Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 25 June 2024 – Wednesday, 3 July 2024
Monday, 2 December 2024 – Friday, 6 December 2024
Tuesday, 10 December 2024

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ
Virtual Hearing (Friday 6 December 2024 & Tuesday 10 December 2024)

Name of Registrant:	Julie Ann Pollitt
NMC PIN	90E0867E
Part(s) of the register:	Registered Nurse – RN1, Adult nurse, level 1 (September 1993) & V300, Nurse independent / supplementary prescriber (September 2008)
Relevant Location:	Essex
Type of case:	Misconduct
Panel members:	Louise Fox (Chair, lay member) Janine Ellul (Registrant member) Margaret Jolley (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Clara Federizo (25 June – 27 June 2024) Franchessca Nyame (28 June 2024) Muminah Hussain (1 July – 3 July 2024, 2 December – 6 December 2024 & 10 December 2024)
Nursing and Midwifery Council:	Represented by Claire Stevenson, Case Presenter Represented by Leeann Mohamed, Case Presenter (10 December 2024)
Ms Pollitt:	Present and/or represented by Tom Orpin-Massey, Counsel with Stephen Hooper (25 June

	– 3 July 2024) and Jodie Daly (2 December – 6 December 2024 & 10 December 2024)
Facts proved (by way of admission):	Charges 5 & 6
Facts proved:	Charges 1(b), 4(b), 4(c), 4(d), & 7
Facts not proved:	Charges 1(a), 2, 3, 4(a) & 8
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

1) On 28 February 2020, or dates thereafter, in relation to Patient A:
   a) Failed to carry out a cosmetic procedure with due care;
   b) Failed to immediately act on and/or manage concerns arising from the cosmetic procedure in charge 1 a) above.

2) Between 28 February 2020 and 2021 breached your duty of candour in that you failed to be honest and open when the treatment you provided to Patient A went wrong.

3) Between 28 February 2020 and April 2020 failed to treat Patient A with kindness, respect and compassion.

4) Between 17 & 18 March 2020, in relation to medication you dispensed to Patient A:
   a) Failed to properly store the medication;
   b) Failed to take adequate medical and or medication history before dispensing the medication;
   c) Failed to provide Patient A with any or adequate information about the medication and potential side effects;
   d) Failed to write a prescription for the medication.

5) Between 2020 and 2021 offered to carry out surgical procedures namely thread lifting, without having the required CQC registration.

6) In 2020 made claims on social media which were not based on accepted scientific evidence and were misleading and/or exploitative in that you claimed high doses of Vitamins C,D,E & B12 would speed up protection against Coronavirus.

7) On 20 July 2021 provided false and misleading information to the NMC in that you stated in a document 'The Judge threw out her money claim' in reference to a court claim taken by Patient A against you.

8) Your actions in charge 7 above were dishonest in that you knew the claim had not been 'thrown out' and that judgment in default had been awarded to Patient A.

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

Decision and reasons on application to exclude unfair evidence

The panel heard an application made by Mr Orpin-Massey, on your behalf, in relation to objections made to specific paragraphs in Witness 1's statement dated 21 June 2022, and an objection to Witness 1's statement dated 12 September 2022 in its entirety.

Mr Orpin-Massey submitted that these were not fair to admit as it is evidence of prejudicial opinion that is not presented in appropriate expert witness format. He made the following submissions both orally and in writing:

*"**Introduction***

1. This is an application made with reference to Rule 31 (1) of The Nursing and Midwifery Council (Fitness to Practise) Rules 2004:

Evidence

31.(1) Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in

the appropriate Court in that part of the United Kingdom in which the hearing takes place).

2. *The submission is that the below material is not fair to admit as it is evidence of prejudicial opinion that is not presented in appropriate expert witness format.*

The evidence objected to

3. *The evidence objected to is that of [Witness 1].*

<u>Statement 1 dated 21 June 2022</u>

Paragraph	*Reason*
13	*Opinion, speculation, expert evidence not in appropriate format*
19 (first sentence)	*Not the subject of a charge, prejudicial*
21	*Opinion evidence not in appropriate expert format*
22	*Not the subject of a charge, prejudicial*
23	*Opinion evidence not in appropriate expert format, makes criticisms of matters not the subject of charges so prejudicial, refers to conclusions of other bodies not admissible before a new fact-finding panel*
24	*Opinion evidence not in appropriate expert format*
25	*Opinion evidence not in appropriate expert format*

26	*Opinion, speculation, expert evidence not in appropriate format*
27	*Refers to conclusions of other bodies not admissible before a new fact-finding panel*
31	*Opinion, speculation, expert evidence not in appropriate format*

<u>Statement 2 dated 12 September 2022</u>

In its entirety as it contains complex expert evidence in an inadmissible formation.

Legal principles

4. Evidence admitted before the Committee must be relevant and fair. The Committee will no doubt be well familiar with the usual format of expert evidence. The statements of [Witness 1] do not provide:

1. *Her qualifications*
2. *Her training*
3. *Her skills*
4. *Her experience*
5. *Any form of CV*
6. *Any details of whether she has acted as an expert before*
7. *An expert's declaration*
8. *Sources*
9. *Documents considered*
10. *A statement of truth*

5. *It is submitted that without the above it would be grossly unfair to admit her opinion evidence as the NMC have failed to obtain properly admissible evidence, and her opinion is not properly capable of challenge.*

6. *In addition, despite [Witness 1]' second statement being dated 12 September 2022, it was not provided to the defence until an updated witness evidence bundle was served by email on 19 June 2024. This has given the defence no time to respond to it, for example by instructing our own expert.*

7. *Further, it is well established that prejudicial criticisms of a Registrant that could form the basis of a separate charge are not admissible in a regulatory hearing.*

Conclusion

8. *For the above reasons we invite the Committee not to admit this evidence at the hearing."*

In response, Ms Stevenson on behalf of the Nursing and Midwifery Council (NMC) submitted that the evidence is admissible as it is both relevant and fair as per Rule 31(1) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). She submitted the following both orally and in writing:

*"**Introduction***

1. *Evidence is admissible if it is both relevant and fair as per Rule 31(1) of The Nursing and Midwifery Council (Fitness to Practise) Rules 2004.*

2. *The NMC submit that the material subject to the application to exclude is both relevant and fair.*

The response to the objected evidence

Statement 1 dated 21 June 2022

Paragraph	*Reason*
13	*Appropriate opinion/commentary evidence, relevant to Charge 1a*
19 (first sentence)	*Appropriate opinion/commentary evidence, relevant to Charge 4*
21	***Already partly redacted**. opinion/commentary evidence is appropriate, relevant to Charge 1b* ***Now, partly redacted.***
22	*Direct evidence of Save Face's policies and her view of how Patient A felt during the Save Face's Investigation. Whilst not subject to the charges it provides contextual evidence of the Registrant's responses, or lack of, which can also go towards impairment.*
23	*Appropriate opinion/commentary evidence, relevant to Charges 1 and 2.* ***Now, partly redacted.***
24	*Appropriate opinion/commentary evidence, relevant to Charge 4.*
25	*Appropriate opinion/commentary evidence, relevant to Charge 2*
26	*Appropriate opinion/commentary evidence, not*

	speculative
27	***Already redacted**.*
31	***Already partly redacted**. Appropriate opinion/commentary evidence, relevant to Charge 6*

<u>Statement 2 dated 12 September 2022</u>

Is admissible its entirety as it contains appropriate opinion/commentary evidence.

Submissions

3. *There is no bar to a witness of fact offering their opinion and/or comment.*

4. *This is not a health case where, without an expert, the Panel would be unable to come to a decision.*

5. *Rule 31 is subject only to the requirements of relevance and fairness.*

6. *It is not uncommon to call a witness, working in a profession or a particular area of work, to comment on the appropriateness of acts or omissions etc.*

7. *NMC guidance titled 'Independent Experts' (reference: INV-5, last updated 14/04/2021) states:*

> *We don't always need independent expert evidence. We sometimes need help to understand the basic facts of what happened, and whether it was serious enough to cause concerns about the nurse, midwife or nursing associate's fitness to practise.* ***We can usually discuss these***

issues with professionals at a local level who have the qualifications and technical expertise to help us with these issues.

Sometimes, however, we'll need the opinion of an independent expert during our investigation, and because of the issues involved, it's proportionate for us to instruct one.

We'll usually do this if we need:

- *specialised knowledge or expertise that* ***we cannot obtain locally***
- *an independent opinion*
- *evidence to help us decide whether a nurse, midwife or nursing associate's actions were directly responsible for patient death or serious harm*

[emphasis added]

8. *The authority of E S (By Her Mother and Litigation Friend D S) v Chesterfield, North Derbyshire Royal Hospital NHS Trust [2003] EWCA Civ 1284 provides [at 31 and 32]:*

    a. *31. Before the master, the application for two experts in the field of obstetrics seems largely to have been based on the argument of "equality of arms". The master rejected that argument since he drew a sharp distinction between witnesses of fact and expert witnesses. Of course that distinction does exist. It is an important one, and it underpins the scheme of Part 35 of the CPR . But in my view it should not obscure the realities of a case such as this. As the master himself recognised,* ***"it is inevitable that a witness who happens to be a professional will give evidence of his actions based upon his or her professional experience and expertise …"*** *It is, in my view,* ***not only inevitable but appropriate, for no professional person can explain or justify his or***

her actions and decisions save by reference to his or her training and experience*.*

b. *32. In my view this is of particular relevance* ***to an action which alleges professional negligence, governed by the Bolam test. When a court is considering what practices may be adopted by a responsible body of medical opinion****, it seems to me impossible to exclude evidence given by two doctors, now both of consultant status, of their own experience, however much they may be labelled and confined as "witnesses of fact".* ***The reality is that they have and profess expertise and, if credible, their evidence based on their experience and expertise cannot be ignored.*** *So in my view there is an issue of equality of footing if the claimant is only permitted to call one obstetric expert while the defendants can rely upon two consultants plus an expert. However that is not decisive, for equality of footing is only one of the considerations in the overriding objective.*

[emphasis added]

9. *[Witness 1] is the Clinical Director of Save Fact and has been in post for around seven years. She is also a registered nurse and qualified in 1987. Therefore, she does have some expertise and experience. It is inevitable and appropriate that [Witness 1], who happens to be a professional, will give evidence of her actions based upon her professional experience and expertise. She is able to give insight on this particular situation and the appropriateness of what has or has not occurred and why she took the action and/or decisions that she did.*

10. *There is a level of unfairness regarding the late stage upon which this issue has been raised. The Defence have had the witness statement of [Witness 1] since 29 June 2022. The Defence was served the supplementary statement of [Witness 1] on 21 September 2022. There have also been previous listings of*

this matter whereupon this issue could have been raised but was not. The Defence therefore could have instructed their own expert and/or liaised with the NMC prior to today's hearing.

11. *The NMC were clearly relying on the statements of [Witness 1] as a witness of fact and not an expert as the statements are not in an expert format. If there was any doubt around this, the Defence had not sought clarification.*

12. *The CMF was sent on 27 June 2022 there is no reference to the NMC indicating that it would rely on expert evidence. The CMF, which provides the Registrant to opportunity to raise points of law, was not returned.*

13. *Furthermore, given concerns surrounding [Witness 1] lack of expertise or experience (as set out at paragraph 4 of the Defence Skeleton), a further statement and/or a CV could have been sought of the witness, could have been obtains if this issue had been raised earlier.*

14. *Therefore, in light of the above submissions, the NMC submit that the evidence in dispute is admissible in its entirety.*

Conclusion

15. *For the above reasons the NMC invite the Panel to admit this evidence at the hearing.*

16. *If the Panel agrees with the Registrant, that [Witness 1] is an expert witness, then the NMC asks for time to resolve her expertise."*

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 accepted that Witness 1 will be called in to give evidence at this hearing as a witness of fact and not as an expert witness. The panel noted that it had limited information on Witness 1’s experience and expertise. It noted that Witness 1 is the clinical director of Save Face (for around seven years), and that she is also a registered nurse who qualified in 1987.

The panel carefully considered each of the sections of evidence objected to and made individual decisions on its admissibility.

Statement 1: Witness 1’s initial witness statement for the NMC

Paragraph 13

The panel determined that the contents of this paragraph were relevant as this was evidence that linked to the allegations in charge 1.

The panel accepted that there is some opinion and speculation made by Witness 1 in this section. It decided that it would be fair to redact the last sentence because this should be evidence that comes from an expert witness. This states:

> *“This is not a common mistake and the Nurse should have sought advice from an experienced colleague or used hyaluronidase to dissolve the filler.”*

The panel concluded that it would be fair to allow the rest of paragraph 13, as the witness will be in attendance to give evidence and there will be opportunity for cross-examination. Therefore, Witness 1’s evidence can be tested, and the panel would give what it deemed appropriate weight once the panel has heard and evaluated all the evidence before it.

Paragraph 19

The panel accepted that the contents of paragraph 19 had no relevance to the charges. It also noted that the information in the paragraph does not provide relevant context to the charges. The panel determined this did not meet the 'relevance and fairness' test and it would not affect its findings of fact. The panel determined that it would be fair not to admit paragraph 19 of Witness 1's initial statement into evidence.

Paragraph 21

The panel determined that the contents of this paragraph were relevant as it was evidence that linked to the allegations in charge 1(a) and 1(b).

The panel accepted that there is some opinion made by Witness 1 in this paragraph. However, the panel concluded that given its relevance, it would be fair to allow paragraph 21 into evidence. It determined that any unfairness can be mitigated as the witness will be in attendance to give evidence and there will be opportunity for cross-examination. Therefore, Witness 1's evidence can be tested, and the panel would give what it deemed appropriate weight once it has heard and evaluated all the evidence before it.

Paragraph 22

The panel accepted that the contents of paragraph 22 was subjective and had no relevance to the charges. It also noted that the information in the paragraph does not provide relevant context to the charges as were not being held to the standards of Save Face. The panel determined this did not meet the 'relevance and fairness' test and it would not affect its findings of fact. The panel determined that it would be fair not to admit paragraph 22 of Witness 1's initial statement into evidence.

Paragraph 23

The panel determined that the contents of this paragraph were relevant as it was evidence that linked to the allegations in charge 1(b) and 2.

The panel accepted that there is opinion made by Witness 1 in this paragraph which should be made by an expert witness, and it is not in the appropriate format. However, the panel concluded that given its relevance, it would be fair to allow paragraph 23 into evidence with redactions made to not consider the following:

> *"…and can be attributed to improper placement of the dermal filler. It is not normal for post procedure swelling to persist beyond two weeks and the subsequent management of Patient A's complaint was unacceptable, leaving the to suffer, for an unnecessarily protracted period of time, which caused harm to* [PRIVATE] *and has possibly exacerbated the issues of concern…"*

The panel determined that any unfairness can be mitigated as the witness will be in attendance to give evidence and there will be opportunity for cross-examination. Witness 1's evidence can be tested, and the panel would give what it deemed appropriate weight once it has heard and evaluated all the evidence before it.

Paragraph 24

The panel determined that the contents of this paragraph were relevant to the allegations in charge 4.

The panel accepted that there is some hearsay and opinion evidence made by Witness 1 in this paragraph which is not in the appropriate format. However, the panel concluded that given its relevance, it would be fair to allow the paragraph into evidence with redactions made to not consider the following:

> *"…As above, nurses are not permitted (by legislation – The Medicines Act) to hold stock medicines..."*

The panel determined that any unfairness can be mitigated as the witness will be in attendance to give evidence and there will be opportunity for cross-examination. Witness 1's evidence can be tested, and the panel would give what it deemed appropriate weight once it has heard and evaluated all the evidence before it.

Paragraph 25

The panel determined that the contents of this paragraph were relevant to the allegations in charge 2.

The panel accepted that there is some speculation and opinionated evidence made by Witness 1 which is not in the appropriate expert format. However, the panel concluded that given its relevance, it would be fair to allow the paragraph into evidence with redactions made to not consider the following:

> *"…and it was clear Patient A did not have the resilience to cope. Providing further treatment without resolving or diagnosing the initial problems was not appropriate."*

The panel determined that any unfairness can be mitigated as the witness will be in attendance to give evidence and there will be opportunity for cross-examination. Witness 1's evidence can be tested, and the panel would give what it deemed appropriate weight once it has heard and evaluated all the evidence before it.

Paragraph 26

The panel determined that the contents of this paragraph were relevant to the allegations in charge 1(b).

The panel accepted that there is some speculation made by Witness 1 in this paragraph. However, the panel concluded that given its relevance, it would be fair to allow the paragraph into evidence with redactions made to not consider the following:

> *"…which is likely due to damaged lymphatics and may take some time to resolve. Indeed, it may not resolve. There is a possibility the lump may have resolved if it had been corrected earlier by the Nurse. It is a known rarer complication when filler is administered superficially into the cheeks were* [sic] *the lymphatics lie but is not commonly included in consent forms."*

The panel determined that any unfairness can be mitigated as the witness will be in attendance to give evidence and there will be opportunity for cross-examination. Witness 1's evidence can be tested, and the panel would give what it deemed appropriate weight once it has heard and evaluated all the evidence before it.

Paragraph 27

The panel noted that the parties have mutually agreed to redact this paragraph.

Paragraph 31

The panel determined that the contents of this paragraph were relevant as it was evidence that linked to the allegations in charge 6.

The panel accepted that there is some opinion made by Witness 1 in this paragraph. However, the panel concluded that given its relevance, it would be fair to allow paragraph 31 into evidence. It determined that any unfairness can be mitigated as the witness will be in attendance to give evidence and there will be opportunity for cross-examination. Therefore, Witness 1's evidence can be tested, and the panel would give what it deemed appropriate weight once it has heard and evaluated all the evidence before it.

Statement 2: Witness 1's supplementary witness statement

The panel gave serious consideration to this application and determined that Witness 1's supplementary statement was relevant to multiple alleged charges.

In evaluating fairness, the panel recognized that the statement contained speculative and opinion-based evidence from Witness 1, which was not presented in the appropriate expert format. The panel had limited information about Witness 1's professional background and expertise and noted the absence of qualifications that would support Witness 1's expert opinion. Additionally, there was no medical documentary evidence to corroborate these. For instance, Witness 1 stated that malar oedema placement caused the side effects, but there was no medical evidence of a diagnosis or proof that Witness 1 was professionally capable/qualified to diagnose such symptoms. The panel accepted that there was insufficient clarity about Witness 1's background and qualifications to validate her expert testimony.

Consequently, the panel determined that it would not be fair to admit the entirety of this statement into evidence. Therefore, it allowed the application to exclude this evidence.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Stevenson under Rule 31 of the Rules to allow the statement of Patient A and the hearsay evidence from Patient A within the statements of Witness 1 into evidence. Patient A had been expected to give evidence via video link and had been warned to attend on the first day of the hearing but had not responded to communications from the NMC.

Ms Stevenson submitted that Patient A's evidence is highly relevant and fair. She submitted that as managing witness attendance is the NMC's responsibility, if a witness does not attend, an application to admit hearsay evidence can be made under Rule 31.

Ms Stevenson submitted that the panel should consider the merits of the evidence and decide whether to admit it formally. As per *El Karout v NMC* [2020] EWHC 3079, *Ogbonna* [2010] EWCA Civ 1216 and *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), the panel must carefully balance fairness before admitting hearsay evidence, especially if it is the sole or decisive evidence. She expanded on the public interest considerations and submitted that the NMC wants to rely on Patient A's evidence to meet their statutory objectives and to progress the hearing fairly and expeditiously.

Ms Stevenson referred the panel to the guidance set out at paragraph 56 of Thorneycroft, which states:

> *"56. The decision to admit the witness statements despite their absence required the Panel to perform careful balancing exercise. In my judgment, it was essential in the context of the present case for the Panel to take the following matters into account:*
>
> > *(i) whether the statements were the sole or decisive evidence in support of the charges;*
> > *(ii) the nature and extent of the challenge to the contents of the statements;*
> > *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> > *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
> > *(v) whether there was a good reason for the non-attendance of the witnesses;*
> > *(vi) whether the Respondent had taken reasonable steps to secure their attendance; and*
> > *(vi) the fact that the Appellant did not have prior notice that the witness statements were to be read."*

Ms Stevenson submitted that Patient A's evidence is relevant to all charges and that admitting the evidence is fair, considering the following factors from Thorneycroft:

i. Sole or Decisive Evidence: Patient A's evidence is sole and decisive for charges 1, 2, 3, 4, 7, and 8. It is not sole or decisive for charges 5 and 6, which are supported by Witness 1's direct evidence. Ms Stevenson submitted that this is direct evidence because, as a result of Patient A's complaint, Witness 1 did some extra due diligence and found on your website that you were offering thread lifting and the information regarding the vitamin drips.

ii. Challenge to Statements: Ms Stevenson accepted that Patient A's evidence is contested by you. She highlighted that your representative could address the panel further in this regard.

iii. Fabrication of the Allegations: You have suggested that Patient A has reasons to fabricate allegations.

iv. Seriousness of Charges: The charges are serious and allegedly resulted in harm to Patient A (physically and emotionally), which was prolonged over a period of time. The concerns overall raise a real risk of harm to patients.

v. Non-attendance Reason: Ms Stevenson stated that the NMC was not aware of any good reason for Patient A's non-attendance.

vi. Efforts to Secure Attendance: Ms Stevenson submitted that the NMC made reasonable efforts. She emphasised that there was no suggestion that Patient A would not attend as she previously engaged and confirmed intention to attend. She submitted that the NMC had no reason to doubt her engagement as this is not a witness who has made a positive assertion of refusing to attend. She outlined, however, Patient A's concerns about the impact on her of receiving a high number

of emails. She also outlined that the NMC would contact if there was a need to e.g. for updates.

vii. Prior Notice to Appellant: Ms Stevenson accepted that you were not given prior notice of Patient A's disengagement. However, she submitted that there was no obligation to put you on notice of witness difficulties. She also added that Patient A was notified of the dates to attend, and sometimes witnesses may show a lack of engagement and still attend on the day they were warned. Therefore, the NMC would allow opportunity for Patient A to attend before 'jumping the gun' and risk her evidence being determined inadmissible prematurely.

For the reasons outlined above, Ms Stevenson invited the panel to consider that Patient A's statement is relevant and fair to admit as hearsay evidence.

In response, Mr Orpin-Massey opposed the application. He submitted that as Patient A's attendance at this hearing was not secured, it would be *'grossly unfair'* towards you if Patient A's evidence were admitted as hearsay. He also addressed the panel on the following factors from Thorneycroft:

i. Sole or Decisive Evidence: Mr Orpin-Massey agreed with the NMC that Patient A's evidence is sole and decisive for charges 1, 2, 3 ,4, 7, and 8. He submitted that great care is needed in admitting such evidence without the opportunity for cross-examination.

ii. Challenge to Statements: Mr Orpin-Massey submitted that you deny all charges and Patient A's statements and accounts given to Save Face are disputed. You would have cross-examined Patient A to challenge these statements fully. He submitted that you intended to challenge Patient A's claim of additional filler treatment on 5 April 2020, as you believe you only injected Patient A on 28 February 2020 and all other appointments were 'follow-ups'.

iii. Fabrication of Allegations: Mr Orpin-Massey suggested to the panel that Patient A may have fabricated her allegations due to [PRIVATE], a vendetta against you, or a desire for financial compensation. He also submitted that metadata from photographs allegedly contradicts Patient A's timeline, suggesting fabrication. Further, he submitted that Patient A's history of difficult interactions with various bodies and dissatisfaction with previous cosmetic treatments from different practitioners supports this suggestion.

iv. Seriousness of Charges: The charges are serious, alleging negligent harm, dishonesty, and professional misconduct. Mr Orpin-Massey submitted that adverse findings would severely impact your career. He submitted that you have a 34-year unblemished nursing career.

v. Non-attendance of Witness: Mr Orpin-Massey submitted that no good reason has been provided for Patient A's non-attendance and that the NMC's efforts to contact Patient A were 'insufficient and sporadic'.

vi. Reasonable Steps to Secure Attendance: Mr Orpin-Massey submitted that the late attempts to contact Patient A were inadequate, and that more consistent and sensitive engagement was necessary.

vii. Prior Notice to Registrant: Mr Orpin-Massey submitted that you were only notified about the hearsay application a day before and earlier notice could have led to alternative strategies, such as a preliminary hearing.

Mr Orpin-Massey requested the panel to reject the hearsay application as admitting Patient A's evidence would be *'grossly prejudicial'* towards you.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. He referred the panel to the case of *R v (on the application of Bonhoeffer) v GMC* [2011] EWHC 1585 (Admin).

The panel next considered whether to admit the disputed evidence as hearsay. It accepted the position of both parties that the documentation from Patient A is relevant to the charges.

In relation to the question of fairness, the panel had particular regard to the guidance set out at paragraph 56 of Thorneycroft.

The panel accepted that it is common ground between the parties that Patient A's evidence is sole or decisive in relation to the majority of the charges. However, it also noted that relevant case law does not automatically exclude hearsay evidence that is sole or decisive. The key consideration is the fairness of admitting this material.

The panel concluded that Patient A's evidence was not sole or decisive for charges 5 and 6, and there is another witness scheduled to give evidence in relation to these.

The panel took into account the extent of challenge and that you robustly dispute a large part of Patient A's statement and would therefore wish to have the opportunity to cross-examine Patient A.

The panel considered the issues Mr Orpin-Massey raised in relation to the possibility of Patient A's fabrication of allegations. It noted there were some issues raised about the reliability of some of Patient A's evidence. It also noted that Patient A has consistently raised the same issues over an extended period of time to a number of different bodies and has provided contemporaneous evidence to support this. The panel determined it could not come to any conclusions in relation to this until all of the evidence has been adduced.

The panel determined that the allegations are serious, particularly the allegation of dishonesty, to which the evidence from Patient A is relevant. If found proved, these allegations could have a significant impact on you.

The panel considered whether there was a good reason for Patient A's non-attendance and concluded that the reason was unknown. Based on the correspondence presented, it noted that Patient A had informed the NMC of ongoing health issues and expressed that the process had been stressful for her. After reviewing the correspondence bundle, the panel determined that the NMC had taken reasonable steps to secure Patient A's attendance.

The panel considered that did not have prior notice that the witness statements were to be read. The panel noted that Patient A's statement had been prepared in anticipation of it being used as evidence in these proceedings and contained the paragraph, *'This statement … is true to the best of my information, knowledge and belief'* and signed by her.

The panel noted that you were already aware of Patient A's statements, and this was not new information presented to you. It also recognized that you have professional legal representation. While there is some disadvantage in not having prior notice, the panel concluded that the NMC had taken reasonable steps, and given that Patient A had previously engaged with the process and expressed interest in attending, it was reasonable to leave open the possibility of her attendance. The NMC did not have prior notice that she would not attend.

The panel accepted that there was some disadvantage to you by admitting the hearsay evidence as you would not be able to directly challenge it through cross-examination. The panel considered that the unfairness in this regard worked both ways in that the NMC was also deprived, as was the panel, from reliance upon the live evidence of Patient A and the opportunity of questioning and probing that testimony. Throughout its decision making, the panel was also mindful of the overarching objectives of the NMC and in particular the protection of the public. There was also a public interest in the issues being explored fully, which supported the admission of this evidence into the proceedings.

Although cross-examination may often be the most effective way of testing evidence, the panel considered that there are other means available of testing the reliability of Patient A's evidence as there are contemporaneous documents that can be referred to and there is another witness due to attend, who will be subject to cross-examination.

In these circumstances, the panel determined that it would be fair and relevant to accept into evidence the hearsay evidence of Patient A but would give what it deemed appropriate weight once the panel has heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Stevenson to amend the wording of charges 1 (the stem), 1(b) and 7.

Ms Stevenson provided the panel with written submissions. The proposed amendments were as follows:

> "That you, a registered nurse:
>
> 1) On 28 February 2020, **or dates thereafter**, in relation to Patient A:
>
> a) …
>
> b) Failed to immediately act on and**/or** manage concerns arising from the cosmetic procedure in charge 1 a) above.
>
> …
>
> 7) On ~~21~~ **20** July 2021 provided false and misleading information to the NMC in that you stated in a document 'The Judge threw out her money claim' in reference to a court claim taken by Patient A against ."

Mr Orpin-Massey did not oppose the application.

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 interests of justice. The panel was satisfied, having regard to the merits of the case and the fairness of the proceedings, that there would be no prejudice to and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Stevenson under Rule 31 made on Day 5 of the hearing to allow the hearsay testimony of Person 1 into evidence. She provided the panel with written submissions and addressed the panel in relation to the judgement of *Thorneycroft*:

> *" Firstly, it is submitted that the evidence is relevant as it goes toward Charges 1 and 2 in this case.*
>
> *Secondly, the NMC submit it would be fair to admit the evidence.*
>
> *…*
>
> *Dealing with each of those* (Thorneycroft) *factors in turn:*
>
> *i. whether the statements were the sole or decisive evidence in support of the charges*
>
> *a. Evidence of [Person 1] is not sole and decisive evidence. The Panel have evidence of [Witness 1] and the hearsay evidence of Patient A.*
>
> *ii. the nature and extent of the challenge to the contents of the statements*

a. The Registrant disputes and challenges the charges in this case.

iii. whether there was any suggestion that the witnesses had reasons to fabricate their allegations

a. It has not been clearly articulated that there is a suggestion that [Person 1] has a reason to fabricate her evidence however there are allegations that Patient A had fabricated her evidence.

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

a. The charges are serious, the allegations are said to have resulted in harm to Patient A. Furthermore, the concerns overall raise a real risk of harm to patients and a risk of serious damage to the reputation of the profession;

b. The allegations are wide ranging and have occurred over a period of time;

c. Additionally, the allegations in and of themselves are serious:

1. failing to carry out a procedure with dure care;

2. failing to immediately act on and manage concerns;

3. breaching the duty of candour by failing to be honest and open;

4. failing to treat Patient A with kindness, respect and compassion;

5. failing to adequately dispense medication;

6. offering to carry out surgical procedures without being registered with the CQC;

7. making misleading claims on social media during a period of national emergency;

8. providing false and misleading information to the NMC which was also dishonest to their regulator.

v. whether there was a good reason for the non-attendance of the witnesses

a. There is no good reason for the non-attendance of the witness.

vi. whether the Respondent had taken reasonable steps to secure their attendance

a. This case was an externally investigated case. The NMC have not made any attempts to contact [Person 1] outside of the email received from her at exhibit JP/13.

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

a. As stated at the start of the submissions, the NMC submit there was no obligation to put the Registrant on notice of witness difficulties. Please see paragraph 3."

In response to panel questions, Ms Stevenson said she did not know why the NMC had not obtained a witness statement from Person 1.

Mr Orpin-Massey opposed the application. He submitted that Person 1 has not given a witness statement, and the NMC had an opportunity to procure a witness statement but had not. Mr Orpin-Massey submitted that Person 1's evidence is of a technical nature and has been disputed.

In relation to Thorneycroft, Mr Orpin-Massey informed the panel that it was only related to charge 1(a), but is not the only evidence for this charge. He submitted that the statement in the evidence is challenged. Mr Orpin-Massey submitted that charge 1(a) is serious. He submitted that the NMC should have taken a formal witness statement from Person 1 and made provision for her to attend. Mr Orpin-Massey submitted that you have not had prior notice of the application for Person 1's evidence to be admitted as hearsay, although her evidence is in the bundle.

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 was of the view that:

- Person 1’s evidence is not ‘sole and decisive’ as there is other evidence in respect of charge 1(a)
- You strongly oppose the evidence of Person 1
- There is no evidence to suggest that Person 1 has fabricated her evidence
- The panel determined that charge 1(a) is serious
- The panel was of the view that there is no good reason for the non-attendance of Person 1
- The panel saw no evidence that the NMC had taken reasonable steps to secure Person 1’s attendance
- The NMC did not obtain a witness statement for Person 1

In addition, the panel determined that you did not have prior notice that the NMC was going to apply for Person 1’s evidence to be accepted as hearsay.

The panel therefore determined that it was unfair for Person 1’s evidence to be allowed into evidence as hearsay.

In these circumstances the panel refused the application.

Background

You were a self-employed cosmetic nurse, owner and director of Collagen Aesthetics (the Clinic) and a nurse prescriber. In January 2017, the Clinic was accredited by Save Face, a voluntary regulator of aesthetic medical practitioners. You have also been suspended from Save Face’s register since January 2021.

The charges alleged arose out of cosmetic dermal filler treatment provided by you to Patient A on 28 February 2020, your alleged failure to provide appropriate aftercare to Patient A and your subsequent management of Patient A's complaint. There are also separate concerns in relation to your alleged failure to discharge your professional duty of candour, allegedly administering medication without a valid prescription, and alleged

failure to obtain CQC registration in relation to treatment (thread lifting) offered at the Clinic.

On 17 March 2020, you gave Patient A a course of antibiotics and steroids due to ongoing swelling, but allegedly without conducting a proper assessment prior to doing so. On or around 5 April 2020, you allegedly administered further dermal fillers to Patient A, however, Patient A's concerns in respect of the standard of the dermal fillers persisted. Patient A underwent corrective treatment elsewhere in October 2020 and made a formal complaint to Save Face.

It is alleged that you failed to comply with the Save Face complaints process, in that you continually failed to provide the requested information and documentation, leading to significant delays in the handling of Patient A's complaint. It is also alleged that you failed to comply with the duty of candour by not conceding that something may have gone wrong with the treatment provided. The referral highlighted concerns with your probity as allegedly you gave misleading and conflicting information to the NMC, and allegedly falsely stating that Patient A's monetary claim in the small claims court had been dismissed.

Decision and reasons on facts

Initially you denied all of the charges, but on Day 3, Mr Orpin-Massey informed the panel that you made admissions to charges 5 and 6.

The panel therefore finds charges 5 and 6 proved in their entirety, by way of your admissions.

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

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

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

- Witness 1: Clinical Director of Save Face (at the time of the incidents)

The panel also heard evidence from you under oath.

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

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

Charge 1(a)

"That you, a registered nurse:

1) On 28 February 2020, or dates thereafter, in relation to Patient A:
    a) Failed to carry out a cosmetic procedure with due care;"

This charge is found NOT proved.

In reaching this decision, the panel took into account your oral evidence, Patient A's written witness statement, and Witness 1's oral evidence.

In your evidence under oath, you gave a detailed description of the cosmetic procedure you carried out and the due care that you undertook. The panel accepted your evidence.

Patient A's written statement reads:

> *"The Nurse informed me that the procedure might 'hurt a bit' and used a cannula to administer the filler into my left cheek first which hurt slightly, and then administered the rest of the filler into my right cheek. I noticed a huge difference in pain from my left to my right cheek as the insertion to my right cheek really hurt and caused immediate pain much more than the left. I had not had cheek filler before, but had previously had lip filler and Botox and felt that the pain I had just experienced in my right cheek was excruciating on the right compared to the left.*
>
> *After the treatment the Nurse handed me a mirror to take a look at my face. I did not immediately realise there was a problem with the filler because I had not had cheek filler before however, I was taken back by the large lump (sausage shaped) under my right eye. I was surprised to see the lump and was not expecting it when handed the mirror. I asked the Nurse about the lump and they advised that it was normal swelling and would go down within two weeks (from 28 February 2020). I thought the lump looked weird however, as I had never had cheek filler before I had nothing else to base the reason for the lump on other than swelling as that is what the Nurse had said. There were also lumps on my right cheek but I assumed this was swelling. I think the Nurse informed me of some 'do's' and 'don'ts' post treatment but I cannot recall the extent of this. I then left the Clinic."*

In your witness statement and oral evidence, you explained to the panel all the steps you took to administer the treatment and advice you gave to Patient A about after care. You told the panel that Patient A was happy after the treatment and did not mention experiencing any pain. The panel looked at the 'before' and 'after' photos of Patient A's face on the day of treatment provided by you. The panel could not see evidence of the lump that Patient A said was visible straight after the treatment. The panel heard no live

evidence from Patient A, and the panel decided that only limited weight could be attached to her written statement, without any opportunity for cross-examination.

In any event, the panel had no expert medical evidence to suggest that the alleged consequences of the cosmetic procedure were attributable to a lack of care, as opposed to a possible side effect.

Therefore, the panel concluded that the NMC has not proved on the balance of probabilities that you failed to carry out the cosmetic procedure with due care.

The panel therefore finds charge 1(a) not proved.

Charge 1(b)

"That you, a registered nurse:

1) On 28 February 2020, or dates thereafter, in relation to Patient A:
b) Failed to immediately act on and/or manage concerns arising from the cosmetic procedure in charge 1 a) above."

This charge is found proved.

In reaching this decision, the panel took into account Patient A's written witness statement, Patient A's treatment records, Witness 1's oral evidence, the recording of the facetime call between you and Patient A, and your evidence.

In terms of immediately acting on concerns arising from the cosmetic procedure, the panel noted that there was no evidence that there was an issue on the day, 28 February 2020, that required an immediate response. The panel accepted there was some swelling, which is normal after such a procedure. Therefore, the panel did not find proved that you failed to immediately act on concerns arising from the cosmetic procedure.

However, the panel did find proved that you had failed to manage Patient A's subsequent concerns arising from the cosmetic procedure.

On 2 March 2020, you recorded in Patient A's treatment records:

> *"Patient A was angry very aggressive and demanding that the filler be dissolved …"*

On 13 March 2020, Patient A's treatment records stated:

> *"Patient rang and booked in with reception staff for dissolving Dermal Filler consultation, saying "she didn't like her face and wanted it dissolved"."*

On 17 March 2020, Patient A's treatment records stated:

> *"…she was complaining of lumpy, uneven filler. Stating she wanted the dermal filler dissolved as she was unhappy with her face."*

On 3 April 2020, Patient A's treatment records stated:

> *"Colleague took 16 messages plus calls from Sunday 29 March. Patient A wanted to have her fillers removed. She didn't like her face. No pain in face."*

Patient A's statement reads:

> *"I went back to the Clinic on either 17 or 18 March 2O2O (I cannot recall which) and spoke with the Nurse as two weeks had passed since the date of treatment and the lump under my eye and on my cheek was still as visible and has not gone down as advised by the Nurse. The Nurse informed me that swelling can take up to four weeks to go down despite stating two week previously."*

(On 25 march 2020) *“I was really upset and crying at the Clinic because of how I looked and opened up to the Nurse about* [PRIVATE] *and that I had wanted the treatment to cheer myself up and do something nice for myself but had not expected the outcome to be worse.”*

“I feel the Nurse should have known the lump under my right eye and cheek was filler and I even suggested this to them but they rebutted this. It is now clear, I did not require medication and I instead needed the filler to be removed which I feel the Nurse should have known to do.”

(On 29 March 2020) *“I suggested during the call that the lump could be misplaced filler and the Nurse did not accept this and said it did not need removing”*

The panel noted that Patient A had repeatedly asked to have filler removed on several occasions.

You informed the panel in your evidence that you were unable to remove filler because of COVID guidelines. The panel was not provided with guidance that related to February – April 2020. The panel had sight of the Save Face COVID 19 operational protocol from some date post May 2020, and noted that the guidance on removal of dermal filler did not prohibit its removal at this time, rather it expressed concern that this would require a face to face appointment which could breach lockdown restrictions. The panel noted that you met with Patient A face to face a number of times following the treatment (two prior to the lockdown) where you could have removed the filler as requested in order to manage Patient A’s concerns.

The panel therefore finds charge 1(b) proved.

Charge 2

“That you, a registered nurse:

2) Between 28 February 2020 and 2021 breached your duty of candour in that you failed to be honest and open when the treatment you provided to Patient A went wrong."

This charge is found NOT proved.

In reaching this decision, the panel ascertained the subjective state of your knowledge or beliefs as to the facts and the reasonableness of your belief. It referred to *Ivey v Genting Casinos* [2017] UKSC 67.

The panel determined that between 28 February 2020 and 2021, you genuinely believed that the treatment you had provided Patient A was successful. It accepted that this was your genuinely held belief.

As you did not believe the treatment had gone wrong, the panel concluded you were not in breach of any duty of candour to Patient A.

The panel therefore finds charge 2 not proved.

Charge 3

"That you, a registered nurse:

3) Between 28 February 2020 and April 2020 failed to treat Patient A with kindness, respect and compassion."

This charge is found NOT proved.

In reaching this decision, the panel took into account your evidence, the witness statement of Patient A, and Witness 1's evidence.

The panel determined that Patient A had called you many times after her appointment, and you had responded each time. The panel noted you arranged face to face visits to reassure Patient A and responded as soon as you could when she contacted the clinic. The panel considered your advice at times was vague or contradictory but did not find evidence to the extent that you were unkind, disrespectful or lacked compassion.

The panel determined that the NMC has not met the burden of proof in relation to this charge.

The panel therefore finds charge 3 not proved.

Charge 4(a)

"That you, a registered nurse:

4) Between 17 & 18 March 2020, in relation to medication you dispensed to Patient A:
a) Failed to properly store the medication;"

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient A's written statement and your oral evidence.

Patient A's written statement reads:

> *"During this visit, the Nurse took three boxes of medication out of the treatment room of the Clinic, scribbled on them with biro and told me to take them to help with the swelling. I am unsure if they came from a drawer or cupboard."*

It is clear from this statement that Patient A did not know how or where the medication was stored in the clinic. Therefore, Patient A cannot give insight as to whether the medication in the clinic was stored correctly.

In your oral evidence, you were clear that all medication at the clinic was kept in a locked cupboard or a locked refrigerator. The panel accepted your evidence.

The panel determined that the NMC has not met the burden of proof in relation to this charge.

The panel therefore finds charge 4(a) not proved.

Charge 4(b)

"That you, a registered nurse:

4) Between 17 & 18 March 2020, in relation to medication you dispensed to Patient A:
b) Failed to take adequate medical and or medication history before dispensing the medication;"

This charge is found proved.

In reaching this decision, the panel took into account Patient A's written statement, your written statement and your oral evidence.

Patient A's written statement reads:

> *"The Nurse did not ask for my medical history or go through what the medications were and potential side effects…"*

In your oral evidence, you explained to the panel that before a patient undergoes any treatment, you give them a medical questionnaire form to fill out. You explained that when a patient returns to the clinic, they resubmit a form online to say if there have been any changes to the form they previously filled out.

You told the panel that you rely on this form to keep up to date with a patient's medical history. You told the panel that you did not complete any further history at this appointment. The panel determined that this was not appropriate in this case given that you were dispensing antibiotics and steroids for symptoms reported by Patient A, and that you were prescribing to treat those rather than a further cosmetic procedure. On the balance of probabilities, the panel determined that you did fail to adequately take medical or medication history of Patient A.

The panel therefore finds charge 4(b) proved.

Charge 4(c)

"That you, a registered nurse:

4) Between 17 & 18 March 2020, in relation to medication you dispensed to Patient A:
c) Failed to provide Patient A with any or adequate information about the medication and potential side effects;"

This charge is found proved.

In reaching this decision, the panel took into account Patient A's written statement, your written statement and your oral evidence.

Patient A's written statement reads:

“The Nurse did not ask for my medical history or go through what the medications were and potential side effects…

There are specific instructions on how to take the medicine as it can upset your stomach, amongst other things (there were lots of precautions) however, I was not advised of any of these and there was no information leaflet in the medication boxes. I was taking two other medications at the time which the Nurse did not ask about and did not inform my GP of.”

In your oral evidence, you explained to the panel that you wrote information on the medication boxes. You also said you wrote a prescription which would need to be fulfilled by a pharmacist and your expectation was that they would provide appropriate information to the patient about the medication. The panel determined that this was not sufficient and therefore you failed to provide Patient A with adequate information about the medication and potential side effects.

The panel therefore finds charge 4(c) proved.

Charge 4(d)

“That you, a registered nurse:

4) Between 17 & 18 March 2020, in relation to medication you dispensed to Patient A:
d) Failed to write a prescription for the medication.”

This charge is found proved.

In reaching this decision, the panel took into account the photograph of the medication that you provided to Patient A, the photo of the prescription, and your evidence.

It was not in dispute that you had a duty to write a prescription when dispensing medication.

The panel had regard to the photograph of the medication that you provided Patient A with. The instructions written by you on the boxes were:

1. Flucloxacillin 500mg, *'1am, 1pm, 7 days'*
2. Prednisolone, *'5mg 1 day, 5 days 10mg 2 tabs, 1 day 5mg 7 days, after that 7 days'*
3. Hydrocortisone 1% cream, *'apply sparingly 1 day'*

The medication doses and length of time was different to that shown on the prescription given to Patient A on that day.

1. Flucloxacillin 500mg, *'QDS 14 days'*
2. Hydrocortisone 0.5% cream, *'15g use sparingly over the affected area 1-2 daily times 2 am week topical'*
3. Prednisolone *'40mg PO for 5 days, day 1: 5mg, 2: 10mg, 3: 5mg'*

When questioned about these discrepancies in your oral evidence, you were unable to give a clear answer as to why these had occurred.

The panel accepted that you wrote a prescription, but it did not reflect the medication that you dispensed. Therefore, the panel concluded that between 17 and 18 March 2020, you failed to write a prescription for the medication you dispensed to Patient A.

The panel therefore finds charge 4(d) proved.

Charge 7

"That you, a registered nurse:

7) On 20 July 2021 provided false and misleading information to the NMC in that you stated in a document 'The Judge threw out her money claim' in reference to a court claim taken by Patient A against you."

This charge is found proved.

In reaching this decision, the panel took into account 'the records of appointments and contact' dated 30 January 2021 (the document you created and sent to Save Face and subsequently the NMC outlining the chronology and your response to Patient A's complaint), and your witness and oral evidence.

In the document section dated October 2020, you stated:

> *"She did not supply any information to the Court regarding the reason for the claim or evidence to support this allegation or name the salon therefore my solicitor could not prepare a defence. The judge threw out her money claim"*

It is not disputed that you sent this document to the NMC on 20 July 2021.

Your witness statement reads:

> *"I deny that in making this statement I made a false and misleading statement to the NMC. I genuinely believed that the money claim had been thrown out…"*

You told the panel that you started writing the document in November 2020. Your solicitor had told you that the judge would throw out the case so you assumed that was the case when you wrote the entry.

The panel had sight of the court order dated 5 February 2021 stating that judgement had been made against you. You confirmed you were aware of this in February 2021. The panel noted the email from your solicitor to Patient A dated 1 March 2021 explaining their

instructions to set aside the judgement as you were unable to give instructions at the time because you were working as a pandemic nurse. The panel also noted an email sent to Patient A by the court on 24 May 2021 explaining that an application to set aside the judgement had been made.

You told the panel that you did not update or amend the document before you sent it to the NMC.

The panel concluded that the document you sent the NMC in July 2021 was misleading as it stated that Patient A's money claim had been thrown out, and there was evidence to show that this was not the case.

The panel therefore finds charge 7 proved.

Charge 8

"That you, a registered nurse:

8) Your actions in charge 7 above were dishonest in that you knew the claim had not been 'thrown out' and that judgment in default had been awarded to Patient A."

This charge is found NOT proved.

In reaching this decision, the panel took into account *Ivey v Genting*, and your oral and written statement.

Your written statement reads:

> *"I deny that in making this statement I made a false and misleading statement to the NMC. I genuinely believed that the money claim had been thrown out based on*

information provided to me by my legal representative, who I thought had successfully applied to have the Judgment in Default set aside."

When questioned in your oral evidence, you stated that you thought setting aside the judgement was the same as having the claim thrown out.

The panel ascertained the subjective state of your knowledge or beliefs as to the facts and the reasonableness of your belief. The panel considered your oral evidence explaining why you did not update or amend the document before sending it to the NMC was muddled, and you did not appear to understand the purpose of the document which was to give the NMC an up to date view of your position on the facts. You also said that you did not see the point of checking the document before sending it to the NMC, because as far as you were concerned, it was part of the background.

The panel considered you were not sufficiently diligent in checking the information you sent to the NMC, but determined that your intention was not to deliberately mislead. The panel determined that an ordinary, decent person would not find this dishonest, albeit that it might well be regarded as careless.

The panel therefore finds charge 8 not proved.

Decision and reasons on proceeding in your absence

The panel next considered whether it should proceed in your absence. It had regard to Rule 21.

Mr Orpin-Massey informed the panel that you were upset upon receiving the NMC's submissions on facts, as you thought that this was the panel's findings on facts. He had spoken to you at 5pm to explain this was not the case, and to discuss the panel's actual findings on fact. He had arranged to speak to you the following morning at 9am (Day 11) before giving submissions on misconduct and impairment, but had not been able to

contact you by phone or email. Mr Orpin-Massey informed the panel that he is confident that he has sufficient instructions from you, and is aware of your stance on impairment. He submitted that you would not have been giving evidence on misconduct and impairment, and the panel has received a bundle on your behalf. Mr Orpin-Massey submitted that from previous conversations with you, that he is confident you would want this hearing to be continued, and would not welcome a delay.

Ms Stevenson invited the panel to continue in your absence. She submitted that there is a strong public interest in the expeditious disposal of the case.

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 your absence. In reaching this decision, the panel has considered the submissions of Mr Orpin-Massey, Ms Stevenson, 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:

- No application for an adjournment has been made by you;
- There is no reason to suppose that adjourning would secure your attendance at some future date, and you are welcome to join the hearing at any stage should you wish to;
- You had made written submissions specifically for this stage of the hearing and made your views known to Mr Orpin-Massey who will represent you, and;
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair to proceed in your absence. The panel will draw no adverse inference from your absence in its findings on misconduct and impairment.

Fitness to practise

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

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

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

Submissions on misconduct

Ms Stevenson invited the panel to take the view that the facts found proved amount to misconduct and they are serious breaches. 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 Stevenson submitted that your actions fell short of what is expected of a registered nurse. She submitted that the public would expect a professional to be dependable and to uphold a professional reputation. Ms Stevenson took the panel to breaches of the Code. She submitted that there is misconduct in relation to all of the charges found proved and admitted.

Mr Orpin-Massey submitted the charges found proved do not amount to misconduct, neither individually or cumulatively.

Submissions on impairment

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

Ms Stevenson submitted that the first three limbs of Grant have been engaged. She submitted that your behaviour has brought the profession into disrepute. Ms Stevenson submitted that the concerns regarding medication related matters and the procedure itself, can be addressed. She submitted that the remaining charges found proved raise serious public interest concerns, there is an unwarranted risk of patient harm, and that you have demonstrated underlying attitudinal issues. She submitted that these concerns are difficult to address.

Ms Stevenson submitted that a bundle has been provided to the panel by you, however it is limited as there is no explanation in relation to the charges found proved. In relation to insight, she submitted that there is no explanation on how you would act differently in a similar situation in the future. Ms Stevenson submitted that there is evidence of further training, and a positive testimonial, but that they all seem to be dated in 2021.

Ms Stevenson submitted that the concerns are wide-ranging and that there are concerns regarding attitudinal matters, but there is limited evidence in convincing the panel that you are not at a risk of repeating the behaviour that was found proved. She submitted that some of the concerns are difficult to provide evidence of remediation as they are in and of themselves, difficult to remediate.

Ms Stevenson invited the panel to find that you are currently impaired.

Mr Orpin-Massey submitted that if the panel does find your behaviour to amount to misconduct, that you are not impaired today.

Mr Orpin-Massey informed the panel that you are of good character, and have significant experience both as a general nurse and as an aesthetic nurse. He submitted that the charges found proved are of an isolated nature, from a single patient amongst many patients that you have dealt with over the course of your career. Mr Orpin-Massey submitted that the date of these charges go back to about five years, and that there have been no other findings against you in this period of time.

Mr Orpin-Massey submitted that in relation to charges 5 and 6, you admitted this which shows insight and remorse and that you have taken responsibility for those failings.

Mr Orpin-Massey referred the panel to your bundle and outlined the courses that you have attended since the allegations.

Mr Orpin-Massey informed the panel that whilst dealing with Patient A, you were also dealing with [PRIVATE].

Mr Orpin-Massey submitted that your failings, in relation to the background of the case and how long ago the allegations were, would not be described as deplorable by a fellow

practitioner in all the circumstances. He submitted that Patient A was a very difficult patient, and that you did your best in the circumstances.

Mr Orpin-Massey submitted that there is no patient harm in this case, only a risk of harm in relation to the medication. He informed the panel that you are no longer living in the UK, and it is your plan to set up a business in Italy.

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

Decision and reasons on misconduct

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

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

> *'**2 Listen to people and respond to their preferences and concerns***
>
> ***6 Always practise in line with the best available evidence***
>
> *6.1 make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services*
>
> *8.2 maintain effective communication with colleagues*

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

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

20 Uphold the reputation of your profession at all times

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times.

21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications

24 Respond to any complaints made against you professionally'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel was of the view that Code 8.2 linked to charge 6, in that you failed to exercise proper oversight and communication in relation to the information being uploaded by your marketing manager. The panel determined that as a professional who ran their own practice, you should have maintained effective communication with your staff, so that information that is not reliable should not be published on your website or social media channels. In relation to Code 24, the panel noted that you had delayed your response to Save Face, and did not send them a response to the allegations in a timely manner. It also found that you had provided the NMC with misleading information, and you

explained in your evidence that this was because you did not have time to read it before you sent it off. The panel found this to be unprofessional.

The panel took each of the facts found proved in turn, and decided whether they amounted to misconduct.

The panel did not find misconduct for charge 1(b). It took into account the context of the situation at the time, in that you were having difficult personal circumstances, and it was also the beginning of the COVID-19 Pandemic. The panel was aware that Patient A was caused psychological harm because of your failure to manage her concerns, but noted that the incidents related to a single patient over a short period of time. The panel could not find that charge 1(b) meets the threshold of seriousness in relation to misconduct.

The panel found your actions in relation to charge 4(b), 4(c) and 4(d) did amount to misconduct. The panel noted that you were a nurse prescriber, and as such, you were held to a different standard than solely being a registered nurse. By not checking Patient A's current medication or medical history when dispensing the medication, you were not aware of any possible contraindications to the medication you prescribed. This put Patient A at a risk of harm. The panel determined that Patient A had not been given clear instructions in relation to the medication you dispensed to her, in that the instructions on the medication boxes were different to the prescription you had written. Without clear and consistent instruction, the panel found that Patient A could have been either undermedicated or overmedicated, and you had not fulfilled your duty as both a registered nurse and a nurse prescriber. The panel determined that you did put Patient A at an unwarranted risk of harm, and therefore found misconduct in relation to charges 4(b), 4(c) and 4(d).

In relation to charge 5, the panel did not find that your behaviour amounted to misconduct. It determined that although you continued to advertise the thread lifting procedure, you did not put patients at risk as you had not carried out the surgical procedure without having the required CQC registration. However, the panel was of the view that you did have a

responsibility to ensure that information was up to date, and reflected proper compliance with regulations, but that your behaviour was not serious enough to amount to misconduct.

The panel found that your behaviour in relation to charge 6 did amount to misconduct. The panel determined that by making claims on social media which were misleading, the information exploited people's fears at the outset of the COVID-19 Pandemic. The panel found this to be opportunistic and for possible financial gain, given that the post was dated 14 March 2020. It noted that at this time, people were vulnerable to misinformation as they were not sure on what treatments were effective for protection against the virus. It was wrong to amplify such information through your social media marketing. The panel noted that you had told them that you were unaware this had been posted on the website by your marketing manager, but it determined that you had a duty as manager of your business to oversee and approve what went out on your social media. The panel therefore found that your behaviour in relation to charge 6 was sufficiently serious to be viewed as deplorable by fellow registered nurses and does amount to misconduct.

In relation to charge 7, the panel considered you were careless in sending false and misleading information to the NMC and in your evidence, you took insufficient responsibility for this. You said when questioned that it was the NMC's responsibility to investigate the background of the matter so it should have been aware of the true situation. The panel took into account your difficult personal circumstances during this time, and in these circumstances decided that this charge is not serious enough to amount to misconduct.

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

Decision and reasons on impairment

The panel next went on to decide if as a result of the charges found to amount to misconduct, your fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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;…'

The panel finds the first three limbs of the Dame Janet Smith test above engaged in this matter. The panel finds that Patient A was put at risk and was caused emotional harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession. By putting Patient A at unwarranted risk of harm and allowing false and misleading information to be shared with others on your behalf, you brought your own reputation and that of your profession into disrepute.

Regarding insight, the panel considered that you have not provided it with evidence that you fully appreciate what went wrong and the gravity of these matters. In relation to medications management, your answers to the panel were unclear, and you did not appear to acknowledge the risks to Patient A. You did not explain what you would do differently in the future if the same problem was to arise. The panel also noted that you had taken limited responsibility for your actions, and at times placed the blame on others, instead of understanding where your responsibility was as a professional. The panel appreciated that you admitted to charges 5 and 6 throughout the course of the hearing, but decided that your insight is only just developing.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account that you had provided it with evidence of courses you had been on, but had no evidence of any certificates from the courses. It considered these courses were relevant to your practice as an aesthetic nurse, but did not address the failings in the charges found proved. Therefore, the panel determined that you had not yet strengthened your practice.

The panel determined that there is a risk of repetition based on your lack of insight into your failings, and that you have not strengthened your practice. 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. It concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

On Day 13 of the hearing, Mr Orpin-Massey informed the panel that you [PRIVATE]. He confirmed that you had given him instructions and was content for the hearing to proceed in your absence. [PRIVATE]

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 6 months. The effect of this order is that the NMC register will show that your 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 Stevenson submitted the following in relation to sanction:

"The NMC invite the Panel to make a striking off order…

Aggravating Features

- *Emotional harm was caused to Patient A;*
- *The Registrant's conduct put Patient A at an unwarranted risk of harm in relation to the medication concerns;*
- *The Registrant gave misleading information (at a time when people were vulnerable to misinformation) which exploited people's fears at the outset of the COVID-19 Pandemic. This was opportunistic and for possible financial gain.*
- *Breached a fundamental tenant* [sic] *of the profession;*
- *Insufficient level of insight;*
- *Lack of evidence of a strengthened practice;*
- *Risk of repetition.*

Mitigating features

- *Admission to Charge 6;*
- *Personal hardship;*
- *(Mr Orpin-Massey will no doubt have further submissions to make in relation to mitigation).*

… the NMC consider that a striking off order is appropriate. The Registrant's conduct is fundamentally incompatible with that of a registered nurse. The Registrant's conduct raises fundamental concerns about her professionalism. It is also the appropriate outcome which could maintain public confidence in registrants and the profession."

Mr Orpin-Massey submitted there were a number of mitigating factors including:

- There were isolated failings

- There was no harm to Patient A
- The medication prescribed led to an improvement in Patient A's condition
- The COVID-19 pandemic was a contextual factor
- Your personal circumstances at the time

Mr Orpin-Massey informed the panel that you are currently living in Italy and hope to set up a business there. He submitted that you wish to retain your position as a nurse on the register in this country, and that you would love to return to nursing in the future. Mr Orpin-Massey submitted that you feel a great pride and attachment to nursing.

Mr Orpin-Massey submitted that a conditions of practice order would be appropriate in this case. He submitted that conditions would allow you to demonstrate insight and remediation in relation to the failings identified in this case. He submitted that although you are not planning to work as a nurse in the UK, and you are not registered to work as a nurse in Italy, you would be able to address the failings through a Professional Development Plan (PDP) and training.

The panel heard and accepted advice from the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The risk of harm to Patient A

- The seriousness of the posts on social media in that there were unverified claims made at a time when people were vulnerable to misinformation in relation to COVID-19
- Limited insight and reflection
- Insufficient evidence of strengthening practice

The panel also took into account the following mitigating features:

- Your personal circumstances at the time of the incidents

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 your 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 your 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 your 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, including the factors which are likely to be relevant where such an order is appropriate.

The panel decided that there would have to be conditions which included a refresher course in prescribing, and a period of supervised practice in relation to prescribing and dispensing medication, which you would not be able to complete as you do not intend to work in the UK as a nurse currently. The panel considered your submissions that the failings in relation to prescribing and dispensing could be remedied without any supervised practice, but that this demonstrated a lack of insight into the risks to the public and the wider public interest.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case. The panel did not have any reflections from you which demonstrated your insight into the seriousness of allowing misinformation about COVID-19 to be shared on your behalf as a registered nurse, or what you would do differently in the future. This lack of insight caused concern to the panel as to whether conditions of practice would be enough to mark the seriousness of the case in relation to upholding professional standards. Therefore, the panel determined that not imposing a more serious sanction would undermine the public's trust in the profession and the role of the regulator in upholding standards.

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 Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel determined there were two discrete failings in this case. The panel did not find evidence of harmful deep seated personality or attitudinal problems, but it was concerned

you have shown insufficient insight into the seriousness of your failings. There is no evidence of the repetition of the behaviour.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. However, the panel decided that a significant amount of strengthening practice and reflection would be required to enable you to return to safe practice. The panel was of the view that you had not sufficiently demonstrated remorse or insight into your failings or adequately taken steps to strengthen your practice.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

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.

In making this decision, the panel carefully considered the submissions in relation to the sanction that the NMC was seeking in this case. However, the panel concluded that it would be disproportionate, taking account of all the information before it. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

The panel noted the hardship such an order will inevitably cause you. However this is outweighed by the public interest in this case.

The panel determined that a suspension order for a period of 6 months with a review was appropriate in this case to mark the seriousness of the misconduct, and this would be sufficient time for you to develop your insight as detailed above.

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:

- A reflective piece addressing the failings found proved in this case and setting out what you would do differently in the future
- Evidence of relevant training courses and Continuing Professional Development (CPD) addressing the failings in this case
- A PDP which focuses on areas including prescribing and social media usage
- Relevant references and testimonials

This will be confirmed to you 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 your own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Mohamed. She submitted that an 18 month interim suspension order would be appropriate to protect the public and is in the public interest.

Mr Orpin-Massey asked the panel to consider the necessity of an interim order.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to allow sufficient time for an appeal in the event that one is made.

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

That concludes this determination.