Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
16 December 2024 - 20 December 2024

Virtual Hearing

Name of Registrant:	Jacqueline Kerr Vallance Morse
NMC PIN	87Y0177S
Part(s) of the register:	Registered Nurse - Sub Part 1 RN1: Adult Nurse (Level 1) - 11 April 1990
Relevant Location:	Ilford
Type of case:	Misconduct
Panel members:	Adrian Blomefield (Chair, Lay member) Allwin Mercer (Registrant member) David Boyd (Lay member)
Legal Assessor:	Martin Goudie KC
Hearings Coordinator:	Rose Hernon-Lynch
Nursing and Midwifery Council:	Represented by Richard Webb, Case Presenter
Mrs Morse:	Not present and unrepresented
Facts proved:	Charges 1,3(a)
Facts not proved:	Charges 2, 3(b), 4(a) and 4(b)
Fitness to practise:	**Impaired**
Sanction:	**Suspension Order (12 months)**
Interim order:	**Interim Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Morse was not in attendance and that the Notice of Hearing letter had been sent to Mrs Morse's registered email address by secure email on 14 November 2024.

Mr Webb, 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 Morse's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision and reasons on proceeding in the absence of Mrs Morse

The panel next considered whether it should proceed in the absence of Mrs Morse. It had regard to Rule 21 and heard the submissions of Mr Webb who invited the panel to continue in the absence of Mrs Morse. He submitted that Mrs Morse had voluntarily absented herself from proceedings.

Mr Webb submitted that there had been no engagement by Mrs Morse with the NMC in relation to these proceedings since an email sent by Mrs Morse to the NMC on 1 November 2023 in which she wrote:

'*yes I would like information regarding agreed removal'.*

The NMC replied by email to Mrs Morse on 1 November 2024 providing details as to how a registrant can apply for agreed removal. Mrs Morse did not respond to this email. The NMC then sent Mrs Morse a follow-up email on 28th November 2023 and again received no response from Mrs Morse.

Mr Webb submitted that there had been no engagement at all by Mrs Morse with the NMC in relation to these proceedings save for an email sent on 1 November 2023 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 (Anthony William)* (No.2) [2002] UKHL 5.

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

- Mrs Morse has not responded to any of the calls and voicemails made to her by the NMC on 10 October 2024 and 9 December 2024
- Mrs Morse has not responded to any of the emails sent to her on 8 November 2024, 14 November 2024 and 9 December 2024 about this hearing
- Mrs Morse has not engaged with the NMC since her email of 1 November 2023
- No application for an adjournment has been made by Mrs Morse
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Number of witnesses are due 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 2015 and 2016
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Morse in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, She has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Morse'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 Morse. The panel will draw no adverse inference from Mrs Morse's absence in its findings of fact.

Details of charges (as amended)

That you, while working as a senior ward sister/ward manager at King George Hospital in Essex:

1) On multiple occasions between 6/7/15 and 9/8/16 failed to work the complete bank shift for which you were paid

2) In relation to multiple bank shifts between 6/7/15 and 9/8/16, claimed payment at a higher rate than should have been paid for that shift

3) And your actions as specified in charges 1 and 2 were dishonest in that:

a) You knew it was wrong to fail to work a complete shift for which you were paid

b) You knew it was wrong to claim payment at the rate of Band 6 in respect of shifts which had been designated as Band 5 shifts.

4) Following an assessment of a patient's deep tissue injury on or around 1 March 2016, failed to subsequently implement a plan to prevent similar injuries occurring in that:

a) A further patient developed a deep tissue injury on or around 11 April 2016

b) A patient's deep tissue injury deteriorated following their admission to Gentian Ward on or around 24th April 2016

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

Decision and reasons on application to amend the charge

The panel heard applications made by Mr Webb, on behalf of the NMC, to amend the wording of charges 1,2 and 4.

The proposed amendment to Charge 1 was to correct a grammatical and date error. It was submitted by Mr Webb that the proposed amendment would provide clarity.

The proposed amendment to Charge 2 was subsequent to the amendment of Charge 1. It was submitted by Mr Webb that the proposed amendment would provide clarity.

The proposed amendment to Charge 4 was to ensure it more accurately reflected the evidence and the position of Mrs Morse as the Ward Manager. It was submitted by Mr Webb that the proposed amendment would more accurately reflect the evidence.

That you, while working as a senior ward sister/ward manager at King George Hospital in Essex:

1) On ~~38~~ **multiple** occasions between 6/7/~~2~~15 and 9/8/16 failed to work the complete bank shift for which you were paid

2) ~~On 24 of the 38 occasions mentioned in charge 1~~ **In relation to multiple bank shifts between 6/7/15 and 9/8/16** claimed payment at ~~Band 6~~ **a higher** rate ~~when payment~~ **than** should have been **paid for that shift** ~~claimed at Band 5 rate~~

3) And your actions as specified in charges 1 and 2 were dishonest in that:
a) You knew it was wrong to fail to work a complete shift for which you were paid
b) You knew it was wrong to claim payment at the rate of Band 6 in respect of shifts which had been designated as Band 5 shifts

4) Following an **assessment** ~~incident~~ of a **patient's** deep tissue injury ~~on the Gentian Ward on~~ or around 1 March 2016 ~~which resulted from not being turned and poor documentation~~, failed to successfully implement a plan to prevent ~~a~~ similar ~~reoccurrence~~ **injuries occurring** in that:

a) A further patient developed a deep tissue injury on or around 11 April 2016 ~~from not being turned and poor documentation~~

b) A ~~further~~ patient**'s** ~~developed a~~ deep tissue injury **deteriorated following their admission to Gentian Ward** on or around ~~19~~ **24** April 2016 ~~from not being turned and poor documentation~~

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

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 amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Morse and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendment, as applied for, with regards to Charges 1 and 2, provide clarity. The panel was of the view that the amendments to Charges 1 and 2 do not fundamentally change the charges. The panel was satisfied that, although Charge 1 is now less specific, this does not provide any injustice to Mrs Morse.

The panel also considered that the amendment to Charge 4 and, while it is a significant amendment, it streamlines the charge and narrows the NMC's case to make clear the focus is purely on management and not causation and there was no unfairness or injustice to Mrs Morse identified.

Background

On 9 August 2017, the NMC received a referral from the Head of Nursing at Barking, Havering and Redbridge University Hospital Trust (the Trust) in relation to allegations which occurred in 2015 and 2016. At the time of these allegations, Mrs Morse was working as a Band 7 Ward Manager/Sister on Gentian Ward at the Trust.

The initial investigation was delayed due to the NMC awaiting disclosure in relation to a fraud investigation that had taken place by the Trust.

The NMC accepts it did not chase disclosure as frequently as it should have which led to further delays. The NMC found that there was a case to answer in mid-2019. Shortly after this the Covid 19 pandemic impacted proceedings and caused further delays.

The NMC resumed the case in late 2019 and identified that further investigation work was required which took a significant amount of time. Subsequently a hearing was considered but had to be cancelled as further investigation work was sought by the NMC.

It is alleged that Mrs Morse did not work the full hours of bank shifts on multiple occasions, and for a number of them claimed pay at a higher rate than she should have done. The Counter Fraud Investigation found that this caused a financial loss of £974.14 and amounted to 49.66 clinical hours.

The findings of the Counter Fraud Investigation related to the first aspect of the referral to the NMC and clinical concerns formed the second aspect of the referral. The clinical concerns were in relation to Mrs Morse becoming subject to a performance improvement plan due to having not taken action that should have been taken in her position as ward manager.

Decision and reasons on facts

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

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

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: Band 9 Divisional Manager in Specialist Medicine at the Hospital at the time of the incidents

- Witness 2: Acting Head of Nursing at the Hospital and Mrs Morse's Line Manager at the time of the incidents

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor which included reference to the case of *Ivey v Genting Casinos [2017] UKSC 67*. It considered the witness and documentary evidence provided by the NMC.

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

Charge 1

"That you, while working as a senior ward sister/ward manager at King George Hospital in Essex:

1) On multiple occasions between 6/7/15 and 9/8/16 failed to work the complete bank shift for which you were paid"

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence provided by Witness 1 and the evidence provided in their witness statement. The panel had specific regard to the information provided in Witness 1's statement which detailed that on 7 March 2017, they interviewed Mrs Morse as part of an investigation. Witness 1 stated:

> *"Jacqueline admitted that she had not worked the correct number of hours on each of the 38 bank shifts highlighted in the investigation. Jacqueline stated that the reason she worked less hours on each of these occasions was because she would rarely take a lunch break or that she would start early for each shift. Jacqueline did recognise that this was not justification for leaving these shifts early."*

The panel also considered the Counter Fraud Investigation report which included an analysis of Mrs Morse's bank shifts cross referenced with the car parking data and found numerous occurrences when Mrs Morse left bank shifts early "*between 1 March 2016 and 8 August 2016*". The report also stated that:

> *"Morse was interviewed under caution on 21 December 2016 and accepted that the car park data which details her leaving the Trust early was correct".*

The panel also took into account the detailed bank shift data from the Counter Fraud Investigation report which provided dates, bank shift start and end times, and car park exit

times for the period from 1 March 2016 to 8 August 2016. This showed on numerous occasions that Mrs Morse exited the car park before her bank shift end time.

The panel also considered the work roster and bank shift data provided by the Trust. The bank shift data covers a period from 7 July 2015 to 30 August 2016 and details regarding bank shifts their:

- Date
- Start and end time
- Ward
- Request Grade
- Staff member
- Booked Grade
- Requester
- Cost

Whilst the panel identified that Mrs Morse was not the requester of all of the bank shifts, the panel did find that Mrs Morse requested the majority of bank shifts that she was allocated.

The panel also considered the investigation meeting the Trust held with Mrs Morse on 7 March 2017 and in which Witness 1 interviewed Mrs Morse. The panel took account of the fact that Mrs Morse was reminded that *"under caution on 21st December 2016 you advised that you were unable to offer an explanation"* regarding leaving bank shifts early. The panel also took into account that Witness 1 asked Mrs Morse during the interview held on 7 March 2017: *"Did you fill in a timesheet?",* to which she replied *"No".* Witness 1 also asked Mrs Morse *"Should you have filled [out] a timesheet?"* and Mrs Morse replied *"Yes".* The panel noted Mrs Morse's admission that she did not fill out a time sheet but should have done.

The panel considered the evidence of when Mrs Morse left the car park, the written and oral evidence of Witness 1, the Counter Fraud Investigation data and the two interviews with Mrs Morse and found that Mrs Morse did leave early on multiple occasions and failed to complete the bank shifts.

The panel found, on the balance of probabilities, Charge 1 to be proved.

Charge 2)

> "That you, while working as a senior ward sister/ward manager at King George Hospital in Essex, in relation to multiple bank shifts between 6/7/15 and 9/8/16:
>
> 2) Claimed payment at a higher rate than should have been paid for that shift."

This charge is found NOT proved.

In reaching this decision, the panel took into account the bank shift data which includes details of the requester, request grade, booked grade and dates and cost. The panel also took into account the oral evidence of Witness 1 and the oral evidence of Witness 2.

The panel confined the questioning of Witness 2 regarding Charge 2 to shifts listed on the bank shift and car park exit data which range from 1 March 2016 to 8 August 2016. This was to ensure the focus of questioning is in relation to Charge 2 and to ensure fairness to Mrs Morse.

The panel noted that Witness 1 stated in oral evidence that claiming payment at a higher rate was not something that should be done. The panel noted that this was inconsistent with the oral evidence of Witness 2, however the panel considered that Witness 1's position in the Trust meant that they were detached from the ward and common practice

with regards to bank shift payment claims. The panel also found that, through no fault of their own, Witness 1 did not have a full understanding of the booking system having not worked the system herself.

The panel noted that Witness 2 stated in her oral evidence that a Band 7 working a Band 5 shift is able to claim Band 6 rates. The panel identified that Witness 2's oral evidence was inconsistent with the answer they gave in an Investigation Meeting on 9 March 2017 when they were asked: *"Is it usual for a bank shift to be put out as a 5 and the person gets paid as a 6?",* as Witness 2 stated:

> *"No I've not seen that before. I did have a question once about a Band 5 who was showing working a Band 6 shift".*

However, the panel found Witness 2 to be clear in their oral evidence that a Band 7 nurse could claim Band 6 rates when working a Band 5 requested shift. The panel also took into account that Witness 2 stated that Mrs Morse did not do anything wrong in booking those shifts.

The panel preferred the evidence of Witness 2 as she was Mrs Morse's direct line manager, understood the booking system, and had responsibility for the ward. It was accepted practice for a Band 7 to book her own Band 5 shifts and to be paid at the rate for a Band 6.

The panel noted that the bank shift of 22 April 2016, was signed off by Mrs Morse's manager at a higher rate than booked and that the bank shift of 21 May 2016 was booked at Band 7 and paid at Band 7.

The panel took into account that the NMC submitted that they are solely relying on Witness 1's written statement that details:

“In this case Jacqueline booked her own bank shifts. Jacqueline was given the authority as the Ward Manager to arrange staffing levels on her ward if she considered additional staff to be a requirement necessity for the ward. Of the 38 bank shifts, 27 were only available at a band 5 rate of pay but Jacqueline wrongly requested 24 of these 27 shifts to be paid at a band 6 rate of pay”.

The panel further noted that the NMC accepted this evidence was at odds with the oral evidence of Witness 2. The panel also took into account that Witness 1 stated in oral evidence that they had no working knowledge of the booking system.

The panel preferred the oral evidence of Witness 2 and noted that it was not provided with Trust policy documentation regarding protocol at that time, and so the panel had to rely on the evidence that has been given. The panel found that the booking process documentation and data does not go to the matter of requesting one grade and receiving payment at a higher grade. The panel therefore found Charge 2 to be not proved.

Charge 3a)

“And your actions as specified in charges 1 and 2 were dishonest in that:

a) You knew it was wrong to fail to work a complete shift for which you were paid,

This charge is found proved.

In reaching this decision, the panel took into account the bank shift data which shows that Mrs Morse was the requester of the majority of the bank shifts in which she was the staff member allocated. Furthermore, the panel noted that the shift start and end times are clearly set out and so, as the requester of the shift, Mrs Morse would have known and had sight of the start and end times of the banks shifts.

The panel also considered the summary of the Trust's interview held under caution with Mrs Morse on 21 December 2016 and in which Mrs Morse tells interviewers she would come into work early; this was her own choice and also said a manager would not get a half hour break. The panel also noted that the interview record states that Mrs Morse told the interviewers when asked for an explanation regarding dates and times of entry and exits on bank shifts that:

> *"she could not work these out but it was nothing intentional; it was her being naïve. She never got time or got her breaks; she would take work home with her"*

The panel accepted that Mrs Morse arrived early to work as evidenced by the car park data. The panel also noted that in the local interview Mrs Morse stated that she knew she had to complete a time sheet but did not.

The panel found that Mrs Morse was a Band 7 registered nurse and knew it was wrong to leave early without permission. The panel further found that Mrs Morse was present on a bank shift as the ward was short of staff and thus required bank shift cover. The panel also found that bank shifts are separate to a substantive post with contractual hours and so bank shifts are not to be used to take time back from working longer hours in a substantive role. The panel considered that a bank shift is a different role with different needs and that Mrs Morse should have remained until the end of the shift.

The panel also found that this was not an isolated event as there were consistent times Mrs Morse left early showing a habit formed and time sheets had not been completed. The panel found this to be dishonest behaviour that became repeated.

The panel took account of the car park data and made the findings regarding bank shifts that Mrs Morse:

- On 34 occasions finished early

- On 4 occasions did not finish early
- On 7 occasions finished under 30 minutes early
- On 6 occasions finished between 30 minutes and an hour early
- On 18 occasions finished over an hour early
- On 2 occasions finished over 2 hours early
- On 1 occasion left 12 minutes into a bank shift

There appears to be one outlier where Mrs Morse leaves twelve minutes into a bank shift on 22 June 2016. The panel accepted that, having regard to all of the data provided, this was out of character for Mrs Morse to leave so early. The panel considered that perhaps there was a genuine reason, which was not put to Mrs Morse in her interview in order for her to provide an explanation, for this occasion. The panel noted it would have been preferable for Mrs Morse to retrospectively identify this and ask for pay to be deducted but the panel did not hear any evidence as to the possibility of this.

Whilst the panel was of the view leaving a bank shift early was not acceptable under any circumstances as this was a 'shop floor' role which requires Band 5 staff to look after the needs of patients in care, the panel did understand that on occasion there might be a situation where a Band 5 nurse might leave early. The panel considered occasions under 30 minutes might fall under this. However, the panel considered leaving thirty minutes or more before a shift's end time was unacceptable, and that a senior nurse would know that leaving thirty minutes or more before a shift's end time is wrong.

The panel found Mrs Morse's actions were dishonest as she had requested bank shifts in the knowledge that they were for a Band 5 nurse and was aware of the start and end times. The panel also found Mrs Morse's actions to be dishonest as she was paid for the entirety of the shift and, although the panel found some instances where Mrs Morse left bank shifts less than 30 minutes early, the majority of early exits are over thirty minutes in the instances put before the panel. Therefore, the panel find Charge 3a to be proved.

Charge 3b)

"And your actions as specified in charges 1 and 2 were dishonest in that:

b) You knew it was wrong to claim payment at the rate of Band 6 in respect of shifts which had been designated as Band 5 shifts."

This charge is found NOT proved.

In reaching this decision, the panel took into account that Charge 3(b) alleges dishonesty in respect of Charge 2. The panel found Charge 2 not proved and subsequently finds Charge 3(b) not proved.

Charge 4)

"That you, while working as a senior ward sister/ward manager at King George Hospital in Essex:

4) Following an assessment of a patient's deep tissue injury on or around 1 March 2016, failed to subsequently implement a plan to prevent similar injuries occurring in that:

a) A further patient developed a deep tissue injury on or around 11 April 2016

b) A patient's deep tissue injury deteriorated following their admission to Gentian Ward on or around 24th April 2016"

This charge is found NOT proved.

In reaching this decision, the panel took into account the job description and Pressure Ulcer Investigations provided by the Trust. The panel also took into account the oral evidence and witness statement of Witness 2.

The panel noted that it did not have sight of:

- agreed written plan(s) that Charge 4 related to
- medical records
- Trust policy for the prevention and management of pressure damage

The panel further noted that the job description provided did not have a person specific breakdown nor expectation of the unit.

The panel found that while Witness 2 was clear on some aspects of the plan, they were unable to confirm to the panel the dates of when the plan was discussed and agreed, or the specific content of the plan. The panel also considered that in Witness 2's statement she stated that, with regards to an initial plan:

> *"Jackie completed a plan and added it to the file. This was a satisfactory course of action at this stage in my view".*

In addition, the panel noted that Witness 2 went on to state in their statement in regards to a second plan requested of Mrs Morse:

> *"I was not overly concerned as it appeared that Jackie was taking steps to prevent the same thing occurring again."*

The panel also noted that it did not have sight of patient records or discharge forms and were not provided with a policy which showed pathways, expectations or responsibilities.

When the panel asked Witness 2 in oral evidence whether any of the action plans attached to the Pressure Ulcer investigation documents exhibited was the plan referred to in Charge 4, Witness 2 confirmed that they were not.

While the panel found there to have been a discussion that took place between Mrs Morse and Witness 2, it have not been presented with any evidence of this and therefore the panel were unable to discern what the failure was. Furthermore, the panel found that Witness 2's issue was that not all staff were aware of the plan rather than failure of the plan or competency of the plan itself. The panel found that it did not have adequate information regarding the content of the plan in order to find Mrs Morse having failed to implement the plan.

The panel found that, due to the lack of information, the panel was unclear if the plan was for the overall ward or for individual patients.

Charge 4a)

In reaching this decision, the panel took into account the Pressure Ulcer Investigation provided by the Trust and the oral and written evidence of Witness 2.

This patient was originally admitted to the Gentian ward in February 2016 and stayed until 7 March 2016 when discharged to a different hospital. Between the 7 March 2016 and 10 April 2016, the patient resided at the second hospital where their deep tissue injury deteriorated. The patient was readmitted to the original hospital on 10 April 2016 and was then under the care of Ash Ward thereafter.

On 6 March 2016, prior to their discharge from the Gentian Ward, the patient did have a discolouration of his heel which was identified following a senior review. The patient was then discharged on 7 March 2016. At this time the patient was seen by a consultant on a ward round, his Braden score was taken and found to be 19 and on the same day medical photography of the heel was taken. Witness 2 in oral evidence stated a score of 19 was

not a risk. The panel considered that the patient was not under Mrs Morse's care on 11 April 2016.

The panel did not have sight of any of the patient's notes or of the discharge letter from Gentian ward, when patient was discharged to a second hospital on 7 March 2016.

The panel noted the patient's Braden scores to be 16 when brought initially to the Gentian Ward and subsequently had a Braden Score on:

- 28 February 2016 of 17
- 4 March 2016 of 17
- 7 March 2016 of 19

The panel found this showed that the patient did have assessments. The panel also noted that the patient had Tissue Viability Nurse (TVN) advice given over the phone. The panel also took account of the registrar ward round which took place on 2 March 2016.

The panel found that the patient was deemed medically fit for discharge on 4 March 2016 and was subsequently discharged on 7 March 2016 following a ward round on the same day. The Pressure Ulcer Investigation highlighted missing Braden scores and other factors which could precipitate pressure damage. The panel also considered that Witness 2 in her written statement said:

> *"at this stage I was not overly concerned as it appeared that Jackie was taking steps to prevent the same thing occurring again"*

The panel did not find enough evidence to show that the patient's injury was caused directly by Mrs Morse not implementing a plan. The panel therefore found Charge 4(a) not proved.

Charge 4b)

In reaching this decision, the panel took into account the Pressure Ulcer Investigation provided by the Trust and the oral evidence of Witness 2.

The patient was at the Medical Assessment Unit (the MAU) and was admitted on 19 - 23 April 2016 and then moved to the Gentian Ward on 23 April 2016, before being discharged home on 17 May 2016. The panel noted that the Investigation report deemed the pressure ulcer as avoidable. It was on 1 May 2016, when discolouration of the left heel was recorded.

The panel noted that the Braden score was not recorded daily whilst the patient was on the Gentian Ward, but it also noted that after a Braden score of 10 being recorded on 26 April 2016, the scores improved thereafter and were above 14 from 9 May 2016 to 16 May 2016, when the patient was discharged.

The panel further found that the investigation report confirmed that between 24 April 2016 and 1 May 2016, a turning regime was maintained and there was a variance recorded on one day, however there was no documentation to show that heel protectors were in place.

The panel noted that records indicate that from 1 May 2016 to 16 May 2016, a turning regime was completed daily, and an air mattress was ordered and delivered. The panel also observed that there is, for the majority of days, confirmation that heel protectors were in use.

The panel could not see that the deep tissue injury did deteriorate whilst the patient was on the Gentian Ward.

The panel also noted that records show that the patient was non-compliant in that the patient:

- refused to be turned on 22 April 2016
- refused to be turned on 27 April 2016
- refused to take heel protectors on 29 April 2016
- refused heel protectors on 3 May 2016

Whilst the Pressure Ulcer Investigation detailed the discolouration of the left heel being discovered on 1 May 2016, a TVN review took place on 3 May 2016 and the investigation reports that the discolouration should be treated as Grade 3 deep tissue injury. The panel also found that there is nothing in the Ulcer Investigation Report subsequently to evidence that the deep tissue injury deteriorated further.

The panel found the NMC have not proved their case that the patient's deep tissue injury deteriorated, nor have the NMC proved in what regards. The panel have not been provided with the specific details of the plan that Witness 2 said had been created by Mrs Morse after the first incident on 1 March 2016, and therefore the panel cannot say, on the balance of probabilities, that the plan failed to be implemented. However, the panel found that, for this patient, there was evidence of a turning regime and other measures having been put in place to manage the patient's deep tissue injury and prevent deterioration. The panel therefore find charge 4(b) not proved.

The panel finds charge 4 not proved in its entirety.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Morse's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

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.'*

Mr Webb invited the panel to take the view that the facts found proved 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.

Mr Webb identified the specific, relevant standards where Mrs Morse's actions amounted to misconduct. Mr Webb submitted that the misconduct relates to Mrs Morse's repeated dishonest behaviour in that she knowingly failed to work complete bank shifts and received full payment for these. Mr Webb further submitted that as Mrs Morse was the requester of these shifts the start and end times of these shifts were clearly set out and Mrs Morse was aware of these.

Mr Webb highlighted the witness statement of Witness 1 and specifically where it states:

> *"Jacqueline was given the authority as the Ward Manager to arrange staffing levels on her ward if she considered additional staff to be a requirement necessity for the ward".*

He further highlighted the risk to patient safety as a consequence of Mrs Morse's actions as detailed in Witness 1's statement:

> "*There is a huge risk to patient safety in this case because Jacqueline was booking extra clinical shifts to support the care of the patients and by not doing those shifts it put the patients care at risk."*

Mr Webb also submitted that while the NMC does not rely on the exact calculated loss to the Trust as detailed in Witness 1's written statement and which amounts to *"£974.14"*, it is an estimation of Mrs Morse's financial gain due to her dishonest actions.

Mr Webb submitted that nurses occupy a position of trust and abusing that position for financial gain undermines public confidence. Mr Webb further submitted that the panel's findings of Charges 1 and 3(a) being found proved, amounts to misconduct and would be considered deplorable by fellow practitioners.

Submissions on impairment

Mr Webb moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) *(CHRE v NMC and Grant*) and *Cohen v GMC* [2008] EWHC 581 (Admin).

Mr Webb submitted that the panel found repeated dishonesty and that this is indicative of a deep-seated attitudinal issue. Mr Webb noted that there has been limited engagement by Mrs Morse and no evidence of remediation or insight and Mr Webb submitted therefore that there remains a continuing risk to the public.

With regards to public interest Mr Webb referred to *CHRE v NMC and Grant* and submitted that this is a concern which has not been put right and is likely to require a finding of impairment in order to uphold proper professional standards and maintain public confidence. Mr Webb further submitted that Mrs Morse's conduct engages public interest as the charges involve concerns with regards to honesty and trustworthiness.

Mr Webb submitted that Mrs Morse's actions were repeated over a period of time and only ceased when an anonymous referral was made and a fraud investigation commenced.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cheatle v GMC* [2009] EWHC 645 (Admin), *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Royal College of Veterinary Surgeons v Samuel* [2014] UKPC 13, *R. (Remedy UK Ltd) v GMC* [2010] EWHC 1245, *CHRE v NMC and Grant* and Article 22 of the Nursing and Midwifery Order 2001.

Decision and reasons on misconduct

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

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

> '***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*
>
> ***20.2*** *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
>
> ***20.3*** *be aware at all times of how your behaviour can affect and influence the behaviour of other people*
>
> ***20.8*** *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to.'*

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 Morse's conduct amounted to serious misconduct.

The panel took the view that Mrs Morse knowingly left bank shifts early because she had requested the shift and therefore knew the start and end times. The panel considered that this was repeated behaviour over a prolonged period of time.

The panel considered with regards to public protection that Mrs Morse's actions of knowingly leaving early potentially put patients at risk, and that as a bank nurse Mrs Morse was supposed to be on the 'shop floor'. The panel further took the view that if there had been an incident after Mrs Morse left a shift early that this could put patients at risk.

The panel considered that public confidence in the nursing profession would be lost if the public knew that a Band 7 Ward Manager was not completing shifts, leaving the ward and patients early on a frequent basis while being paid for shifts she had not worked.

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

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Morse'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 and to act honestly and be on shift for the duration of the allocated shift. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity.

They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that patients were put at risk as a result of Mrs Morse's misconduct. Mrs Morse's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. Therefore, the panel finds that all four limbs of the test are engaged.

Regarding insight, the panel considered that the only evidence in which Mrs Morse accepts the charge was when she was interviewed by the Trust on 21 December 2016 where an explanation was given by Mrs Morse for her actions. However, the panel found that, although Mrs Morse accepted the facts at this time, there was no real understanding shown at the time.

The panel found that there is nothing before the panel to demonstrate Mrs Morse's insight into her actions and the impact on patients. The panel considered that Mrs Morse showed no insight into the position she put colleagues in by leaving them short staffed and acting dishonestly and the potential impact of her misconduct, whilst working as a Band 7 nurse, had on her colleagues.

The panel also took account of Witness 1's written statement which stated:

> *"Jacqueline lacked insight and didn't reflect well on the risk to patient safety and the extra pressure she had put on her colleagues".*

The panel also noted, and was submitted by Mr Webb, that Witness 1 stated in their written statement that "*There is a huge risk to patient safety".*

The panel accepts that it is considering impairment today some eight years after the incidents occurred. However, the panel, as a result of Mrs Morse's lack of engagement, have no new up to date material or evidence to consider with regards to Mrs Morse's impairment.

The panel is of the view that there is a risk of repetition based on there being minimal evidence of insight and remediation, and the panel also took into account Mrs Morse's dishonesty is a deep-seated attitudinal issue. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because public confidence would be lost in the nursing profession if the public knew that a Band 7 Ward Manager was not completing bank shifts and leaving the ward and patients early on a frequent basis, whilst also being paid for hours not worked.

Having regard to all of the above, the panel was satisfied that Mrs Morse's fitness to practise is currently impaired.

Sanction

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

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

Submissions on sanction

Mr Webb informed the panel that in the Notice of Hearing, dated 14 November 2024, the NMC had advised Mrs Morse that it would seek the imposition of a Suspension Order for 12 months with a review if it found Mrs Morse's fitness to practise currently impaired.

Mr Webb submitted that these were the mitigating features:

- Mrs Morse accepted her actions at a local level during the Trust's investigation

Mr Webb submitted that these were the aggravating features:

- The dishonesty was repeated over a period of time
- Mrs Morse knowingly left early
- Mrs Morse has demonstrated no real understanding or insight since the referral to the NMC

Mr Webb further submitted that the panel consider the applicable NMC Guidance SAN-2 *Considering sanctions for serious cases* which states:

> *"allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. However, in every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct that has taken place.*
> *Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*

- *personal financial gain from a breach of trust*
- *premeditated, systematic or longstanding deception"*

Mr Webb further submitted that Mrs Morse's actions amounted to significant dishonesty and that her lack of insight makes a conditions of practice order inappropriate in this case. Mr Webb highlighted that Mrs Morse's actions occurred over a sustained period of time and were repeated and that, as a Band 7 Ward Manager, Mrs Morse abused her position by allocating herself shifts that she did not complete.

Mr Webb reminded the panel that it found that there was a deep-seated attitudinal issue in this case. However, Mr Webb also noted that there have been no previous regulatory concerns regarding Mrs Morse and there was an early admission by Mrs Morse at a local level.

In conclusion, Mr Webb invited the panel to impose a 12 month suspension order subject to review which will afford Mrs Morse the opportunity to explain her failings and demonstrate insight whilst affording protection to the public and public interest.

Decision and reasons on sanction

Having found Mrs Morse'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:

- Abuse of a position of trust and seniority

- Lack of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put patients at risk of suffering harm

The panel also took into account the following mitigating features:

- Early admission to the Trust's local investigation

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.

It then 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 Morse'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 Morse'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 Morse'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, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the lack of insight, nature of the charges in this case which are attitudinal and repeated, and the lack of engagement from Mrs Morse.

Furthermore, the panel concluded that the placing of conditions on Mrs Morse's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel was of the view that this case does not represent the most serious case of dishonesty and also took into account the financial amount calculated to be lost by the Counter Fraud Investigation.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. The panel also considered that a suspension order provides Mrs Morse with the opportunity to come before a reviewing panel and demonstrate remediation and insight, and possibly return to the nursing profession. The panel noted that Mrs Morse's failings were not clinical, and so a suspension order with review allows the opportunity for a Band 7 nurse with good clinical skills to return to the register.

The panel also noted the passage of time which has occurred in this case. The panel was mindful that it has taken several years for this case to come before them and the challenges that this creates. The panel were satisfied that a suspension order proportionately marks the gravity of what has happened and ensures the public can see standards in the nursing profession upheld. The panel also was satisfied that this sanction allows Mrs Morse the opportunity to reengage with the regulator and evidence proper standards required of the nursing profession.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it including the admissions made to the Trust at the

time of their investigation by Mrs Morse, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Morse'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 may cause Mrs Morse, however this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by:

- Mrs Morse's attendance at the review hearing
- Testimonials or references from paid or unpaid work
- A reflective account addressing the misconduct and the effects of Mrs Morse's actions on patients, the public and the nursing profession

This will be confirmed to Mrs Morse in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Webb who submitted that, due to the panel's earlier findings, an interim suspension order is required both for the protection of the public and is in the public interest.

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 due to its previous findings and the seriousness of the case for a period of 18 months in order to cover any appeal period.

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

That concludes this determination.