Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 9 September 2024 - Friday, 13 September 2024
Monday, 16 September 2024 - Wednesday, 18 September 2024
Tuesday, 17 December 2024 - Friday, 20 December 2024

Virtual Hearing

Name of Registrant:	**Nicola Ann Fraser**
NMC PIN:	06B0420E
Part(s) of the register:	Nurses Part of the Register- Sub Part 1 RNA: Adult Nurse, Level 1 (31 May 2006)
Type of case:	Misconduct and Health
Panel members:	Alan Greenwood (Chair, Lay member) Esther Craddock (Registrant member) Carson Black (Lay member)
Legal Assessor:	Angus Macpherson
Hearings Coordinator:	Samantha Aguilar (9 September 2024- 13 September 2024, 16 September 2024-18 September 2024, 18 December 2024-20 December 2024) Audrey Chikosha (17 December 2024)
Nursing and Midwifery Council:	Represented by Rebecca Paterson, Case Presenter
Mrs Fraser:	Not present and not represented at the hearing
Facts proved:	Charges 1 (in relation to the past), 2, 3a, 3b, 3c, 4, 5a, 5b, 6b, 8a, 9a, 9b, 9c, 9d, 11a and 11b
Facts not proved:	Charges 6a, 7, 8b, 8c, 10a, 10b, 10c, and 10d
Fitness to practise:	Impaired by reason of Mrs Fraser's misconduct

Sanction:	**Suspension order with review (8 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 Fraser was not in attendance and that the Notice of Hearing letter had been sent to Mrs Fraser's registered email address by secure email on 5 August 2024.

Ms Paterson, 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 Fraser's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In light of all of the information available, the panel was satisfied that Mrs Fraser 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 Fraser

The panel next considered whether it should proceed in the absence of Mrs Fraser. It had regard to Rule 21 and heard the submissions of Ms Paterson who invited the panel to continue in the absence of Mrs Fraser. She submitted that Mrs Fraser voluntarily absented herself. Ms Paterson acknowledged that in circumstances where registrants do not attend, there will be some disadvantage. They would not be able to address the charges or anything that arises. However, she submitted that in these particular circumstances, it is fair to proceed. Fairness applies not only to Mrs Fraser, but also to the NMC and the witnesses that they intend to call. Ms Paterson submitted that it is also in the public interest to conclude proceedings such as these expeditiously.

Ms Paterson directed the panel to the proceeding in absence bundle. This included an email from Mrs Fraser dated 29 August 2024 to the NMC:

'Please bear in my absence
Regards
Nicola'

Ms Paterson informed the panel that following that email, the NMC Senior Case Coordinator replied on 29 August 2024 and invited her to confirm her consent to a hearing in her absence but received no response. Ms Paterson invited the panel to consider that Mrs Fraser's lack of response to the further email is a strong indication that she is happy for the panel to proceed in her absence.

Ms Paterson submitted that the next factor to consider is whether an adjournment might result in Mrs Fraser attending the proceedings at a later date. She submitted that there is no indication that Mrs Fraser wished for this hearing to adjourn. She has not requested an adjournment and there is no indication that should the panel decide to adjourn this would result in her attendance at a later date nor is there any indication as to how long the panel would have to adjourn in order to secure her attendance. Mrs Fraser has also not indicated that she wished to be represented at the hearing.

Ms Paterson submitted that the panel has seen correspondence from Mrs Fraser that was sent in March 2024, in which she outlined her [PRIVATE], and that was likely to be something that the panel takes into consideration. Ms Paterson submitted that there is no objective evidence to support that Mrs Fraser is unwilling to participate in these proceedings [PRIVATE]. [PRIVATE]. [PRIVATE]. Mrs Fraser has not suggested that would be a reason for the panel to adjourn.

Ms Paterson invited the panel to consider that there is insufficient evidence to warrant adjourning in light of any concerns it may have about Mrs Fraser's [PRIVATE]. She

submitted that an adjournment would be unfair to the NMC. A further delay in these proceedings would likely have an effect on the memory of the witnesses that the NMC intends to call in support of the case and it would not be in keeping with the public interest and the expeditious disposal of proceedings.

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 decided to proceed in the absence of Mrs Fraser. In reaching this decision, the panel has considered the submissions of Ms Paterson, and the advice of the legal assessor. It had particular regard to the factors set out in the decisions 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 considered that:

- No application for an adjournment has been made by Mrs Fraser;
- Mrs Fraser was called on two occasions by the NMC Senior Case Coordinator regarding these proceedings, however the first call was sent to voicemail. An email was also sent by the NMC to Mrs Fraser; A further attempt to contact her was made on the first day of the hearing but also failed.
- It had sight of an email from Mrs Fraser dated 29 August 2024 which stated, *'Please bear in my absence'*, the panel took the view that this could be a typographical error, and it may be that Mrs Fraser meant *"please hear in my absence".*
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Eight witnesses are due to attend 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;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Fraser in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her registered email address. She will not be able to challenge the evidence relied upon by the NMC 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 in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Fraser's decision to absent herself from the hearing, waive her right to attend, and/or be represented, and not to provide evidence or make submissions on her own behalf.

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

Decision and reasons on application for hearing to be held partly in private

Ms Paterson made an application that this case be held partially in private on the basis that proper exploration of Mrs Fraser's case involves [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold

hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in connection with [PRIVATE] as and when such issues are raised.

Decision and reasons on application to amend the Charge

The panel heard an application made by Ms Paterson to amend the wording of Charge 1.

The proposed amendment was to amend the typographical error in Charge 1. She submitted that this should read as:

> "That you, a registered nurse:
>
> 1. Have, or have had in the past~~, more of~~ the [PRIVATE] set out at Schedule 1"

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 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 Fraser 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 correct the typographical error contained within Charge 1.

Details of Charges (as amended on 9 September 2024)

That you, a registered nurse:

1. Have, or have had in the past [PRIVATE] set out at Schedule 1

As a consequence of your [PRIVATE]

2. On 19 December 2019 attended work as a nurse while unfit

That you, a registered nurse:

Whilst working at Blyth Country House Nursing Home:

3. On 19 December 2019 when treating Resident A's wound:
    a. Failed to apply an aseptic technique by creating a sterile field;
    b. Failed to clean the wound before applying Flaminal cream;
    c. Failed to apply Flaminal cream to the wound bed.

4. On 19 December 2019 failed to undertake the teatime medication round on time and when instructed to do so

Whilst working at Mickley Hall

5. On 29-30 August 2021:
    a. Failed to consult electronic medication administration record ('MAR') charts before administering medication;
    b. failed to take any, or any adequate, steps to escalate your difficulty operating the electronic MAR system.

6. On 29 August 2021
    a. failed to administer, or alternatively failed to record that you had administered, 88 medications to 18 residents;
    b. overdosed 7 residents by administering medications already received.

7. On 30 August 2021 failed to administer any medication in the 6am round

8. On 29-30 August 2021 failed to prioritise patients in that you:

a. did not respond to a request to review Resident A in a timely manner;
b. did not commence Resident B's PEG feed;
c. did not flush Resident C's PEG feed;

9. On 30 August 2021 failed to give an adequate and/or accurate handover in that you:
    a. Mixed up information about residents;
    b. did not handover that Resident D was in hospital;
    c. stated that Resident D had received medication when they had not;
    d. failed to provide adequate information about Resident E;

Whilst working at Breagha House

10. On 22 November 2021 in relation to Resident A (Breagha House) you breached professional boundaries in that you:
    a. cuddled the resident;
    b. kissed the resident;
    c. Sat on the resident's knee;
    d. Made inappropriate comments that the resident 'had a boner' or words to that effect

Whilst working at [PRIVATE]

11. On 6 December 2021 failed to treat Resident B ([PRIVATE]) with dignity in that, you:
    a. showed the resident's underwear to other staff members;
    b. made inappropriate comments about the resident being 'a crossdresser' or words to that effect.

AND in light of the above your fitness to practise is impaired by reason of your [PRIVATE] *in respect of charges 1 - 2, and by reason of your misconduct in respect of charge 3 – 11.*

[PRIVATE]

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Paterson under Rule 31 to allow the hearsay evidence of Colleague A and Colleague B into evidence. This includes Colleague A's local statement which goes to proving Charge 10, the communication log between the NMC and Colleague B dated 25 August 2023, the account of Colleague B as set out in Witness 7's local incident statement and the account of Resident B as set out in Witness 7's evidence which go to proving Charge 11. Ms Paterson submitted that unfairness can be sufficiently mitigated by procedural safeguards, for example, comparing evidence against other documents and testing them for any consistencies and/or considering the appropriate weight to be attached to certain section of the evidence. Ms Paterson referred the panel to *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), which identified a number of factors to consider when determining to admit hearsay evidence.

Ms Paterson first addressed Colleague A's evidence which relates to Charge 10. Ms Paterson submitted that there are some similarities between the account provided by Mrs Fraser and those set out in Colleague A's local statement. She submitted that the panel may consider that as a potential means by which the evidence can be tested. In considering the nature and extent of the challenge, Ms Paterson submitted that Mrs Fraser has already set out her position in that she denied sitting on the resident's knee. There is no other denial mentioned in Colleague A's evidence and also no admission. There is also no suggestion that Colleague A had any reason to fabricate the allegations.

In considering the seriousness of Charge 10, Ms Paterson submitted that this charge is undoubtedly serious and adverse findings would likely have an impact on Mrs Fraser's career.

Ms Paterson referred the panel to the Hearsay Bundle submitted in respect of Colleague A. Ms Paterson submitted that Colleague A was no longer employed by the Kisimul

School Holdings Limited ("Kisimul"), as evidenced by the automatic email dated 5 June 2023 from Colleague A's previous work email which states:

> *'I am no longer employed by Kisimul'*

Ms Paterson submitted that this is supported by the Home Manager (at Breagha House)'s Communications log dated 30 August 2023 with the NMC which states the following:

> '*Question: Does* [Colleague A] *still work in the home?*
> *Answer: No,* [Colleague A] *left around October 2022. […]*
> *Question: What was* [Colleague A]*'s role when she worked in the home?*
> *Answer: She was a Senior Support Worker* […]. *We're not nursing home so have no registered nurses. We are health and social care.*
> *Question: Do you know where* [Colleague A] *works now / have any contact details for her?*
> *Answer: No, I don't – the last I was aware she was working for an agency somewhere. I have no contact for her.'*

Ms Paterson invited the panel to consider whether the steps taken by the NMC were reasonable in the circumstances. Ms Paterson submitted that Colleague A is not a nurse, she is a carer, and contact had been made to Breagha Home in an attempt to obtain further contact information.

Ms Paterson submitted that the last consideration that the panel must take into account is whether or not Mrs Fraser had notice that the NMC intended to read her evidence rather than call Colleague A as a witness. In Ms Paterson's submission there is no evidence that Mrs Fraser was specifically told that Colleague A would not be called as a witness.

Ms Paterson next proposed that the communication log between the NMC and Colleague B dated 25 August 2023, the account of Colleague B as set out in Witness 7's local incident statement and the account of Resident B as set out in Witness 7's evidence which

go to proving Charge 11 should be admitted as evidence in these proceedings. Ms Paterson submitted that the accounts provided by Witness 7 can be tested and are therefore not the sole and decisive evidence. Ms Paterson submitted that Witness 7 spoke directly to Colleague B and Resident B, as such, she is able to speak to the consistency of the accounts provided by both. She submitted that when looking at Witness 7's statement to the NMC dated 16 July 2024, it appeared that the two accounts corroborate each other. In looking at challenging the nature and strength of the evidence, Ms Paterson submitted that Mrs Fraser has not specifically denied the allegations set out at Charge 11; she does accept having made assumptions about who the garment belonged to and allegedly went to apologise to the resident. The charges are serious and could have an impact on her career if found proven.

Ms Paterson first addressed the reason for Colleague B's non-attendance and referred the panel to the hearsay bundle. Ms Paterson submitted that an email was sent by the NMC to Colleague B, however this returned an *"undeliverable"* notification on 16 July 2024. A call was attempted on 22 July 2024, but there was no answer. The last evidence of successful communications was dated 25 August 2023. Therefore, Ms Paterson submitted that it appears that the reason for Colleague B's non-attendance appears to be that Colleague B stopped engaging with the NMC's proceedings.

Ms Paterson submitted that it is a matter for the panel to consider whether the NMC has taken the reasonable steps to secure Colleague B's attendance and with regards to the contents of the hearsay bundle. Ms Paterson submitted that in circumstances where Colleague B is not a registered nurse, it may be that the NMC was unable to identify another way of getting hold of Colleague B.

Ms Paterson next addressed the reason for Resident B ([PRIVATE])'s non-attendance. Ms Paterson submitted that according to Witness 7's statement to the NMC dated 16 July 2024, contacting Resident B ([PRIVATE]) in relation to this particular incident could upset him. Witness 7 stated:

'[…] *I don't know if it would be appropriate to contact him about the incident. He doesn't usually like to be reminded of things that have upset him in the past. When you do, it sets him off and can make him depressed* […]'

Ms Paterson submitted that there is good reason for the NMC not to contact Resident B ([PRIVATE]). Resident B ([PRIVATE]) is inherently vulnerable by virtue of his status as a resident in a nursing home and in the circumstances, it would be disproportionate to risk causing further harm to Resident B ([PRIVATE]) in trying to secure direct evidence from him.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is *'fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel first considered the application in respect of Colleague A's evidence which relates to Charge 10. The panel noted that Colleague A provides two lines of evidence and alleges that Mrs Fraser had instigated the behaviour and therefore this is a serious allegation. Mrs Fraser is clear in her account that there was an incident in which the Resident at Breagha House followed her around and thrusted himself upon her. It appears therefore that according to Mrs Fraser she was the victim of this behaviour, and she asked him to stop and refused his advances. The panel took the view that it would be difficult to assess Colleague A's evidence without her attendance.

The panel bore in mind the seriousness of the allegation and took into account the relevant guidance. It decided that Colleague A's evidence is sole and decisive for Charge 10, which Mrs Fraser has clearly challenged based on her local response to the allegations. In these circumstances, the panel refused the application.

The panel next considered the evidence of Colleague B which is linked to the evidence of Resident B ([PRIVATE]) and Witness 7's evidence. The panel noted that this relates to

Charge 11. The panel accepted that the reason for Colleague B's non-attendance was that she has disengaged from the NMC proceedings and there was no other means for the NMC to contact her. In respect of Resident B ([PRIVATE]), the panel agreed that considering the impact that it had on him and his vulnerability by virtue of his status in a residential care home, it would not be appropriate for the NMC to contact him.

The panel understood that Witness 7 is due to attend the hearing to give live oral evidence. It noted that the evidence that Witness 7 is due to provide is based on the direct conversation she had with Colleague B and Resident B ([PRIVATE]). The panel decided that when weighing up Mrs Fraser's response contained within the documentation and Witness 7's account of her conversation with Colleague B and Resident B ([PRIVATE]) that it can give this the appropriate weight. As such, it has decided to admit the communication log between the NMC and Colleague B dated 25 August 2023, the account of Colleague B as set out in Witness 7's local incident statement and the account of Resident B ([PRIVATE]) as set out in Witness 7's evidence which goes to proving Charge 11 into evidence.

Application for Witness 1 to give evidence via phone

Prior to Witness 1 giving evidence, Ms Paterson made an application to allow Witness 1 to give her evidence via phone. Ms Paterson apologised for not raising this sooner and that it only became apparent towards the end of the week of 2 September 2024 that Witness 1 would not be able to join via video link. Further, Witness 1 had been given a very specific time slot to give evidence by her manager at work. Witness 1 does not have access to a device which would allow her to join the link virtually. Ms Paterson told the panel that she checked with Witness 1 whether she could join via video using her phone however, Witness 1 told her that her phone does not have the ability to do that.

The panel heard and accepted the advice of the legal assessor. He referred the panel to *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin), where demeanour is something which is said nowadays not to be of the greatest importance when assessing

witness' credibility, and that it would be a matter for the panel to determine whether or not to allow the application.

The panel decided that it was appropriate to explore with Witness 1 as to whether arrangements could be made to facilitate giving her live evidence via a video link.

Witness 1 joined the virtual hearing via phone. The panel informed Witness 1 that her role in these proceedings is important in that she is a witness with important evidence to provide the panel. However, in the normal course, evidence should be given by a witness who can be seen by the panel. Witness 1 told the panel that she could obtain a device at work which would allow her to join via a video link. However, she believed that a firewall system at her place of work is blocking her access. The panel asked whether it would be a possibility for Witness 1 to travel to London to give her evidence at one of the NMC offices. Witness 1 told the panel that she would not be able to travel to London. Witness 1 told the panel that her next availability would be Wednesday, 18 September 2024. The panel asked Witness 1 if there was a possibility for her to be available earlier than that. Witness 1 told the panel that this was her earliest availability and that she would be able to secure a laptop by then. The legal assessor asked Witness 1 whether she could possibly swap her working days to Wednesday, 18 September 2024. Witness 1 said that she was unable to do so. The panel noted that this was the last day listed for this hearing to take place. The panel invited Witness 1 to disconnect from the hearings link.

Ms Paterson submitted that whilst it is acknowledged that giving evidence via telephone is not ideal, considering the time that has been reached, she asked the panel to press ahead and receive evidence by telephone rather than wait until Wednesday, 18 September 2024. She informed the panel that delaying her evidence would inevitably lead to a need for an adjournment of the hearing and further delay, which would not be in keeping with expeditious disposal nor in the public interest. She acknowledged that the time was 16:20 and that she did not anticipate that the evidence will take particularly long.

The panel informed Ms Paterson that given the time that it was unlikely that it would finish with Witness 1's evidence in the time that it has available at present. The panel also invited Ms Paterson to put forward any relevant authority that showed a requirement that a panel must hear evidence over the phone when it cannot see the witness and assess the witness's manner when they have the option of seeing and hearing the witness on another day.

Ms Paterson informed the panel that she does not have the relevant authority to hand. However, she relied on similar authorities raised by the legal assessor in that demeanour is of less importance than might otherwise have been thought previously. Ms Paterson further reiterated her position that it is preferable for Witness 1 to give evidence over the phone rather than not at all.

Ms Paterson proposed that the panel continues to hear from the other witnesses set to attend the hearing and make progress on hearing the evidence for the other charges.

The panel withdrew and decided to discuss the matters in private and in the presence of the legal assessor and the hearings coordinator.

The panel decided to accept Witness 1's offer to reschedule her evidence to Wednesday, 18 September 2024. Witness 1 confirmed that she would be available to attend.

Admissibility of Witness 4's exhibit

Ms Paterson submitted a contemporaneous handwritten note from Witness 4 dated 30 August 2021. Ms Paterson submitted that this document had been previously disclosed to Mrs Fraser and should have been included in the bundle. She requested the panel's permission to accept the evidence on the basis that this document is clearly relevant and that there is very little unfairness to Mrs Fraser because she has seen the document. Ms Paterson submitted that this does not add to what was already in Mrs Fraser's statement.

The panel heard and accepted the legal assessor's advice.

The panel considered the matter and decided that there was no difficulty about admissibility. It agreed that the document should be admitted, and it was omitted by pure oversight. It saw no reason why that should not be rectified.

Further application to amend the Charges on 12 September 2024

The panel heard an application made by Ms Paterson to amend the wording of charge:

> *'AND in light of the above your fitness to practise is impaired by reason of your* [PRIVATE] *in respect of charges 1 - 2, and by reason of your misconduct in respect of charge 3 – 11.'*

Ms Paterson submitted that after having some time to reflect on the case and the evidence as a whole, the current wording as it stands is perhaps inconsistent with the case that is being advanced at Charges 1 and 2. It is the NMC's position that Mrs Fraser had a [PRIVATE] that impaired her fitness to practice and that on 19 December 2019, she attended work whilst unfit. [PRIVATE] is the likely cause of falling short in respect of treating the resident's wound and failing to undertake the medication round. However, she referred the panel to the [PRIVATE] dated 26 February 2021 which set out the side effects of [PRIVATE], one of which was cognitive impairment. There are also references in Mrs Fraser's account in which she sets out that she believed that the combination of [PRIVATE] negatively affected her ability to practise:

> *'During my employment with Blyth Country House I was suffering from a* [PRIVATE]*. It is my belief that* [PRIVATE] *had a detrimental effect on me and the performance of my duties at work.'*

Ms Paterson informed the panel that Mrs Fraser also provided the NMC with [PRIVATE] and the date of 18 December 2019, which fits her account. Ms Paterson submitted that

whilst Mrs Fraser is unable to state what she thinks about the application, it is perhaps the evidence that the panel has sight of which indicates her position. Ms Paterson submitted that whilst the application is late, it is not based upon any new evidence.

Ms Paterson's proposed amendments would state as follows:

> 'AND in light of the above your fitness to practise is impaired by reason of [PRIVATE] in respect of charges 1 – 2, **by reason of your misconduct** [PRIVATE] **respect of charges 3-4**, and by reason of your misconduct in respect of charges **5 - 11** ~~3 – 11~~.'

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel considered the matters carefully and noted the stage at which this application is being made. Mrs Fraser would not have been informed that this application was being made and have only had sight of the original charges. However, the panel accepted that it is in the nature of proceeding in absence. In effect, the particular registrant is not present for a development such as this, which occurred during the hearing and therefore would not have notice as and when they arise.

The panel next considered whether this amendment can be made without injustice. It took into account the fact that these charges relate to Blyth Country House Nursing Home. The panel has heard Witness 2's oral evidence and Witness 1 is yet to give evidence on Wednesday, 18 September 2024 which can be heard with the new amendment. In respect of the evidence provided by Witness 2, who is the owner of Blyth Country House Nursing Home, he was not actually present at the time of the incident but instead provided the panel with a description of what he saw on the CCTV. If the application is granted, it is unlikely that any member of the panel or anyone else would want to ask Witness 2 questions which have not already been asked. However, if the panel, legal assessor or Ms Paterson wanted to do so, it would be possible to ask Witness 2 to be recalled.

In applying the relevant principle, the panel determined that there is no injustice. It bore in mind that fairness must be applied to both parties, and that includes the NMC. Accordingly, the panel decided to allow the amendment.

Details of Charges (as amended on 12 September 2024)

That you, a registered nurse:

1. Have, or have had in the past [PRIVATE] set out at Schedule 1 **[FOUND PROVED IN RELATION TO THE PAST]**

As a consequence of [PRIVATE]

2. On 19 December 2019 attended work as a nurse while unfit **[FOUND PROVED]**

That you, a registered nurse:

Whilst working at Blyth Country House Nursing Home:

3. On 19 December 2019 when treating Resident A's wound:
    a. Failed to apply an aseptic technique by creating a sterile field; **[FOUND PROVED]**
    b. Failed to clean the wound before applying Flaminal cream; **[FOUND PROVED]**
    c. Failed to apply Flaminal cream to the wound bed. **[FOUND PROVED]**

4. On 19 December 2019 failed to undertake the teatime medication round on time and when instructed to do so **[FOUND PROVED]**

Whilst working at Mickley Hall

5. On 29-30 August 2021:

a. Failed to consult electronic medication administration record ('MAR') charts before administering medication; **[FOUND PROVED]**
b. failed to take any, or any adequate, steps to escalate your difficulty operating the electronic MAR system. **[FOUND PROVED]**

6. On 29 August 2021
    a. failed to administer, or alternatively failed to record that you had administered, 88 medications to 18 residents; **[FOUND NOT PROVED]**
    b. overdosed 7 residents by administering medications already received. **[FOUND PROVED]**

7. On 30 August 2021 failed to administer any medication in the 6am round **[FOUND NOT PROVED]**

8. On 29-30 August 2021 failed to prioritise patients in that you:
    a. did not respond to a request to review Resident A in a timely manner; **[FOUND PROVED]**
    b. did not commence Resident B's PEG feed; **[FOUND NOT PROVED]**
    c. did not flush Resident C's PEG feed; **[FOUND NOT PROVED]**

9. On 30 August 2021 failed to give an adequate and/or accurate handover in that you:
    a. Mixed up information about residents; **[FOUND PROVED]**
    b. did not handover that Resident D was in hospital; **[FOUND PROVED]**
    c. stated that Resident D had received medication when they had not; **[FOUND PROVED]**
    d. failed to provide adequate information about Resident E; **[FOUND PROVED]**

Whilst working at Breagha House

10. On 22 November 2021 in relation to Resident A (Breagha House) you breached professional boundaries in that you:

a. cuddled the resident; **[FOUND NOT PROVED]**
b. kissed the resident; **[FOUND NOT PROVED]**
c. Sat on the resident's knee; **[FOUND NOT PROVED]**
d. Made inappropriate comments that the resident 'had a boner' or words to that effect **[FOUND NOT PROVED]**

Whilst working at [PRIVATE]

11. On 6 December 2021 failed to treat Resident B ([PRIVATE]) with dignity in that, you:
    a. showed the resident's underwear to other staff members; **[FOUND PROVED]**
    b. made inappropriate comments about the resident being 'a crossdresser' or words to that effect. **[FOUND PROVED]**

AND in light of the above your fitness to practise is impaired by reason of your [PRIVATE] *in respect of charges 1 – 2, by reason of your misconduct and/or* [PRIVATE] *in respect of charges 3-4, and by reason of your misconduct in respect of charges 5 - 11*

[PRIVATE]

Background

Mrs Fraser joined the NMC register on 31 May 2006. Mrs Fraser was referred to the NMC on 24 December 2019 by her former Agency, Kareplus Agency ("Kareplus"). The concerns were raised by the Home Manager at Blyth Country House Care Home who alerted Kareplus to concerns regarding Mrs Fraser's clinical practice following a shift worked by Mrs Fraser on 19 December 2019. It is alleged that Mrs Fraser worked at the nursing home whilst unfit. The allegations are as follows:

1. On 19 December 2019 when treating Resident A's wound:

a. Failed to apply an aseptic technique by creating a sterile field;
b. Failed to clean the wound before applying Flaminal cream;
c. Failed to apply Flaminal cream to the wound bed.

2. On 19 December 2019 failed to undertake the teatime medication round on time and when instructed to do so

A further concern was raised by the Home Manager at Mickley Hall Care Home ("Mickley Hall"). Ms Fraser is said to have worked a night shift at the care home through Florence Agency on 29 to 30 August 2021.The following concerns were raised:

1. On 29-30 August 2021:
    a. Failed to consult electronic medication administration record ('MAR') charts before administering medication;
    b. failed to take any, or any adequate, steps to escalate her difficulty operating the electronic MAR system.

2. On 29 August 2021:
    a. failed to administer, or alternatively failed to record that she had administered, 88 medications to 18 residents;
    b. overdosed 7 residents by administering medications already received.

3. On 30 August 2021 failed to administer any medication in the 6am round

4. On 29-30 August 2021 failed to prioritise patients in that she:
    a. did not respond to a request to review Resident A in a timely manner;
    b. did not commence Resident B's PEG feed;
    c. did not flush Resident C's PEG feed;

5. On 30 August 2021 failed to give an adequate and/or accurate handover in that she:

a. Mixed up information about residents;
b. did not handover that Resident D was in hospital;
c. stated that Resident D had received medication when they had not;
d. failed to provide adequate information about Resident E;

A further incident was alleged to have taken place whilst Mrs Fraser worked at Breagha House Care Home ("Breagha House"). It is alleged that on 22 November 2021, Ms Fraser whilst working as a care assistant failed to maintain professional boundaries with a resident.

On 6 December 2021, whilst Mrs Fraser was working at [PRIVATE], it is alleged that she failed to treat a resident with dignity. It is alleged that she made inappropriate comments as to his preferences regarding clothing. There were also concerns about [PRIVATE].

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 Ms Paterson on behalf of the NMC.

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

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: Home Manager at Blyth Country House Nursing Home during the alleged event.
- Witness 2: Owner of Blyth Country House Nursing Home.
- Witness 3: Registered Home Manager at Mickley Hall during 29-30 August 2021.
- Witness 4: Nurse colleague at Mickley Hall on 29 August 2021 who provided Mrs Fraser a handover at the start of Mrs Fraser's nightshift.

- Witness 5: Nurse colleague at Mickley Hall that received handover from Mrs Fraser on 30 August 2021.
- Witness 6: Nurse colleague (Agency Staff) at Mickley Hall that received handover from Mrs Fraser on 30 August 2021.
- Witness 7: Home Manager at [PRIVATE] on 6 December 2021.
- Witness 8: Senior Carer on nightshift on 29 August 2021-30 August 2021 at Mickley Hall.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1

That you, a registered nurse:

1. Have, or have had in the past [PRIVATE] set out at Schedule 1

Charge 1 is found proved in the past but not in the present.

The panel noted [PRIVATE] dated 26 February 2021 which stated:

‘[PRIVATE]

[…]

[PRIVATE]*'*

The panel had regard to Mrs Fraser's letter to the NMC dated 17 August 2021:

'When I registered with Kare Plus [PRIVATE]*.*

[PRIVATE]*.*

[PRIVATE]*.*

[PRIVATE]*.'*

The panel also took into account that response written by Mrs Fraser in her consent form signed 20 September 2020:

'[PRIVATE]*'*

The panel therefore found Charge 1 proved given that by Mrs Fraser's admission that she [PRIVATE]. However, the panel found that there is insufficient information before it to suggest [PRIVATE]. Accordingly, the panel found Charge 1 proved only in relation to the past.

Charge 2

As a consequence of your [PRIVATE]

2. On 19 December 2019 attended work as a nurse while unfit

Charge 2 is found proved.

The panel took into account the oral evidence of Witness 1 in which she described the event:

> *"*[…] [PRIVATE]*."*

This was further supported by Witness 1's statement to the NMC dated 23 November 2022:

> *'That morning, Nicola had been working fine and I hadn't noticed anything unusual in her presentation or behaviour. Around lunchtime, I was having a conversation with Nicola, and she told me* [PRIVATE] *but stated that she was feeling ok.* [PRIVATE]*. However, she told me she was feeling ok and at that point, she appeared fine.'*

The panel also heard oral evidence from Witness 2 in which he described what he saw:

> *"It was very obvious. With my CCTV, I can expand the pic and go in close on the individual* […] *and get an appreciation of exaggerated movements or whatever. The fact that her movements caused concern* […] *She was stationary, attempting to remain stationary. She was having difficulty maintaining her balance. She wasn't walking anywhere, she was near the trolley, I don't remember her moving a step left or right, I could see clearly that she had difficulty maintaining balance where she was."*

This was further supported by Witness 2's statement to the NMC dated 22 August 2023:

> *'When I saw Nicola on the CCTV, I could see that she wasn't stable on her feet in terms of balance. I could see her moving from side to side, like someone who was drunk and not in control. I am not proposing she was*

drunk, that is a strong word but from what I observed, she appeared similar in presentation.'

The panel noted the letter from [PRIVATE] dated 26 February 2021 which stated:

'[PRIVATE]*'*

The GP provided a further document which references the side effects of [PRIVATE] which included, *'cognitive impairment* […] *movement disorders'.*

The panel had regard to Mrs Fraser's letter to the NMC dated 17 August 2021:

'[PRIVATE]*.'*

In light of the above evidence, the panel found Charge 2 proved.

Charge 3

That you, a registered nurse:

Whilst working at Blyth Country House Nursing Home:

3. On 19 December 2019 when treating Resident A's wound:
    a. Failed to apply an aseptic technique by creating a sterile field;
    b. Failed to clean the wound before applying Flaminal cream;
    c. Failed to apply Flaminal cream to the wound bed.

Charge 3 is found proved in its entirety.

In considering Charge 3a and 3b, the panel took into account Witness 1's email to the NMC dated 2 January 2020, which took place less than a month after the incident:

‘*left NF in the resident's room applying the dressing. About half an hour later, a care assistant who is working Bank for Blyth Care Home but who is a highly trained HCA at Kings Mill Hospital full time, came into my office and asked me to come into the room and look at what the Agency Nurse was doing. She said 'I don't think she knows what she is doing* […] [Mrs Fraser] *had also not used aseptic technique as the dressings pack was unopened and on the end of the bed.’*

This was further supported by Witness 1’s statement to the NMC dated 23 November 2022:

‘[…] *(‘Resident A’) got discharged back from Doncaster Royal Hospital. Resident A had been admitted to hospital with what we thought was a deep tissue injury to her back leg. However, they sent her back to Blyth Country House inappropriately. When Resident A arrived back to the home, she was in a terrible state. Just by chance, the tissue viability nurse was present and together, we had a look at her leg. We were horrified as there was no dressing on her leg. When we lifted her leg, her tendons and flesh were hanging*. […] *Due to the condition of Resident A, this immediately turned into an emergency and the tissue viability nurse stated that we had to get things moving. We had to phone 999 as she needed to go back to hospital, and we needed an urgent prescription for her. We also had to get her leg dressed. I said I will go phone 999 and Nicola can do the dressing as she was the nurse in charge.*

Resident A was compliant, there were no issues with her capacity or anything.

Not long after I had given Nicola the instructions, the carer assisting her came and told me that she didn’t think Nicola was doing the dressing

correctly and asked if I could go have a look. When I arrived, I found that she was not using an aseptic technique and there was no dressing pack out. This meant that she hadn't made a sterile field. This was my first concern. Then what I saw was Nicola trying to put the flamazine cream into the wound, but she was completely missing it. It looked like she was drunk.

[…]

I asked Nicola if there was a problem and she told me she hadn't bought the right glasses with her. I didn't think anything much of it, as it wasn't like Nicola to be dressing a wound in such a poor and unsafe way. I told her I would clean and dress the wound and instead I asked her to go chase the urgent prescription. From what I remember, Nicola agreed and went off.

What Nicola should have done was get a sterile dressing pack from the cupboard and create a sterile field with that pack. Within the pack is everything you need to enable you to do that. Nicola then should have cleaned the wound with Octenilin, a sterile solution and then applied the Flaminol dressing. None of these steps had happened.

The risk was that infection could have been introduced as Nicola hadn't created a sterile field. In additions, without having cleaned the wound prior to applying Flaminol, this again poses risk of infection. You need to ensure the wound is as clean as possible. You wouldn't put any kind of liquid or cream on a wound that hadn't been first cleaned. Lastly, by missing the wound when applying the Flaminol, it essentially meant it was ineffective. Therefore, Nicola's actions could have introduced infection to Resident A. However, it turned out that Resident A was actually reaching the end of her life, so no actual harm was caused. She died several days later, and it wasn't because of what Nicola did.

I can't remember how long Nicola had been trying to dress Resident A's leg.'

During Witness 1's oral evidence, she was asked to confirm how she knew that Mrs Fraser failed to create a sterile field (Charge 3a). Witness 1 said that there was no sterile pack out and that Mrs Fraser had been in the middle of *"dressing"* when she came in to observe.

Ms Fraser's response to this allegation in her email dated 18 May 2020:

'In one of the accusations I was said not to have helped or been able to complete a dressing for a resident but time sheet states clearly and is signed by senior staff that I was there at Blyth Country House until 21:30pm as I spent 3 hours with the TVN nurse attempting the get the service users leg dressed correctly. This was a very complex wound with bone and tendon visible and extremely difficult to dress due to the position it was in (the calf)and the pain the resident was suffering, despite giving strong pain relief prior to dressing.'

In Mrs Fraser's most recent response dated 25 March 2024:

'The lady I had to do the dressing on, the TVN nurses were present and the wound was very difficult for me to get to as she was in so much pain when her leg had to be lifted for the appropriate dressing to be applied. I did use aseptic technique and if I hadn't, why didn't anyone inform me at the time.'

In considering Charge 3c, the panel had regard to the same evidence referenced above, in particular, in Witness 1's email dated 2 January 2020:

'I went to the room to find NF was trying to apply Flaminol (ointment) from a tube to the back of the calf, and she was completely missing the wound bed.'

This was further supported by her statement to the NMC dated 23 November 2022:

> *'Then what I saw was Nicola trying to put the flamazine cream into the wound, but she was completely missing it. It looked like she was drunk.'*

In Mrs Fraser's email dated 25 March 2024, she stated:

> *'Not one person in that room offered the lady any pain relief prior to doing the dressing nor did they attempt to help hold her leg up so that I could see the would [sic] clearly.'*

The panel determined that in respect of Charges 3a, 3b and 3c, there is sufficient evidence before it to suggest that Mrs Fraser did not carry out the aseptic technique, create a sterile field and clean the wound before applying the flaminal cream and failing to apply the flaminal cream to the wound bed. Whilst the panel understood Mrs Fraser's assertion that the wound was complex and difficult to dress, Mrs Fraser was aware that she needed to be careful, but she was not careful enough. Mrs Fraser could have exposed Resident A to risk by not sterilising properly and therefore should not have embarked on the activity if she was unable to carry this out. Accordingly, the panel found Charge 3 proved in its entirety.

Charge 4

4. On 19 December 2019 failed to undertake the teatime medication round on time and when instructed to do so

Charge 4 is found proved.

The panel had regard to Witness 1's statement to the NMC dated 23 November 2022:

'[…] *one of the care assistants came and told me that Nicola hadn't started the 4pm medication round and it was 5pm. I went to find Nicola and I found her in the kitchen having a cup of tea and a brownie. I asked her what she was doing, and she told me that she hadn't had a drink or anything to eat all day. I said to Nicola that she needed to get on with her medication round. I asked* [the care assistant], *who was trained in medications if she would help Nicola, and I advised Nicola that [the care assistant] would help her. I then went back to the office, trusting she would get on with the medication round.*

I don't remember what time it was but later, [the care assistant] came back to me and told me that Nicola still hadn't started the medication round.

[…]

Later, around 6.50pm I received a phone call from the owner. He stated that he had received a call from [the care assistant] *advising him that Nicola was not fit to give out medications. He told me that he had looked at CCTV and seen Nicola swaying with her eyes closed in the corridor. He asked me if I could go back but I told him it would take me 45 minutes and by that time, the night time nurse would have arrived and Nicola would be gone.*

[…]

Due to Nicola delaying the medication round, the knock-on effect was that the medication round was very late and residents did not get their medication in a timely manner. This meant that residents could have been in pain, as there were pain killers that needed administering. This also meant those who had the same medication at night time, couldn't get them until midnight, which is highly disruptive.'

The panel also had regard to Witness 1's oral evidence in which she that although she had trouble recalling the incidents given the time that has lapsed, she recalls that she had been informed that Mrs Fraser had not undertaken the teatime medication and had asked a Care Assistant to assist Mrs Fraser due to the *'knock on affect'* that a late medication would have on the residents.

The panel noted that Mrs Fraser denied this and claimed that she stated had given the teatime medication round. However, the panel found that Witness 1 was clear in her evidence that this had not been carried out in a timely manner. Accordingly, the panel found Charge 4 proved.

Charge 5

Whilst working at Mickley Hall

5. On 29-30 August 2021:
    a) Failed to consult electronic medication administration record ('MAR') charts before administering medication;
    b) failed to take any, or any adequate, steps to escalate your difficulty operating the electronic MAR system.

Charge 5 is found proved in its entirety.

In considering Charge 5, the panel had regard to the legal advice about the word *'failed'.* The panel considered the following questions. Did Mrs Fraser have a duty to do what is alleged she did not do? If so, what was that duty? Did Mrs Fraser not discharge that duty? If so, does she have a proper reason for not doing so?

In respect of Charge 5a, the panel heard from Witness 3 that it was not uncommon for agency nurses to have difficulties in accessing the eMAR system. Witness 3 stated in her statement to the NMC dated 6 January 2023:

‘Within Mickley Hall, an electronic medication system is used where you access all the MAR sheets and Nicola stated to staff that she was aware of the system and had used it before. The nurses set Nicola up with a user log in and password and tested it so they didn’t have any worries.’

Witness 4 said in her statement to the NMC dated 31 May 2023 that she had given Mrs Fraser a handover:

‘When Nicola first arrived, I asked if she was familiar with the Electronic MAR (EMAR) system that we used, which she said she was. The EMAR system is what agency nurses usually had trouble with, so even though she was familiar, I still went through it with her just to be sure. We went through it step by step. I showed her how to log on, how to access the medication charts and how to give medication. Nicola said that she understood everything as she had given medication using the EMAR with no problems. I also told her that there were instructions on how to use the system on the side of the cupboard.

I then made Nicola a temporary username and used the generic password of 1234. Nicola then logged on with this username and changed the password to her own personal password.

[…]

After the walk around, we went back to the computer, and I asked Nicola to log on again to double check everything was working, which she did with no problem. Nicola then gave a resident their medication, so I could see her administer it and sign it off on the system correctly.’

The panel noted that this was supported by Witness 4’s contemporaneous note dated 31 August 2024:

'She said she knew a bit about computerised administration. Went through log onto computer then set up password for EMAR. She had managed to get on computer.'

Witness 4 further reiterated the handover she provided Mrs Fraser in her oral evidence and stated that Mrs Fraser could access the eMAR system when she left.

Witness 3 explained that at the time of the alleged event, she lived within proximity to Mickley Hall and could attend Mickley Hall if needed. She stated that a similar situation had occurred a few weeks prior to the incident and that she had come in to resolve the issue. Witness 3 told the panel that she recalled receiving a call at approximately 21:30 on 29 August 2021 and later around midnight and that she provided advice to Witness 8 and Mrs Fraser, which included contacting various people that may assist Mrs Fraser in regaining access to the eMAR system. Witness 3 stated that on the last call, she had advised them to call her back if the issue was not resolved. Witness 3 stated that she did not receive a further call.

The panel also had regard to Witness 5 and Witness 6's evidence as they received the handover from Mrs Fraser on the morning of 30 August 2021. Their account further supports that Mrs Fraser did in fact have an issue accessing the eMAR system.

The panel noted Mrs Fraser's incident statement dated 15 September 2021:

'After handover I started the medications round using the EMAR system […] *During the medications round I was then distracted by the emergency bell* […]

Following this incident I then returned to my computer to find that both laptops had timed out, and I was unable to get back into the EMAR system using my login code. […] [Witness 8] *attempted to login with my code but this*

was also unsuccessful. I then rang the nurse who was on duty earlier, this was around 22:30pm (approx.) but there was no answer. So I contacted the [Witness 3]- *she advised me to try the other computer and ring her back if we couldn't get in. We both looked around the treatment room and the nurses station several times to look for a back up plan in case the EMAR system goes down. We couldn't find one anywhere.*

I rang the number on the screen which said IT Department, but was informed 'this number is no longer in use'. Additionally we looked for the current prescriptions which we were again unable to find.

[Witness 8] *then rang* [Witness 3] *again for support; I understand that* [Witness 3] *shared her login code with* [Witness 8] *but this was also unsuccessful.* [Witness 3] *did not come to the building to support us at that time but advised switching the system off and waiting for 30 minutes and trying again. It was approximately 11:30 at that point I was becoming very anxious about the time and felt I had little choice but to give the medication that was prescribed for night time and the QDS medications, taking instruction from the prescription on the medication boxes*

This took a long time as I was careful doing this and was aware of the residents who had already received their night medications at the teatime round as this had been handed over to me by the first nurse […]*'*

The panel was sympathetic to the events that unfolded and recognised that the shift was difficult for Mrs Fraser given that she was the sole nurse in charge and did not have access to the eMAR system throughout the shift. However, the panel was of the view that Mrs Fraser had a duty to consult the eMAR system before administering any form of medication to the residents and the panel considered that it was unsafe for Mrs Fraser to proceed as she did. There was a risk to the residents' safety. By her own admission, Mrs

Fraser stated that she felt anxious of the time and felt pressured to administer medication using medication boxes. Accordingly, the panel found Charge 5a proved.

The panel next considered the evidence for Charge 5b. The panel noted that the first call to Witness 3 took place around 21:30, however, there appears to be no further call to Witness 3 until midnight. Witness 3 told the panel that Witness 8 was also present during those two calls, and since she was not subsequently contacted again, she assumed that the issue had been resolved. Witness 3 further reiterated in her oral evidence that she would have attended Mickley Hall had the problem persisted, although, she also stated that the reason that they had engaged agency staff such as Mrs Fraser was to allow her to rest as she had worked the previous night.

The panel noted that Mrs Fraser appeared to accept her duty as she stated in her incident statement dated 15 September 2021:

> *'I have not been in a situation like this before. However, having reflected on the night shift I do realise that I should have been much more persistent and called* [Witness 3] *again to ask her to come in and set up the system once more, especially as she was aware that it was my first time in the building. Despite that I was anxious that the medications needed to be given and believed I made a professional decision in error to administer the medications where I felt it was safe to do so. It has been an extremely difficult learning situation for me. I am frustrated at the lack of guidance and support we received from the senior management team that night but I am fully aware of how I may have impacted on the safety of the service users and I apologise for the risk that this action caused.'*

In the circumstances, the panel took the view that Mrs Fraser had a duty to persevere in contacting Witness 3 and exhaust this option because there was no other way in which Mrs Fraser could have been able to access the system. Mrs Fraser's decision to administer medication without the guidance of eMAR risked patients' safety. The panel

concluded that she should have escalated the matter by a further call to Witness 3 even at that late hour. As such, the panel found Charge 5b proved.

Charge 6

6. On 29 August 2021
    a. failed to administer, or alternatively failed to record that you had administered, 88 medications to 18 residents;
    b. overdosed 7 residents by administering medications already received.

Charge 6a is found NOT proved.

Charge 6b is found proved.

The panel considered the following questions. Did Mrs Fraser have a duty to do what is alleged she did not do? If so, what was that duty? Did Mrs Fraser not discharge that duty? If so, does she have a proper reason for not doing so?

The panel carefully noted the timeline of events and the context surrounding the shift. After failing to access the eMAR system, the panel heard from Witness 8 that she and Mrs Fraser had contacted Witness 3 on two occasions during that nightshift for assistance. On both occasions, Witness 3 provided practical advice but did not attend Mickley Hall.

The panel also took into account Mrs Fraser's response to the allegations dated 25 March 2024:

> '[…] *I can dispute what some employers are saying that are not true such as mickley hall, when I got logged out of the computer for the meds, I tried my very best to get back in, I called the manager twice and she didn't sound happy for waking her when she was off duty. My anxiety then kicked in and I didn't know what to do for the best. The manager arrived to work at 06:30am*

the next morning, she went straight to her office instead of coming to see if I was getting on ok, if she had have, she could have got me logged on and I could have done all the am meds. […]*'*

The panel took the view that Mrs Fraser had a duty to consult the system and dispense the medication accordingly. However, at that specific time, she was not able to access the eMAR system, therefore she could not with certainty know what medication was required. Given that Mrs Fraser had no way of checking this information, the panel found that it was reasonable for Mrs Fraser not to do so. Accordingly, the panel found Charge 6a not proved.

The panel next considered the evidence in respect of Charge 6b. The panel had regard to Witness 3's statement to the NMC dated 6 January 2023:

'It was only after Nicola had left that I had time to investigate the occurrences of the night shift more that I realised how many medications she had missed and how many she had overdosed. I went and accessed the electronic medication system (with no issues) and found there were 88 missed medications from the night before. There were also 7 residents that Nicola had overdosed as the medication she gave them, they had already received.

[…]

The only way I could figure out what medication had been missed was by looking at what medication had been due and not signed on the electronic system and comparing it to the piece of paper Nicola had handed me. But really all I could rely on was this bit of paper from Nicola stating what she had given and comparing it, so it was not 100% reliable. The missed medications only relate to the night time medications, I did not include the 6 am medications on the list. Although Nicola missed ALL these medications, it

was remedied by the day staff giving them, albeit late meaning they were not missed.'

The panel had regard to the contemporaneous documents collated by Witness 3 which included the missed medication report for 29 August 2024, overdosed medication information, accident/incident report form and medicines error notification form.

The panel had regard to Mrs Fraser's incident statement in relation to the Mickley Hall incident dated 13 September 2021. She wrote:

'Here is my statement for Mickley Hall where I did a night shift on Sunay 29th August 2021 [sic]
This was the first time I had worked at Mickley Hall, and when I arrived for work I was given a thorough handover by 1 of the nurses and a not so thorough handover from the 2nd nurse on duty.
The first nurse told me which residents had already had their night time medications and I recorded this on the notes I had written. The second nurse gave me a a brief handover and did not advise me of any of her residents who had received their night time medication. She advised me however that the EMAR system would advise me who had already their medication.'

The panel determined that there was sufficient evidence before it to find Charge 6b proved. Mrs Fraser acknowledged that she had taken a risk with patients' health by administering medication without proper information, and hence overdosing seven residents by administering medication again. The panel therefore found Charge 6b proved.

Charge 7

7. On 30 August 2021 failed to administer any medication in the 6am round

This charge is found NOT proved.

The panel took into account the evidence from Witness 3, Witness 4, Witness 5 and Witness 6, who agreed that Mrs Fraser had acted correctly in not administering any medication in the 6am round. The panel has adopted the same reasons as those outlined in Charge 6a in that Mrs Fraser complied with her duty to maintain safety by not administering the morning medication without the relevant information.

Charge 8

8. On 29-30 August 2021 failed to prioritise patients in that you:
    a. did not respond to a request to review Resident A in a timely manner;
    b. did not commence Resident B's PEG feed;
    c. did not flush Resident C's PEG feed;

Charge 8a is found proved.

Charge 8b and 8c are found NOT proved.

The panel noted Witness 8's evidence in respect of Charge 8a. Witness 8 provided the panel with direct evidence, as she was the team leader (care staff) on duty during the night shift on 29 August 2021-30 August 2021. Witness 8 stated that she had heard Resident A (Mickley Hall) *'shouting out'* which was unlike her. Witness 8 said that she went to find Mrs Fraser and expressed her concerns and Mrs Fraser allegedly stated that she would check the observations of Resident A (Mickley Hall) once she has smoked a cigarette. Witness 8 then stated that after 15 minutes, Resident A (Mickley Hall) had confirmed that she was yet to be seen by Mrs Fraser. Witness 8 then approached Mrs Fraser and accompanied her to see Resident A (Mickley Hall).

The panel also had regard to Witness 3's evidence but noted that she was not present when the incident occurred.

The panel found that Witness 8 was clear in her account. Mrs Fraser had a duty to check on Resident A (Mickley Hall) in a timely manner after having been informed that she was feeling unwell and shouting out, which was unlike her. Mrs Fraser failed to prioritise Resident A (Mickley Hall) and, therefore, it found Charge 8a proved.

The panel next considered the evidence in respect of Charge 8b. The panel heard from Witness 4 that Resident B (Mickley Hall) required their PEG feed overnight. The panel had sight of the Feed Regime Record Card for Resident B (Mickley Hall) which shows, *'10pm-200 mls water* […] *start 100 mls NUTRISON ENERGY at 75mls/hr'.*

The panel heard from Witness 4 that the relevant information could be found on the eMAR system and in the PEG folder which was located by the laptop. Witness 3 told the panel that it was in the Nurse's office. Witness 4 stated that if Mrs Fraser could not access the eMAR system, she could have accessed the PEG folder or spoken to someone on call. She acknowledged that if Mrs Fraser could not get into [the Nurse's Office], she could not get access to the PEG folder. Witness 6 stated in her oral evidence that as Mrs Fraser was the only nurse on duty there was no nurse to tell her about the folder and that as Mrs Fraser could not get into [the Nurses' Office], she could not access the folder.

Mrs Fraser stated in her incident statement dated 15 September 2021:

> *'Under these circumstances I did not feel confident to put NG feeds up without a regime of volume over time and I didn't want to cause ReFeed syndrome. I thought it was much safer not to give PEG feeds at all rather than to give and risk causing further problems'*

Mrs Fraser's position was further supported by the witnesses in that they said it would have been dangerous to give a PEG feed without knowing the rate or volume, and therefore Mrs Fraser has taken the correct course of action by not administering this.

The panel took the view that Mrs Fraser had a duty to ensure the safety of her patients, which she had acted upon by not giving the PEG feed. The panel therefore found Charge 8b not proved.

In considering Charge 8c, the panel had regard to Witness 6's contemporaneous evidence which is a handwritten statement dated 8 August 2021:

> *'*[…] *When I started to do PEG medication for Resident C I found a spare extension tube in his room, which did not belong to him, therefore probably no medication or flushes were given to him at night. He was also covered in dry faeces'*

In Witness 6's oral evidence she stated:

> *"*[…] *The day staff or night staff or the nurse who you work with alert you to the additional documentation and additional folders which need to be completed. I don't know whether anybody alerted Nicola, whether she's been told by the day staff or whether she's been told by any other staff at handover. Obviously because she was the only nurse on the shift, there wouldn't have been a work colleague who would have told her about that folder.*
>
> […]
>
> *it is a busy care home with different lengthy medication, you'd have to work consistently and quickly. I would expect her losing time not being able to regain access to the medical room"*

Mrs Fraser stated in her incident statement dated 15 September 2021:

'However, I recall flushing most of the PEGs and some of the residents who had PEGs could drink normally so I ensured they were given oral fluids to prevent dehydration.[…]*'*

The panel was of the view that Witness 6 was uncertain in her evidence about whether Mrs Fraser flushed the PEG tube for Resident C (Mickley Hall). Mrs Fraser refuted this charge and stated that she recalled flushing most of the PEG tubes. The panel noted that Mrs Fraser had been under immense pressure during this nightshift as the sole nurse and without access to the eMAR system. Without sufficient evidence to support charge 8c, the panel found this charge not proved.

Charge 9

9. On 30 August 2021 failed to give an adequate and/or accurate handover in that you:
    a. Mixed up information about residents;
    b. did not handover that Resident D was in hospital;
    c. stated that Resident D had received medication when they had not;
    d. failed to provide adequate information about Resident E;

Charge 9 is found proved in its entirety.

The panel heard evidence from Witnesses 3 and 6. It had sight of the loose handwritten notes written by Mrs Fraser during her shift, and all three witnesses were able to confirm that these were the notes provided to them by Mrs Fraser during handover.

In addressing Charge 9a, Witness 6 wrote in her handwritten contemporaneous statement dated 30 August 2021:

'At the morning handover, the agency nurse Nicola Fraser has given report for night shift. She stated that she couldn't log in into the system and see

electronic MARR chart […] *She had some handwritten notes. At the time of the report, she was keep mixing up residents names and what was given to them.'* [sic]

Witness 6 further stated in her oral evidence:

"Yes, there was quite few loose pages which she had handwritten on They didn't appear to have the page number because she was shuffling the pages in front of us and she was looking at one page, then trying to find information on the different page. So, it was quite few pages. And that probably was making things more confusing for her"

Witness 3 stated in her statement to the NMC dated 6 January 2023:

'At 7.45 am I went to listen to the handover from Nicola to the day nurses. Nicola handed them a bit of paper and advised them that those were the night time medications that she thought she had given to the residents, but couldn't be sure. This was the first I knew of the concerns. This meant she hadn't signed for anything on the computer, so we had no way of knowing for sure what had or hadn't been given.'

The panel found Witness 3 and Witness 6's account corroborated each other, and that Mrs Fraser had mixed up information about residents. Accordingly, it found Charge 9a proved.

In considering Charge 9b and 9c, the panel had regard to Witness 5's local statement dated 30 August 2021:

'NF also handed that she had given Resident D her risperidone, however we later learnt that Resident D had been admitted into hospital the day before […]'

Witness 3 appeared sympathetic to Mrs Fraser's circumstances and stated in her statement to the NMC dated 6 January 2023:

> *'In regard to mixing up information regarding resident in the handover. I was present for the handover so directly witnessed this. I can understand for an agency nurse and can sympathise getting a bit confused regarding each resident and who they are. But it was worrying that* [Resident D (Mickley Hall)] *wasn't even in the home she told the staff in handover that she had given them medication. The worry was if she had given this medication, who did she give it to. But I can understand a bit of confusion for a new agency nurse.'*

Mrs Fraser stated in her incident statement dated 13 September 2021:

> *'In relation to the gentleman who was in the hospital, I can confirm that I didn't give him his medications. I went to his room but he wasn't there and it was then I remembered he was in hospital.'*

The panel determined that Witness 3 and Witness 6 were clear in their accounts that Mrs Fraser had handed over that she gave Resident D (Mickley Hall) their medication. The panel concluded that Mrs Fraser had not mentioned in the handover that Resident D (Mickley Hall) was in hospital. The panel also heard from both witnesses that Mrs Fraser had handed over that Resident D (Mickley Hall) received their medication when they had not. The panel accepted that Mrs Fraser may have been confused given that she referred to Resident D (Mickley Hall) as male. The panel was informed that the resident was female.

The panel therefore found Charge 9b and 9c proved.

In considering Charge 9d, the panel heard evidence from Witness 5. Witness 5 told the panel in her oral evidence that she was astounded by the nature of the language that Mrs Fraser used in her handover of Resident E (Mickley Hall). In her local statement dated 30 August 2021, she stated:

> *'During the handover process NF handed over that Resident E a 'was being naughty and pretending she couldn't breathe' I pointed out to her that this resident had Motor Neuro Disease (MND) Asthma and uses a BiPap so it was likely that she couldn't breathe. She replied with 'the carers took her pillow out and then she was fine' so again I explained that it was likely positional and due to her condition, position changes can eliminate or ease breathing problems.'*

Witness 6 supported the account, as she wrote in her handwritten statement dated 30 August 2021:

> *'One of the other residents (Resident E) was in a lot of pain and had to have some additional pain relieve. Nicola also stated that the resident* […] *was naughty and pretended that she could not breathe* […] *At this time regular nurse* [Witness 5] *pointed out that Resident E had a condition and struggle to breathe when positioned to side.'* [sic]

Mrs Fraser stated in her incident statement dated 13 September 2021:

> *'The night care assistant, whose name I can't remember, said "she's naughty, and does this when she doesn't want to be on her side". I do remember that I did voice this in hand over, but also stated that once I'd repositioned the lady onto her back she was able to breathe much more easily.'*

When Witness 6 was asked whether it was possible that Mrs Fraser may have been repeating a comment she had been told by another staff member during the shift, Witness 6 confirmed that Mrs Fraser said that Resident E (Mickley Hall) had been *'naughty and pretended she couldn't breathe.'*

The panel found the accounts of Witness 5 and Witness 6 corroborated each other. The panel concluded that Mrs Fraser had failed to provide adequate information about Resident E (Mickley Hall) because she had not included in her report at handover that Resident E (Mickley Hall) had been in pain. It therefore found Charge 9d proved.

Charge 10

Whilst working at Breagha House

10. On 22 November 2021 in relation to Resident A (Breagha House) you breached professional boundaries in that you:
    a. cuddled the resident;
    b. kissed the resident;
    c. Sat on the resident's knee;
    d. Made inappropriate comments that the resident 'had a boner' or words to that effect

Charge 10 is found NOT proved.

The panel noted that the evidence on which Charge 10 was based was the subject of a hearsay application which the panel refused. Following this application, the NMC did not adduce any evidence in relation to this charge. Accordingly, the panel found Charge 10 not proved.

Charge 11

Whilst working at [PRIVATE]

11. On 6 December 2021 failed to treat Resident B ([PRIVATE]) with dignity in that, you:
    a. showed the resident's underwear to other staff members;
    b. made inappropriate comments about the resident being 'a crossdresser' or words to that effect.

Charge 11 is found proved in its entirety.

The panel acknowledged that the sole evidence for Charge 11 was the subject of a hearsay application which the panel decided to allow.

The panel first considered Witness 7's statement to the NMC dated 16 July 2024:

> *'It was reported to me by* [Colleague B], *another member of staff that whilst Nicola was putting away Resident B (*[PRIVATE]*) laundry, she noticed a pair of women's knickers to be put away. Nicola proceeded to take the knickers from the pile, out to the corridor where* [Colleague B] *was and waved the pants in the air and shouted something along the lines of, 'These are not Resident B (*[PRIVATE]*) are they – or is he a cross dresser?'*
> *Resident B (*[PRIVATE]*) was able to see and hear Nicola out in the corridor waving the knickers in the air*
>
> […]
>
> *When* [Colleague B] *reported the incident to me, I spoke to about what had happened. He told me that he didn't want it going any further, but that he didn't want Nicola back in the home. I agreed to not have her back and I raised the incident with Florence agency.'*

Colleague B was asked about the incident by the NMC on 25 August 2023:

'I remember who you are talking about and the incident, however it was some time ago, so I can't remember the specific details. I remember Nicola was in [Resident B ([PRIVATE])] *room, putting away his clothes and she came across women's underwear. Nicola took the women's underwear and bought them out into the corridor and shouted across to me asking about if they were his. I can't remember now what she said about them, but I remember thinking it was so inappropriate what she had said/done that I reported the incident to* [Witness 7].

[…]

Nicola made some kind of joke as she was putting them back. Once she knew they were [Resident B ([PRIVATE])]*'s, she didn't act discreetly to put them back. She carried on like it was a bit of a joke.'*

The panel also had regard to Mrs Fraser's response dated 25 March 2024:

'Now I want to talk about the gentleman who like to wear female underware. They forgot to tell you that I had no Ida's that this gentleman likes to wear ladies underware. I pressed the call well when I was putting his clothes away and discreetly asked if some washing had got mixed up as the gentleman had ladies underware in his draws. I didn't stand in the corridoe shouting "this man has female undwrware on his draws" I would ever do such a thing. The underware was not labled so how was I to know that the female underware belonged to the gentleman without being informed prior to during handover. I gently apologised to the gentleman explaining I wasn't made aware and it was my first time working there and his undwrware wasn't labled. The gentleman accepted my apology and said himself I wasn't to blame of if I hadn't been informed. I felt really bad regarding this incident as I didn't want the gentleman to feel embarrassed regarding his cross dressing and if I'd have been told, this would have been avoided.' [sic]

The panel found Charges 11a and 11b proved. It is essential to have high standards in relation to the treatment of people with respect and dignity. This matter should have been dealt with sensitively. Mrs Fraser acknowledged this. She made it clear that she was sorry about the incident and apologised to Resident B ([PRIVATE]) and Resident B ([PRIVATE]) accepted that apology. Mrs Fraser acknowledged that she had mishandled the situation. The panel found that although this was hearsay evidence, it is proved to the required standard, namely, it is more likely than not that it happened. Witness 7 also spoke to Resident B ([PRIVATE]) and wrote an account on the same day of the incident, and that means that it is more likely to be accurate than if it was done later. Accordingly, the panel found Charges 11a and 11b proved.

Decision and reasons on service of Notice of Hearing

The panel was informed at the resumption of this hearing that Mrs Fraser was not in attendance and that the Notice of Hearing letter had been sent to Mrs Fraser's registered email address by secure email on 18 November 2024.

Ms Paterson submitted that it had complied with the requirements of Rules 11 and 34 of 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 Fraser's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In light of all of the information available, the panel was satisfied that Mrs Fraser 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 Fraser

The panel next considered whether it should proceed in the absence of Mrs Fraser. It had regard to Rule 21 and heard the submissions of Ms Paterson who invited the panel to continue in the absence of Mrs Fraser. She submitted that the panel has already made a detailed decision in relation to proceeding in Mrs Fraser's absence at the previous hearing. Ms Paterson submitted that there is no evidence that the previous circumstances have changed and as such she invited the panel to consider that Mrs Fraser has voluntarily absented herself.

Ms Paterson submitted that there had been no engagement at all by Mrs Fraser with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

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*.

The panel decided to proceed in the absence of Mrs Fraser. In reaching this decision, the panel considered the submissions of Ms Paterson and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Fraser;
- Mrs Fraser has not engaged with the NMC and has not responded to the email sent to her about this resuming hearing;
- It had sight of an email from Mrs Fraser dated 29 August 2024 which stated, *'Please bear in my absence'*, the panel took the view that this is

likely to be a typographical error, and therefore it is likely that Mrs Fraser meant *"please hear in my absence".* It has not had any further information suggesting her position has changed since the last occasion.

- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Fraser in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address. She will not be able to challenge the evidence relied upon by the NMC 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 in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Fraser's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider:

- First whether the facts found proved in Charges 3a, 3b, 3c, 4, 5a, 5b, 6b, 8a, 9a, 9b, 9c, 9d, 11a and 11b amount to misconduct.

- Thereafter to consider in respect of Charges 1 and 2, and, if it has determined that Charges 3 and 4 do not amount to misconduct, Charges 3 and 4, whether Mrs Fraser's fitness to practise is impaired by reason of [PRIVATE]; and
- Thereafter in respect of any charges which the panel has found amount to misconduct, whether her fitness to practise is impaired by reason of misconduct.

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.

The panel adopted a two-stage process in its consideration of the allegation that Mrs Fraser's fitness to practise is impaired by reason of misconduct. First, the panel must determine whether the facts found proved which allegedly amount to misconduct do amount to misconduct. Secondly, only if those facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Fraser's fitness to practise is currently impaired as a result of that misconduct.

The panel adopted a one-stage process in its consideration whether in respect of Charges 1 and 2, and, if they are not found to amount to misconduct, Charges 3 and 4, Mrs Fraser's fitness to practise is impaired by reason of [PRIVATE].

Submissions on misconduct

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.'*

Ms Paterson invited the panel to take the view that the facts found proved in Charges 3a, 3b, 3c, 4, 5a, 5b, 6b, 8a, 9a, 9b, 9c, 9d, 11a and 11b amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Ms Paterson identified the specific, relevant standards where Mrs Fraser's actions amounted to misconduct. This included section 1.2, 1.3, 1.4, 5.1, 8.2, 8.6, 18.1, 18.3, 19.1, 20.1, 20.2, 20.3, 20.5, 20.9 and 20.10.

Ms Paterson provided the panel with written submissions:

'6. The Panel should first consider whether the facts found proved at 3a – 11b amount to misconduct.

7. In doing so, the Panel will be mindful of the way in which the Charge was amended in respect of charges 3 and 4, namely, to allow consideration as to whether this conduct occurred as a consequence of Ms Fraser's [PRIVATE]*. The Panel has found that Ms Fraser was at work whilst unfit on the date of her conduct at 3 and 4 and, together with the general observations of Ms Fraser's behaviour during that shift, the Panel may consider that it is probable her conduct arose as a consequence of* [PRIVATE]*. Alternatively, the Panel may take the view that there is insufficient evidence to properly link Ms Fraser's* [PRIVATE] *to her failures in wound care and undertaking a medication round. In such circumstances, the Panel should go on to consider whether or not this conduct amounts to serious professional misconduct.'*

Ms Paterson further submitted:

‘10. Having taken the breaches of The Code into account, the Panel is invited to find that, through her conduct, Ms Fraser has significantly departed from the standards expected of a registered nurse. Medication errors, taking risks with patient safety, mixing up residents, and failing to prioritise patients in distress all put patients at risk of harm and this is serious in any context. In respect of Charge 11, the Panel has found that Ms Fraser failed to treat a resident with dignity and that it is essential to have high standards in this regard. The evidence demonstrates that Ms Fraser’s failure to treat the matter sensitively, as should have been the case, caused Resident B ([PRIVATE]*) discomfort and had the potential to cause serious harm at a time when they were new to expressing themselves in a different way’*

Submissions on impairment

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

Ms Paterson referred the panel to the *Grant* test and provided the following written submissions:

‘15 In respect of past conduct, it is submitted that Ms Fraser’s actions put patients at unwarranted risk of harm and breached fundamental tenets of the profession as set out in The Code,

namely practising effectively, preserving safety, and promoting professionalism and trust.

16 *In considering whether Ms Fraser is liable to put patients at unwarranted risk of harm and breach fundamental tenets of the profession in the future, the Panel may wish to have regard to the context in which the conduct occurred, Ms Fraser's insight, and steps taken to remediate the concerns.'*

Ms Paterson further submitted in respect of impairment:

'Context

17 *Ms Fraser's own personal accounts set out that at the time of the conduct found proved, the working environment was challenging and this was accepted by NMC witnesses. However, it is relevant that her conduct was not isolated to one particular work environment but was instead repeated across several workplaces. This may indicate that Ms Fraser had more general difficulties with her conduct in a nursing/residential home setting, rather than that her misconduct was triggered by an exceptionally challenging situation.*

18 *Ms Fraser has set out that* [PRIVATE] *at the relevant time.*

Insight and remediation

19 *As set out by the Panel in its decision on the facts, Ms Fraser has produced some evidence of reflection and insight into the relevant conduct. By way of example, the Panel highlights in its findings at Charge 11 that Ms Fraser acknowledged she should have handled the situation differently and she made it clear that she was sorry.*

20 *It is submitted that whilst Ms Fraser has, in some respects, begun to demonstrate some insight, there is limited evidence that she has developed good insight into* [PRIVATE] *and the seriousness of her medication errors and failures to prioritise patients. She has not yet demonstrated that she understands the level of risk to which patients were subject as a result, nor that she appreciates the impact that her conduct could have on public confidence in the profession.*

21 *It is submitted that there is insufficient evidence to support that Ms Fraser has remediated her* [PRIVATE].

Risk of Repetition

22 *The NMC's guidance on impairment sets out that the Panel should ask itself whether it is highly unlikely that the conduct will be repeated. It is submitted that the Panel cannot be satisfied of the same because of Ms Fraser's failure to consent to medical testing and/or examination, the repeated nature of her misconduct, and the limited insight and remediation that has been demonstrated.*

The Public Interest

23 *It is submitted that a finding of impairment is required to uphold public confidence in the profession and to maintain proper professional standards of conduct*

Conclusion

24 *The Panel is respectfully invited to find that the facts found proved at 5 to 11 amount to serious professional misconduct, the facts at 3 and 4 may equally amount to the same.*

25 Ms Fraser's fitness to practise is currently impaired by reason of [PRIVATE] *and misconduct.'*

The panel heard and accepted the advice of the legal assessor. This included references to the relevant case law.

Mrs Fraser's [PRIVATE]

During the course of the NMC's submissions, the panel noted Mrs Fraser's email dated 25 March 2024:

'As much as I'd love to return to nursing, [PRIVATE]'

The panel gave consideration as to whether or not it should instruct the NMC to investigate that further.

Ms Paterson was given time to seek further instructions from the NMC. At the resumption of the hearing on 18 December 2024, Ms Paterson addressed the panel in respect of the NMC Guidance DMA-5 *'Directing further investigation during a hearing'.*

The panel ultimately decided that there was insufficient material at present to warrant it directing the NMC to undertake further investigation [PRIVATE]. The reasons for taking this decision were as follows:

- [PRIVATE];
- Whilst Mrs Fraser considers that the mistakes which she has made and which have been proved in this hearing (as set out 3a, 3b, 3c, 4, 5a, 5b, 6b, 8a, 9a, 9b, 9c, 9d, 11a and 11b) [PRIVATE], and therefore may be explained thereby, the only evidence in support of that proposition comes from her. There is no expert evidence to that effect. Moreover, the period when she made those *'mistakes'* was in the second half of 2021, some two and a half years [PRIVATE] refers in her email.

Taking into account the fact that Mrs Fraser did not attend the hearing to support her observation with any submissions or with any detail, the panel did not consider that it would be proportionate to adjourn and direct an investigation especially when she has not submitted herself to an assessment prior to March 2024. There had been several requests on behalf of the NMC for Mrs Fraser [PRIVATE], but she failed to respond.

- The panel considered that it was entitled to take account of the point which Mrs Fraser makes when it reaches its decisions on misconduct and impairment notwithstanding the absence of any expert evidence. It determined that it would attach appropriate weight to her submission in all the circumstances.

Decision and reasons on misconduct

When determining whether the facts found proved in Charges 3a, 3b, 3c, 4, 5a, 5b, 6b, 8a, 9a, 9b, 9c, 9d, 11a and 11b amount to misconduct, the panel had regard to the terms of the Code.

The panel first considered Charges 3a, 3b, 3c and 4. It noted that by Charge 2, it has found proved that Mrs Fraser attended work on 19 December 2019 as a nurse while unfit by reason of [PRIVATE] set out at Schedule 1, and that it has found proved that on that day she failed to treat Resident A's wound properly as set out in Charges 3a, 3b and 3c and that she failed to undertake the teatime medication round as set out in Charge 4. It reached the conclusion that the reason for the mistakes which she made on 19 December 2019 was [PRIVATE], rather than misconduct. It therefore did not find misconduct in respect of the matters found proved in Charges 3a, 3b and 3c and 4.

The panel next considered Charges 5a, 5b, 6b, 8a, 9a, 9b, 9c, 9d, 11a and 11b. The panel was of the view that Mrs Fraser's actions in Charges 5a, 5b, 6b, 8a, 9a, 9b, 9c and 9d did fall significantly short of the standards expected of a registered nurse, and that Mrs Fraser's actions amounted to a breach of the Code. Specifically:

‘1 ***Treat people as individuals and uphold their dignity***
To achieve this, you must:

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.

18 ***Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations***
To achieve this, you must:

18.3 Make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines.

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:

20.1 Keep to and uphold the standards and values set out in the Code.’

The panel did consider whether there may have been another [PRIVATE] which caused or contributed to the failures and mistakes which Mrs Fraser made as set out in Charges 3a, 3b, 3c, 4, 5a, 5b, 6b, 8a, 9a, 9b, 9c, 9d as she submitted in her email dated 25 March

2024. The panel did not consider that the possibility that her past mistakes could have reflected [PRIVATE] was sufficiently grounded in evidence.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Fraser's actions as outlined in Charges 5a, 5b, 6b, 8a, 9a, 9b, 9c and 9d, cumulatively amounted to serious misconduct in that they significantly departed from the standards expected of a registered nurse. As Miss Paterson has argued, medication errors, taking risks with patient safety, mixing up residents, and failing to prioritise patients in distress all put patients at risk of harm.

The panel recognised that Mrs Fraser experienced difficulties with the eMAR system. However, notwithstanding that she was an agency nurse, Mrs Fraser had the responsibility as she was the sole nurse to provide full and appropriate care to vulnerable residents.

The panel found that Mrs Fraser's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In respect of Charges 11a and 11b, the panel noted the context of this Charge in that Mrs Fraser had been working in the capacity of a care assistant when this incident took place. The panel took the view that the event that unfolded appeared to be an honest mistake as a result of a misunderstanding. Mrs Fraser had not been informed of the resident's preferences. The panel therefore decided that Mrs Fraser's actions in this charge did not amount to misconduct.

Decision and reasons on impairment

The panel first considered whether Mrs Fraser's fitness to practise is impaired by reason of [PRIVATE] set out at Schedule 1. This allegation relates to Charges 1, 2, 3a, 3b, 3c and 4 only. The panel noted its finding of facts in respect of Charge 1, namely that she only [PRIVATE] set out at Schedule 1 *'in the past'*. That is a reference to the time when she

made the mistakes in Charges 2, 3a, 3b, 3c and 4. The panel made no finding that that [PRIVATE] persisted thereafter. Accordingly, the panel did not find that her fitness to practise is currently impaired by reason of that [PRIVATE].

The panel next went on to decide if as a result of the misconduct found proved in relation to Charges 5a, 5b, 6b, 8a, 9a, 9b, 9c and 9d, Mrs Fraser'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. 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) […]'

The panel found that patients were placed at unwarranted risk of harm as a result of Mrs Fraser's misconduct.

The panel acknowledged that in Mrs Fraser's absence, the information before the panel is limited given that the panel has no recent evidence before it to establish insight, remorse, remediation and strengthening of practice.

The panel took into account the available information before it. This included Mrs Fraser's response bundle which contained correspondence between Mrs Fraser and the NMC and the most recent email response from Mrs Fraser dated 25 March 2024.

The panel considered that Mrs Fraser offered some context and reflection into the events which occurred in 2021 and demonstrated limited insight. However, the panel concluded that there was insufficient evidence before it to demonstrate that Mrs Fraser has taken the necessary steps to demonstrate strengthening of practice. The panel therefore is of the view that there is a risk of repetition given that Mrs Fraser has been unable to provide evidence of remediation or meaningful insight. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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 Mrs Fraser's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Fraser's fitness to practise is currently impaired by reason of her misconduct.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for eight months with review. The effect of this order is that the NMC register will show that Mrs Fraser'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

Ms Paterson informed the panel that in the Notice of Hearing, dated 8 August 2024, the NMC had advised Mrs Fraser that it would seek the imposition of a 12-month suspension order with review if it found Mrs Fraser's fitness to practise currently impaired.

Ms Paterson referred the panel to the relevant NMC Guidance and highlighted that the panel must take into consideration the principle of proportionality.

In outlining the aggravating features, Ms Paterson submitted that the findings made in this case demonstrate conduct which put patients receiving care at unwarranted risk of harm.

In relation to mitigating features, Ms Paterson submitted that Mrs Fraser provided context in which she set out that this was a challenging shift, and it was her first time working at that particular care home. Ms Paterson submitted that Mrs Fraser also advanced some challenging personal circumstances that she faced at the time. However, Ms Paterson reminded the panel that the guidance advises that less weight should be given to personal circumstances than might otherwise be the case where the panel is considering patient safety and the wider public interest.

Ms Paterson submitted that taking no action or imposing a caution order would be wholly inappropriate where the panel has made a finding that there is a risk to patient safety. She submitted that there is also risk of Mrs Fraser repeating the conduct that put patients at risk of harm.

In relation to a conditions of practice order, Ms Paterson submitted that there appear to be identifiable areas of Mrs Fraser's practice that are in need of supervision, assessment or retraining. However, Mrs Fraser has not been able to demonstrate a willingness to undergo retraining. Ms Paterson submitted that a conditions of practice order would not be workable and would not protect the public in the circumstances.

Ms Paterson submitted that in the event that the panel was minded to impose a conditions of practice order, it may wish to consider the following conditions:

- To work under supervision.
- To work in a substantive placement rather than undertaking any agency work where she would be going to different workplaces and where she would not be familiar with the environment.

Further, Ms Paterson submitted that, when considering those types of conditions, it is also important to bear in mind their workability in the setting in which Mrs Fraser may find employment. Ms Paterson reminded the panel that the evidence that Mrs Fraser provided was that she was often working in an environment where there was only one nurse on shift; such an environment may not be workable for conditions of practice. Ms Paterson further submitted that imposing such conditions may be tantamount to a suspension.

Ms Paterson invited the panel to impose a suspension order. She acknowledged that the charges found proved in this case relate to a single shift, and therefore perhaps a single instance of misconduct. Ms Paterson further addressed the relevant NMC Guidance on suspension orders. She submitted that a suspension order would be appropriate as there is no evidence of harmful deep-seated personality or attitudinal problems. There is no evidence of repetition since the incident. The panel could be satisfied that Mrs Fraser has developed a degree of insight and produced some reflection into what went wrong that night. Ms Paterson further submitted that whilst the panel found that there is a risk of repetition, it has made no finding that there is a significant risk in the circumstances.

Ms Paterson submitted that a suspension order is appropriate and proportionate, and a striking off order would be wholly disproportionate in the circumstances.

The panel asked Ms Paterson to provide observations in respect of the relevance of Mrs Fraser's [PRIVATE]. Ms Paterson acknowledged that, as Mrs Fraser has submitted that her mistakes could have been related to [PRIVATE], that [PRIVATE] could potentially be a

mitigating feature of this case. She submitted that it was for the panel to consider the appropriate weight it should attach to this information in the light of the evidence.

Ms Paterson referred the panel to the fact that the NMC had originally submitted that a suspension order for a period of 12 months with a review was the appropriate sanction; however, she acknowledged that the panel had only found misconduct in respect of one shift in August 2021. Nevertheless, she submitted that the panel may deem it appropriate to impose a suspension order for a minimum of six months to allow Mrs Fraser to receive the panel's findings, reflect, develop insight and undertake any necessary training, reading or remediation, so that she can demonstrate that she is fit and ready to practise safely to a future reviewing panel.

Decision and reasons on sanction

Having found Mrs Fraser'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:

- Vulnerable patients were placed at risk of suffering harm.

The panel also took into account the following mitigating features:

- Mrs Fraser may have been experiencing [PRIVATE] difficulties when the incident took place.
- Mrs Fraser experienced difficulties, not of her own making, with the eMAR system on the night in question when she was the sole nurse in charge of the care home.

The panel also considered that Mrs Fraser had shown frankness and insight by disclosing to the panel her [PRIVATE] and that she acknowledged that she is not currently able to practise safely.

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.

The panel next considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Fraser'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 Fraser'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 Fraser's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, and in particular:

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Conditions can be created that can be monitored and assessed.*

The panel acknowledged that the misconduct identified in this case is capable of being addressed by practicable and workable conditions; however, given that Mrs Fraser's engagement with these proceedings has been limited, the panel took the view that there are no practical or workable conditions that could be formulated without Mrs Fraser's engagement.

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 Mrs Fraser remaining on the register.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. It considered that it would be unduly punitive in Mrs Fraser'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.

The panel noted the hardship such an order will inevitably cause Mrs Fraser. 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 eight months with a review was appropriate in this case to allow Mrs Fraser the opportunity to show insight, take steps to complete training relevant to the charges found proved and strengthen her practice.

Towards 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 this with another order.

Any future panel reviewing this suspension order may be assisted by Mrs Fraser attending the proceedings and providing information about the following matters:

- Evidence that she has kept her training up to date.
- Her engagement with the NMC.
- References or testimonials relating to any recent paid or voluntary work.
- [PRIVATE].
- An update regarding her expectations and plans for her future career as a nurse.

This will be confirmed to Mrs Fraser in writing.

Submissions on interim order

The panel took account of the submissions made by Ms Paterson. She invited the panel to impose an interim suspension order for 18 months. She submitted that an interim suspension order would be appropriate to manage the risks identified in this case whilst the substantive suspension order takes effect. Ms Paterson submitted that an interim

suspension order would cover the appeal period, should Mrs Fraser make a decision to lodge an appeal.

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 on the grounds of public protection and the wider public interest, and to cover the appeal period.

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

That concludes this determination.