Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 29 July 2024 – Tuesday, 30 July 2024

Virtual Meeting

Name of Registrant:	**Joanne Marie Blyth-Smith**
NMC PIN	08L0236E
Part(s) of the register:	Registered Nurse - Mental health nurse, Level 1 RNMH - (September 2009)
Relevant Location:	Norwich
Type of case:	Misconduct
Panel members:	Bryan Hume (Chair, lay member) Pamela Campbell (Registrant member) Paul Hepworth (Lay member)
Legal Assessor:	Joseph Magee
Hearings Coordinator:	Elizabeth Fagbo
Facts proved by way of admission:	Charges 1, 2, 3, 4, and 5
Facts proved:	Charge 6(a) and 6(b)
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Blyth-Smith's old, registered address by recorded delivery on 24 June 2024. The panel also noted that that the Notice of Meeting was sent to Mrs Blyth-Smith's registered email address on 24 June 2024.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was then delivered to Mrs Blyth-Smith's updated registered address on 9 July 2024. It was signed for against the printed name of Joanne Marie Blyth-Smith.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date and the fact that this meeting was heard virtually.

In the light of all of the information available, the panel was satisfied that Mrs Blyth-Smith has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ('the Rules').

Details of charge

That you, a registered nurse, on 8 May 2022

1. Failed to complete the hourly observations for one or more patients between 15:00 and 16:00 on the Blickling Ward.

2. Failed to complete one or more intermittent observations for Patient A between 15:00 and 16:00 on the Blickling Ward.

3. Inaccurately completed the ward's general (hourly) observation chart to show

that you had undertaken the patient observations at charge 1 when you had not.

4. Inaccurately completed the headcount sheet to show that you had undertaken the patient observations at charge 1 when you had not.

5. Inaccurately completed a Datix form indicating that you had checked on Patient A during the allocated time when you had not.

6. Your actions at charges 3-5 above were dishonest in that:

a. you knew the records you had made were inaccurate; and
b. you intended to create a misleading impression that you had completed the observations at charge 1 and/or 2 above when you had not.

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

Background

Mrs Blyth-Smith was referred to the Nursing and Midwifery Council ('NMC') on 12 February 2023 by Norfolk and Suffolk NHS Foundation Trust ('the Trust').

On 8 May 2022, Mrs Blyth-Smith was working a late shift on the Blickling Ward ('the Ward'), an acute psychiatric ward. She was to complete observations between 15:00 and 16:00. This required observing the health and welfare of 17 patients on the ward every hour. One patient was to be observed every 15 minutes as the patient was at a higher risk. Mrs Blyth-Smith had not been allocated any other roles between 15:00 and 16:00 that day.

Mrs Blyth-Smith allegedly failed to complete this task. When this was pointed out to her by her colleague at 16:00, she is said to have made inaccurate recordings on the headcount sheet and the general hourly observations chart to show that she had undertaken the observations at 15:20 when she had not.

It is further alleged that Mrs Blyth-Smith also submitted an incorrect Datix form. The description provided on the Datix form was *'did not complete x4 intermittent observations due to misreading staff allocation sheet*.' It then stated '*as soon as made aware checked on patient, supported with +1 to reposition and offered fluids. Staff had checked on patient during allocated time – patient was observed to be sleeping (breathing observed) but not recorded as misread allocation chart.'*

CCTV footage is said to have shown that the intermittent observations had not been completed by Mrs Blyth-Smith and the hourly observations could only have been partially completed as there was no indication on the CCTV footage that she had checked all the patients. The CCTV footage is alleged to show that Mrs Blyth-Smith was in the nursing office for most of the time.

Mrs Blyth-Smith accepted that she did not complete the hourly and intermittent observations, as she thought she was allocated a different task at the time. She maintained that she saw the patients at some point but accepted that it was not the time she recorded. When Mrs Blyth-Smith was questioned about the discrepancy in the Datix form, she stated that she was distracted at the time of completing the form and did not have time to check through it. She denied being dishonest.

Decision and reasons on facts

At the outset of the meeting, the panel noted the written representations from Mrs Blyth-Smith which stated that Mrs Blyth-Smith has made full admissions to charges 1, 2, 3, 4 and 5.

The panel therefore finds charges 1, 2, 3, 4 and 5 proved in their entirety, by way of Mrs Blyth-Smith's admissions.

The panel are satisfied that the charges are proven by evidence contained within the statement of Witness 1, the Investigation Report, the interview of Mrs Blyth-Smith and the Datix Report. The panel recognised that Mrs Blyth-Smith was an experienced nurse familiar with the Ward and knew that hourly observations were required on all patients and

that these should be recorded contemporaneously. In addition, she knew that Patient A should have been checked every 15 minutes.

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and from Mrs Blyth-Smith.

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 the panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel had regard to the written statements of the following witness on behalf of the NMC:

- Witness 1: The Matron on the Ward

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by both the NMC and Mrs Blyth-Smith including the Case Management Form (CMF) and email correspondence between her and the NMC. The panel noted that the documentary evidence provided by the NMC did not include the actual CCTV footage that is mentioned in Witness 1's statement and the Trust's Investigation Report.

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

Charge 6(a)

"That you, a registered nurse, on 8 May 2022

6. Your actions at charges 3-5 above were dishonest in that:

a. you knew the records you had made were inaccurate;"

This charge is found proved.

In reaching this decision, the panel consider the information before it including, the written statement of Witness 1, and the Investigation Report from the Trust.

The panel took into account Witness 1's written statement where she stated the following:

> *'[…] Although Mrs Blyth-Smith confirmed in her diciplinary Hearing that she did not complete either set of observations (as she thought she was allocated (sic) this task at a different time), they were able to confirm she was not on other allocated roles during this hour and the ward allocation sheet notes the designated time of 15:00 to 16:00 for you to complete this task;*
>
> *When I brought the omission to her attention at 16:00, she completed a Datix report at 16:00 which noted 'I did not complete 4 intermittent observations due to misreading staff allocations sheet.' On this form the section "Initial Action Taken" notes that as soon as she was informed by myself of her omission, she checked on patients and repositioned them. Other staff had however checked on patients during this time, and patient was observed to be sleeping (breathing observed) but not recorded as misread on the allocation sheet;*
>
> *The entries on the intermittent observation sheet were missing from 15:00 to 15:45; […]'*

The panel accepted Witness 1's evidence entirely as she was one of the managers of the Ward at the time. Upon looking at Mrs Blyth-Smith's Datix report, looking at the observing forms and consulting the CCTV camera's, in order to sign off the Datix report, Witness 1 realised that Mrs Blyth-Smith did not carry out the observations and had inaccurately completed the report. Witness 1 then went on to confront her about this in a meeting where it was confirmed that she did not carry out the observations and had falsified records to cover this up.

The panel also took the Investigation Report into account. In the report Mrs Blyth-Smith admitted that she did not carry out the required patient checks and had entered inaccurate information onto the observation sheet and into the Datix form. It was therefore clear to the panel that Mrs Blyth-Smith knew that this information was inaccurate, and her conduct was dishonest by the standards of ordinary people.

Therefore, on the balance of probabilities, the panel found charge 6(a) proved.

Charge 6(b)

"That you, a registered nurse, on 8 May 2022

6. Your actions at charges 3-5 above were dishonest in that:

b. you intended to create a misleading impression that you had completed the observations at charge 1 and/or 2 above when you had not."

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Witness 1, the Outcome of Disciplinary Meeting letter from the Trust dated 20 February 2023, the Investigation Report and the Datix Report.

The panel noted the following from Witness 1's written statement:

'[…] At 16:00 I completed the allocations between 16:00 and 17:00. There is then a note made by Mrs Blyth-Smith from 15:00 to 16:00 "patients had been observed during that hour, drinks offered, feet cold and pad checked.' Additionally notes that Datix to be completed due to omitting 4 checks […]'

The panel was of the view that the entries were so specific and there was no other reason that Mrs Blyth-Smith would have completed the records with inaccurate timings if they had not been falsified in an attempt to cover up her omissions.

The panel took into account the Outcome of Disciplinary Meeting Letter, where Mrs Blyth-Smith was asked what the process was for missed observations, to which she responded with the following:

> *'[…] Check the service users as soon as you realise the check hadn't been done, but this was then done by myself because by the time I noticed it, it was the time I was starting my hour, so I went and did it straight away. I would then expect the Datix to be done and the Line Manager to be informed who would then speak to that member of staff about the importance of checking allocations properly […]'*

The panel also took into account the Datix Form and the Investigation Report which included a chronological timeline of the CCTV footage on 8 May 2022. The panel was of the view that these documents supported the fact that Mrs Blyth-Smith failed to complete the hourly observations and failed to complete one or more intermittent observations for Patient A and that she knew the records she made were inaccurate and had intended to create a misleading impression. It was clear to the panel that Mrs Blyth-Smith knew that the inaccuracies would create a misleading impression and also that her conduct was dishonest by the standards of ordinary people.

The panel therefore found charge 6(b) proved.

Fitness to practise

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

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

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

Representations on misconduct and impairment

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of 3 propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances.'*

The NMC also referred to the case of *Jackson J in Calheam v GMC* [2007] EWHC 2606 (Admin) *and Collins J in Nandi v General Medical Council* [2004] EWHC 2317 (Admin), respectively

> *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired.'*
>
> *And*
>
> *'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'*

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ('the Code') in making its decision. The NMC identified the specific, relevant standards where Mrs Blyth-Smith's actions amounted to misconduct.

The NMC submitted that the misconduct is serious and falls significantly short of what would be expected of a registered nurse. The areas of concerns identified relate to basic nursing skills and practice and consists of Mrs Blyth-Smith failure to complete hourly observations and failure to complete intermittent observations on one or more patients.

The NMC further submitted that Mrs Blyth-Smith's misconduct also included dishonest acts in relation to her inaccurately completing the observation charts, headcount sheets and a Datix form to indicate that she had undertaken the patient observations when she had not. Accordingly, the NMC submitted that these failings and the dishonesty involve a serious departure from expected standards and put patients at significant risk of harm.

In regard to impairment the NMC referred to the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin)) are instructive. Those questions were:

i. *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*
ii. *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
iii. *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
iv. *has in the past acted dishonestly and/or is liable to act dishonestly in the future.in written submissions and submitted that the four limbs are engaged in this case.*

The NMC submitted that that all four limbs can be answered in the affirmative in this case as this case involves numerous clinical failings including falsification of documents and dishonesty directly relating to patient care. Therefore, Mrs Blyth-Smith conduct has in the past and is liable in the future to place patients at significant risk of unwarranted harm. And her dishonest actions compromised patient safety and have the potential to cause serious harm to patients in her care.

The NMC submitted that the misconduct in this case has the potential to cause damage to the reputation of nursing profession both now and, in the future, where a registrant fails to deliver appropriate care and document accurately the level of care that has been provided to patients. Registered professionals occupy a position of trust and must therefore act with integrity and promote a high standard of care at all times. The NMC submitted that Mrs Blyth-Smith's failure to do so has brought the profession into disrepute and is likely to bring the profession into disrepute in the future.

The NMC also submitted that Mrs Blyth-Smith's failings also breached the fundamental tenets of the nursing profession as nurses are expected to be honest and act with integrity while providing a high standard of care at all times. Nurses are expected to treat people with dignity, keep people safe and to uphold the reputation of the profession. They also occupy a position of trust both as a nurse and employee. The NMC submits that Mrs Blyth-Smith's clinical failings and dishonest conduct completely contradicts those fundamental tenets of nursing.

Furthermore, the NMC submitted that Mrs Blyth-Smith's has in the past acted dishonestly and is liable to act dishonestly in the future as she inaccurately completed patients records to indicate observations and checks had been undertaken on patients when they had not. She knew the records she made were inaccurate and had intended to create a misleading impression. Her actions seriously call into question her honesty and integrity.

The NMC referred to the approach of Silber J in the case of *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin) and submitted that Mrs Blyth-Smith has displayed limited insight in that she engaged at local level and made partial admissions. However, she has provided no evidence to demonstrate that she has developed insight, or any training undertaken by her to strengthen her practice.

Regarding the dishonesty element, the NMC submitted that this is indicative of an underlying attitudinal issue which may be difficult to address and calls into question Mrs Blyth-Smith's integrity. The NMC referred to the case of *Professional Standards Authority v HCPC and Wood* [2019] EWHC 2819 (Admin) highlights that *'A person who gives a false or misleading account of actions and events when first confronted with allegations of wrongdoing is highly likely to be a person who does not understand the importance of his professional responsibilities.'*

For these reasons, the NMC submitted that there is a significant risk of harm to the public if Mrs Blyth Smith were permitted to practice without restriction and Mrs Blyth-Smith's falsification of records and dishonest conduct further damages public confidence, undermines the reputation, and trust the public have in the profession. Therefore, the NMC invited the panel to find Mrs Blyth-Smith's fitness to practise impaired on the grounds of public protection and also in the public interest.

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

Decision and reasons on misconduct

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

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

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.2 Make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***8 Work cooperatively***

To achieve this, you must:
8.5 work with colleagues to preserve the safety of those receiving care

10 Keep clear and accurate records relevant to your practice
This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice. To achieve this, you must:
10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code'

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

The panel was of the view that Mrs Blyth-Smith's failure to carry out the required observations, especially her failure to observe Patient A who required intermittent observations could have resulted in serious harm. The panel also noted that Mrs Blyth-Smith entered inaccurate and misleading information into records and found that this was dishonest. For these reasons, the panel found that Mrs Blyth-Smith's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious professional misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 February 2024, which states:

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

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

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

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

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

‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

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

The panel finds that patients were put at risk of harm as a result of Mrs Blyth-Smith’s misconduct, specifically Patient A a higher risk patient, who required intermittent observations.

The panel also finds that Mrs Blyth-Smith’s misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that Mrs Blyth-Smith made full admissions to charges 1, 2, 3, 4 and 5. However it was of the view that Mrs Blyth-Smith had not demonstrated real insight into the potential harm or failure had on patients, staff and reputation or any meaningful reflections. The panel noted that Mrs Blyth-Smith had recently shown remorse in her latest email to the NMC where she also alluded to [PRIVATE] wanting to be removed from the register. However, the panel was of the view that the misconduct in this case evidenced dishonesty which is inherently more difficult to

put right as it raises attitudinal concerns which are difficult to remediate. The panel concluded that there is no evidence of remediation or strengthening of practice, and there remains a risk of repetition. 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 are 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.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Blyth-Smith's fitness to practise impaired on the grounds of public interest. A member of the public in possession of all the facts in this case would be surprised if a finding of impairment was not made by this regulator given that it involved behaviour that is difficult to remediate.

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

Sanction

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

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 8 July 2024, the NMC had advised Mrs Blyth-Smith that it would seek the imposition of a suspension order for six months with a review if it found Mrs Blyth-Smith's fitness to practise currently impaired.

The NMC submitted that taking no further action or imposing a caution order would be wholly disproportionate in this case and would not be sufficient to mitigate future risks in this case and adequately protect the public or satisfy the public interest. Further, the NMC submitted that the clinical failings in this case could be addressed by further training, however, the attitudinal concerns and the dishonesty in the misconduct cannot. Therefore, there are no conditions which can adequately address the dishonesty, nor address Mrs Blyth-Smith's blatant disregard for patient safety. Therefore, in these circumstances a conditions of practice order would not be appropriate or proportionate as it would not adequately protect the public or satisfy the significant public interest in this case.

The NMC referred to the SG:

> • *a single instance of misconduct but where a lesser sanction is not sufficient*
> • *no evidence of repetition of behaviour since the incident*
> • *the seriousness of the case requires temporary removal from the register*

The NMC concluded that a suspension order would be sufficient to protect the public and satisfy the public interest as Mrs Blyth-Smith's dishonest conduct and lack of insight indicates a harmful deep-seated personality and/or attitudinal problem. However, there is no evidence of repetition of behaviour since the incident.

The NMC considered whether a striking-off order would be appropriate in this case and concluded that while Mrs Blyth-Smith's conduct was unacceptable, given her personal circumstances at the time and her partial admissions, there is a lesser sanction which can protect the public and maintain public confidence in the profession. The NMC submitted that permanent removal from the register would be disproportionate at this stage and a six month suspension order with a review would be sufficient to protect the public and

maintain public confidence in the professions. Further, It would also provide Mrs Blyth-Smith the opportunity to reflect, undertake meaningful reflection and provide any steps taken by her to a future reviewing panel.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of insight into Mrs Blyth-Smith's dishonesty
- Putting patients at a risk of suffering harm
- Dishonesty

The panel also took into account the following mitigating features:

- No previous concerns
- Single instance incident
- Significant personal stresses [PRIVATE]
- Signs of genuine remorse

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Blyth-Smith's practice would not be appropriate in the circumstances. The SG

states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Blyth-Smith's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Blyth-Smith's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the dishonesty element in this case. Whilst the clinical issues could be addressed through training the panel was of the view that dishonesty is an attitudinal issue and is not something that can be addressed through training. Furthermore, the panel concluded that the placing of conditions on Mrs Blyth-Smith's registration would not adequately address the seriousness of this case and would not adequately protect the public or satisfy the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel determined that a suspension order is appropriate in this case, as such an order would reflect the seriousness of this case, provide public protection whilst also addressing public interest. The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register as this was a single incident, and the dishonesty aspect was confined to this single event. It noted that Mrs Blyth-Smith accepted responsibility for charges 1, 2, 3, 4 and 5, and that there has been no repetition of the misconduct identified in this case from Mrs Blyth-Smith since the original referral was made. The panel was satisfied that a suspension order would also give Mrs Blyth-Smith the chance to address the clinical concerns identified and to reflect on her dishonesty and how this may have affected patients and the nursing profession.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate as Mrs Blyth-Smith's dishonesty was a spontaneous action taken in order to cover up her omissions. Whilst the panel acknowledges that a suspension may have a punitive effect, it was of the view that it would be unduly punitive in Mrs Blyth-Smith's case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause Mrs Blyth-Smith. However, this is outweighed by the public interest in this case.

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

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

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

Any future panel reviewing this case would be assisted by:

- Engagement with the NMC
- Attendance at the review hearing
- Evidence of ongoing strengthening of practice and engagement in relevant training courses
- A reflective statement

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC, who submitted that, if a finding is made that Mrs Blyth-Smith's fitness to practise is impaired on a public protection basis and a restrictive sanction is imposed, then an interim suspension order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.

The NMC also submitted that if a finding is made that Mrs Blyth-Smith's fitness to practise is impaired on a public interest only basis and that her conduct was fundamentally incompatible with remaining on the register, then an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.

Decision and reasons on interim order

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

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

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

That concludes this determination.

This will be confirmed to Mrs Blyth-Smith in writing.