willis did not have an alternative explanation to making the entries on the observation chart. As a result, Mrs Willis' dishonesty was significant as her conduct and associated dishonesty placed Patient A at a risk of harm.

In light of the above, the panel therefore determined that Mrs Willis' actions in charges 8 and 9 individually fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In light of the above the panel determined that the charges found proved individually amounted to a serious departure from appropriate standards expected and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Willis's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the*

public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

In paragraph 76, Mrs Justice Cox referred to 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) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

For reasons already set out above, the panel considered that limbs a, b, c and d were engaged by Mrs Willis' misconduct in this case.

The panel bore in mind that Patent A was a particularly vulnerable patient. By wearing an eye mask, facing away from Patient A and occasionally falling asleep, Mrs Willis failed to maintain visual observation of Patient A. Mrs Willis therefore would not be able to see if

Patient A needed assistance or was at risk. It was of the view that Patient A was placed at a potential risk of significant harm as a result of Mrs Willis' misconduct.

The panel also considered that Mrs Willis's misconduct had breached the fundamental tenets of the nursing profession due to her failure to provide basic fundamental nursing care to Patient A, in addition to her failure to maintain the dignity of Patient A. She therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel recognised that it must make an assessment of your fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether Mrs Willis would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in Mrs Willis' nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether Mrs Willis had provided evidence of insight and remorse.

Regarding insight, the panel considered that Mrs Willis' undated written response to the charges. It noted that Mrs Willis had demonstrated some remorse, regret and there was some recognition that she did not perform at her best on the night of 1 to 2 August 2022.

The panel bore in mind that Patient A was a vulnerable patient who was completely reliant on his carers to provide him with care and keep him safe. However, the panel noted that Mrs Willis had not demonstrated insight into how her conduct had placed Patient A at significant risk of harm.

Mrs Willis also stated in her written response that she could see how her actions could be misinterpreted. However, the panel's interpretation of her actions was that she had placed Patient A at a risk of serious harm.

There was no recognition of the impact Mrs Willis' misconduct had on Patient A, his parents, the fact that they had entrusted her to keep him safe or the impact her misconduct had on the nursing profession. She provided the panel with limited explanation of how she would approach similar circumstances in the future.

In light of the above, the panel determined that Mrs Willis had limited insight.

The panel was satisfied that the misconduct in this case, namely charges 1 to 8, are capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Willis has taken steps to strengthen her practice. However, in the absence of evidence of significant insight or strengthened practice there was no evidence that the concerns had been remedied to date. The panel noted that it had no evidence before it of any action taken by Mrs Willis to address or remedy the concerns identified in this hearing.

In regard to charge 9, the panel considered that misconduct involving dishonesty is less easily remediable than other kinds of misconduct. However, in the panel's judgment, evidence of insight, remorse and reflection together with evidence of subsequent and previous integrity are all relevant in considering the risk of repetition, as is the nature and duration of the dishonesty itself.

Accordingly, the panel bore in mind that Mrs Willis had recorded that she had repositioned Patient A's saturation probe three times when she knew she had not. It also bore in mind that she stated that she should not have documented care that was not provided and did not intend to be dishonest or mislead anyone. Additionally, she stated that she took full

responsibility for her actions in this regard. The panel noted that Mrs Willis had provided limited insight into this particular matter.

The panel also noted that Witness 1 in her witness statement stated:

> *"No other concerns with Mrs Willis' care for Patient A had been raised before, and she had been working with him 2-3 nights a week since 26 June 2022.*
>
> *Patient A's parents have never raised concerns about his care before…"*

The panel was of the view that the dishonesty in this case appeared to be an isolated incident and therefore it was not satisfied that there was evidence of attitudinal concerns that underpinned her dishonesty.

Nevertheless, the panel was of the view that in the absence of significant insight, remorse and evidence that Mrs Willis had strengthened her practice, in the areas of concern identified by the panel, it cannot be said that her conduct is highly unlikely to be repeated. The panel therefore decided that a finding of impairment is necessary 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 was satisfied that, having regard to the nature of the misconduct in this case, *"the need to uphold proper professional standards and public confidence in the profession would be undermined"* if a finding of current impairment were not made. It was of the view that a reasonable, informed member of the public would be very concerned if Mrs Willis'

fitness to practise was not found to be impaired and therefore public confidence in the nursing profession would be undermined if a finding of impairment were not made.

For all the above reasons the panel concluded that Mrs Willis' fitness to practise is currently impaired by reason of misconduct on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months with a review. The effect of this order is that the NMC register will show that Mrs Willis's registration has been suspended.

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

Mr Edenborough submitted that the appropriate sanction in this case was a 12-month suspension order with a review. He took the panel through the aggravating and mitigating factors he considered to be engaged in this case.

Mr Edenborough submitted that to take no action further action would not address the seriousness of the concerns the panel had found.

Mr Edenborough submitted that the imposition of a caution order would not be appropriate or proportionate in this case. He submitted that the concerns are not at the lower end of the spectrum of fitness to practice. He also submitted that a caution order would not address the risk identified.

Mr Edenborough submitted that a conditions of practice order may have been appropriate if the concerns did not involve Mrs Willis sleeping on duty and the dishonesty associated with the clinical concerns. He submitted that the panel had found that Mrs Willis did fall asleep on duty and identified concerns related to this. He also reminded the panel that it had found that Mrs Willis had a lack of insight regarding the impact her conduct had on Patient A and it had identified continued risk. He submitted that a conditions of practice order could not address this. Mr Edenborough submitted that a future reviewing panel could consider a conditions of practice order, but it would not be appropriate at this stage.

Mr Edenborough submitted that a suspension order was the most appropriate order. He reminded the panel that it had found that the dishonesty identified was a one-off isolated incident and not impossible to remediate. He submitted therefore that permanent removal from the NMC Register was not necessary at this stage.

The panel heard an accepted the advice of the legal assessor. It also took account of the NMC Guidance "Factors to consider before deciding on sanctions" (Reference SAN-1), "Considering sanctions for serious cases" (reference SAN-2) and "Available sanction orders" (reference SAN-3).

Decision and reasons on sanction

Having found Mrs Willis's 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:

- Mrs Willis brought an eye-mask to a waking night shift and used it whilst she was on duty;
- Patient A was a vulnerable child with complex health needs who was put at a risk of suffering harm;
- Limited insight into the risk of harm towards Patient A, including the impact on the family and the wider nursing profession;

The panel also took into account the following mitigating features:

- Mrs Willis had apologised for some of her conduct and had expressed some remorse;
- Mrs Willis demonstrated some insight.

The panel also took account of the NMC Guidance “Considering sanctions for serious cases” (reference SAN-2) which stated:

> *Cases involving dishonesty*
>
> *…In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*
>
> *…*
>
> *Dishonest conduct will generally be less serious in cases of:*
>
> - *one-off incidents*
> - *opportunistic or spontaneous conduct*
> - *no direct personal gain*
> - *incidents outside professional practice*

The panel was satisfied that that the first, second and third bullet points were engaged in this case and was of the view that the dishonesty identified in this case was at the lower end of the dishonesty spectrum. With this in mind, the panel went on to consider what the appropriate sanction would be.

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 risk of repetition and the risk of harm identified towards Patient A. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that, due to the limited insight Mrs Willis had demonstrated into the risk she had placed Patient A, the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Willis's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Willis's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Willis' registration would be a sufficient and appropriate response. It was mindful that any conditions imposed must be proportionate, measurable and workable.

The panel bore in mind that it found that Mrs Willis had limited insight and it had no evidence of strengthened practice.

The panel noted that there could be practical or workable conditions that could be formulated to address some of the misconduct identified in this case. However, the panel bore in mind that it did not have any information before it regarding the current

circumstances of Mrs Willis. As a result, there was no evidence to give the panel any confidence that Mrs Willis would, at this stage, be able or willing to engage or comply with conditions imposed on her practice. Additionally, the panel was of the view that the dishonesty in this case could be addressed by fuller insight and reflection from Mrs Willis. In absence of this, the panel concluded that placing conditions on her registration would not adequately address the seriousness of this case, would not protect the public nor meet the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. It was of the view that Mrs Willis' misconduct occurred on a single night shift and there had been no evidence of repetition. It also bore in mind that Witness 1 in her witness statement stated that Mrs Willis had had no previous concerns raised regarding her care for Patient A. Additionally, the panel have nothing to suggest that any complaints have been raised against Mrs Willis since the incident.

The panel bore in mind the dishonesty it had identified and Mrs Willis' limited insight into this. However, it also noted that it had determined that the dishonesty was at the lower end of the dishonesty spectrum, a one-off incident and that there was no evidence of harmful deep-seated personality or attitudinal problems.

The panel was of the view that a suspension order would be appropriate as this would give Mrs Willis the opportunity, following its findings, to reflect upon the regulatory

concerns. Further, a suspension order would also provide the opportunity for Mrs Willis to engage with NMC to demonstrate to a reviewing panel that she recognises the impact that her actions had on Patient A and the profession in general, as well as providing an assurance that the behaviour would not be repeated.

The panel went on to consider whether a striking-off order would be proportionate. The panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that while Mrs Willis's actions were significant departures from the standards expected of a registered nurse, they were not fundamentally incompatible with her remaining on the register. Taking account of all the information before it, and of the mitigation provided, the panel concluded that a striking off order would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Willis's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction to protect the public. It would prevent her from practising during the period of suspension and until she has satisfied a reviewing panel that she had strengthened her practice and fully remediated her misconduct.

The panel noted the hardship such an order will inevitably cause Mrs Willis, however this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 12 months with a review was appropriate in this case to mark the seriousness of the misconduct. The panel was also satisfied that this would provide Mrs Willis time to reflect on her misconduct and dishonesty and to develop her insight.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Your attendance in person, via video link or telephone at the review hearing;
- A comprehensive reflective piece addressing the clinical failings and your dishonesty;
- Evidence of any training undertaken and completed;
- Evidence of any work undertaken whether it be paid or unpaid;
- References and testimonials from any work undertaken whether it be paid or unpaid;

This will be confirmed to Mrs Willis in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Willis's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Edenborough. He submitted hat given the panel's findings in relation to sanction he submitted that only an interim suspension order for a period of 18 months would be appropriate on the grounds of public protection and otherwise in the public interest. He also submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

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

Decision and reasons on interim order

The panel was satisfied that an interim 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.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's

determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Mrs Willis is sent the decision of this hearing in writing.

That concludes this determination.