Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday, 28 May 2024 - Thursday, 30 May 2024

Virtual Meeting

Name of Registrant:	**Angela Chester**
NMC PIN:	01J0116E
Part(s) of the register:	Registered Nurse- Sub Part 1 RNA, Adult nurse, level 1 12 March 2004
Relevant Location:	Colchester
Type of case:	Misconduct
Panel members:	Adrian Smith (Chair, Lay member) Lucy Watson (Registrant member) Susan Ellerby (Lay member)
Legal Assessor:	Gaon Hart
Hearings Coordinator:	Samantha Aguilar (28 May 2024 and 29 May 2024) Hamizah Sukiman (30 May 2024)
Facts proved:	Charges (as amended) 1a, 1b, 2a, 2b, 2c, 3b, 3c, 4 and 5 (only in relation to 3b and 3c)
Facts not proved:	Charge 3a
Fitness to practise:	Impaired
Sanction:	**Striking-off Order**
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 Chester's registered email address by secure email on 9 April 2024.

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, dates (that this meeting was to be heard on or after the 14 May 2024) and the fact that this meeting was to be heard virtually.

In light of all of the information available, the panel was satisfied that Mrs Chester has been served with notice of this meeting in accordance with the requirements of Rules 11 (2) and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Dealing with Mrs Chester's case as a meeting

At the outset of the meeting, the panel considered whether it would be appropriate to deal with Mrs Chester's case via a substantive meeting. The panel bore in mind that a previous Fitness to Practice Committee held a Notice of Referral meeting on 19 February 2024, and decided that this case should be dealt with as a substantive meeting. The previous panel stated:

> *'In reaching its decision, the panel had regard to all the information available to it. This included the report from the Nursing and Midwifery Council's (NMC) Case Preparation and Presentation Team in which it recommended that a meeting be held as it was unlikely that Mrs Chester would attend a hearing.*
>
> *Further, the panel noted that Mrs Chester had not responded to the Notice of Referral or returned a completed Case Management Form (CMF). The panel noted that on 15 January 2024 the NMC received an email from Mrs Chester's representative stating that she did not intend to attend a*

substantive hearing and indicated that they would be coming off the record as her representatives. On 29 January, Mrs Chester contacted the NMC to say that she would "not be going ahead now to do an appeal(sic)". Mrs Chester also stated that she would be leaving nursing.

Having had regard to the information before it and having borne in mind the recommendation of the NMC for a meeting and Mrs Chester's indication of non-attendance, the panel has concluded that the case be heard as a meeting […]*'*

The panel heard and accepted the advice of the legal assessor. The legal assessor reminded the panel of its powers to proceed under Rule 10 of the Rules.

The panel noted that there was no indication from Mrs Chester as to whether she would prefer a hearing or a meeting, and that Mrs Chester indicated that she would not attend a substantive hearing (15 January 2024 email through her representatives). The panel was satisfied that in light of the relevant information, that it is appropriate for Mrs Chester's case to be dealt with as a substantive meeting.

Proceeding in the absence of Mrs Chester

The panel, having made its decision that the notice of hearing was properly served on Mrs Chester, considered whether it is reasonable to proceed in her absence, notwithstanding that this is being held as a meeting. The panel noted that the NMC invited Mrs Chester to provide comments or a response by 2 May 2024 in respect of the Charges. Mrs Chester has responded via email on 16 April 2024.

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

The panel has decided to proceed in the absence of Mrs Chester. In reaching this decision, the panel considered the advice of the legal assessor and 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 the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Chester;
- Mrs Chester previously engaged with the NMC. However, in an email dated 15 January 2024, from Mrs Chester's former legal representative at the Royal College of Nursing (RCN), it stated:
  'I am emailing […] *to inform you that the above-named member [*Mrs Chester] *doesn't intend on attending the substantive hearing and that we are coming off record as representatives.'*
- The panel also had regard to Mrs Chester's email dated 29 January 2024:
  '[…] *I just don't want to go through it. I will be leaving nursing now which is so sad it was my dream to be a nurse, have many positive memories.',*
  which was reiterated in her email dated 16 April 2024;
- There is no reason to suppose that adjourning would secure Mrs Chester's attendance at some future date.
- The charges relate to events that occurred in 2019 and 2020; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Chester in proceeding in her absence. Although the evidence upon which the NMC relies was sent to her on 9 April 2024 and previously on 11 August 2020. Mrs Chester has not returned the Case Management Form, though she has provided a response via email on 16 April 2024. She has previously submitted her training certificates and reflective documents. She will not be able to challenge the evidence relied upon by the NMC. However, in the panel's judgement, this can be mitigated by attaching the appropriate weight when considering each piece of evidence before it and by considering the matters raised by the Registrant fairly and giving the Registrant's comments and evidence due weight. It noted that the onus rests on the NMC to prove their case against Mrs Chester. In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Chester. The panel will draw no adverse inference from Mrs Chester's absence in its findings of fact.

Amendment of charges

The panel considered the current wording of the charges and whether they reflect the evidence before it. The panel of its own volition decided to amend the Charges.

"That you, a registered nurse, whilst working in a police custody setting:

1. On ~~29~~ **28** November 2019:
   a. Left a bottle of prescription methadone unattended with Person A.
   b. Recorded that you had administered 60mls of methadone at 14:29 ~~and 30mls of methadone at 16:33~~ to Person A when he had in fact taken all 90mls of methadone ~~at around 14:29~~.

2. On 26 June 2020, in relation to Person B:
   ~~a. Failed to assess and/or record his insulin levels.~~
   b. Failed to obtain and/or record a medical history from him.
   c. Failed to handover to Colleague 1 [PRIVATE].
   d. Failed to indicate at handover that Person B would require a medical review.

   […] "

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

Charge 1

The panel decided to amend the date of the charge to 28 November 2019. The panel took the view, that changing the date of the Charge would not materially affect the content within the Charge, but rather more accurately reflect the evidence before it.

Charge 1b

The panel next considered the wording of Charge 1b. It took the view that the Charge, as written, was inherently ambiguous in its current form as it did not appropriately

particularise the allegation. As such, the panel amended Charge 1b to better reflect the evidence before the panel.

Charge 2a

The panel considered Charge 2a as worded. It took the view that the Charge does not make sense as nurses do not assess and record insulin levels. The panel suspected that the charge should have referred to assess and record [PRIVATE], but it would be unfair to the Registrant to amend the charge at this stage. It determined that in the circumstances of this case, the panel decided to remove this as a Charge.

Panel's overall view

The panel was of the view that amendments of Charges 1, 1b and 2a were in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Chester and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to make the amendments to appropriately particularise the Charges before the panel.

Details of charges (as amended on 28 May 2024)

That you, a registered nurse, whilst working in a police custody setting:

1. On 28 November 2019:
    a. Left a bottle of prescription methadone unattended with Person A.
    b. Recorded that you had administered 60mls of methadone at 14:29 to Person A when he had in fact taken all 90mls of methadone.

2. On 26 June 2020, in relation to Person B:
    a. Failed to obtain and/or record a medical history from him.
    b. Failed to handover to Colleague 1 [PRIVATE].
    c. Failed to indicate at handover that Person B would require a medical review.

3. Incorrectly told an investigatory meeting on 1 July 2020 that:

a. Person B denied having any medical and/or mental health conditions.
b. You booked [PRIVATE] and/or a repeat blood sugar test for Person B.
c. Person B's [PRIVATE] had been handed over to the nurse coming on shift.

4. Your actions at charge 1b above were dishonest in that you deliberately sought to represent that Person A hadn't consumed the whole bottle of methadone at around 14:29.

5. Your actions at charge 3a and/or 3b and/or 3c above were dishonest in that you deliberately sought to conceal that you had overlooked that Person B [PRIVATE]

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

Decision and reasons on the NMC's written representation to admit Person B's hearsay evidence

The panel had sight of the NMC's written representation:

> *'In respect of paragraph 10* […] *and charge 3a the evidence in relation to Person B informing* [Witness 5] *that Mrs Chester attended their cell, and they informed her of* [PRIVATE] *and was ignored is relied upon by the NMC as hearsay evidence. Direct evidence from Person B has not been obtained. The NMC sent an initial letter via recorded delivery to Person B on 29 October 2020. The recipient was not at the address so the letter was returned. A trace was then conducted on 13 November 2020 in order to try and locate a current address for Person B but the trace company confirmed that they had not been able to trace a current address for the subject and that there was no evidence on their databases to show that he had been at the address that the NMC were provided with. A copy of the email and trace result is contained within the exhibits bundle.'*

The panel 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,

hearsay evidence can be admitted so far as it is *'fair and relevant'*. He referred the panel to the relevant case law. This included *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), *O'Brien v Chief Constable of South Wales Police* [2005] UKHL 26, *Director of Public Prosecutions v Kilbourne* [1973] AC 729, 756, *R (on the application of H) v Nursing and Midwifery Council* [2013] EWHC 4258 (Admin) and *Shagang Shipping Company Ltd v HNA Group Company Ltd* [2020] UKSC 34.

The panel accepted that Person B's hearsay evidence is relevant and goes towards proving Charge 3a. The panel accepted that the NMC sent an initial letter via recorded delivery to Person B on 29 October 2020, which was returned due to Person B not being at that address. It is submitted that a further tracing attempt on 13 November 2020 was made by the NMC to try and find a current address for Person B, which was unsuccessful. The panel therefore accepted that efforts were made by the NMC to contact Person B.

In considering the nature and the extent of the hearsay evidence, the panel determined that Person B's hearsay evidence in relation to Charge 3a is sole and decisive. It is also potentially unreliable specifically as no signed statement was obtained and Person B has not responded to any attempts made by the NMC to attest to what he said to Mrs Chester. The panel noted that Person B was unwell at the time he was said to have communicated his conversation with Mrs Chester to Witness 3, due to suffering from a lack of insulin. Accordingly, the panel determined that Person B's evidence in relation to Charge 3a is potentially unreliable and thus, it would be unfair to admit such evidence.

The panel noted that Charges 2a, 2b and 2c also relate to Person B. The panel took the view that Person B's evidence is relevant to these Charges. The panel carried out a balancing exercise and noted the principles in *Thorneycroft*. The panel noted that the allegation against Mrs Chester is serious. However, the Panel decided that Person B's evidence was not the sole and decisive evidence in respect of Charges 2a, 2b and 2c, as the Charges appear to be broader than Person B's evidence. The panel therefore decided that it would be fair to admit the evidence, but give this the appropriate weight in due course once it has seen all of the evidence.

Background

On 10 July 2020, the NMC received a referral from the Head of Services at CRG Medical Services (CRG), which raised concerns regarding Mrs Chester's practice. The Charges arose whilst Mrs Chester was working as a Custody Nurse for the Police via CRG. It is alleged that Mrs Chester was placed on an improvement plan between 1 February 2020 and 20 May 2020. By 30 May 2020 CRG was satisfied with Mrs Chester's performance but later raised concerns about the care Mrs Chester had provided to Person A on 28 November 2019 and Person B on 26 June 2020.

Person A

On 28 November 2019, Person A was arrested and taken to Colchester Police station custody suite, where he was cautioned and booked in. Person A was alleged to be a [PRIVATE] and had been prescribed methadone. Person A consented to the police collecting his methadone prescription from the pharmacy for him to take later that day. The methadone arrived in the custody suite at 13:32 and was delivered to Mrs Cheser. The bottle contained 90mls of methadone to be provided in two separate doses, one 60ml dose in the morning and one 30 ml dose in the afternoon. At 13:54, Mrs Chester took Person A from his cell to the medical room to have a consultation. Mrs Chester then recorded that '*Person A had his medication arrived and administered'* and that a review was due at 16:00 as his next dose of methadone was due to be administered at this time. It is alleged that whilst Mrs Chester's back was turned, Person A allegedly drank the entire contents of the bottle of the prescription methadone.

It is further alleged that Mrs Chester then recorded that she had administered the prescribed 1 x 60mls of methadone at 14:29, knowing that Person A had in fact taken the whole 90ml bottle of the prescribed methadone. She did not amend the record until 16:33 when the 30ml dose was due. The custody sergeant became aware the bottle was empty when Mrs Chester booked the bottle in as Person A's property and that Mrs Chester had brought the bottle straight to the custody desk from the medical room leaving Person A alone in the room.

Person B

On 26 June 2020, Person B, was arrested for the offence of rape and taken to Colchester Police where he was cautioned and detained in police custody. Due to the nature of the allegation [PRIVATE], officers were required to obtain both intimate and non-intimate samples from Person B for forensic DNA analysis. It is alleged that a risk assessment carried out on Person B identified them as [PRIVATE] and this was recorded in the custody detention record at 05:05. The recorded entry stated, '*Detainee is an* [PRIVATE] *and also requires intimate samples to be taken* [PRIVATE].

It is further alleged that the Custody Sergeant (Witness 1) then had a conversation with Mrs Chester and informed her that they were keen for Person B to be prioritised as Person B was under constant observations by a police officer until the intimate sample had been taken. Witness 1 additionally mentioned to Mrs Chester that Person B [PRIVATE] and would need to be treated for this condition as well. Witness 1 also confirmed that copies of the medical record and risk assessments were '***provided'*** to HCPs to review before seeing a detained person. Mrs Chester attended Person B at 06:11 to obtain the intimate sample. The Excellicare clinical management plan completed by Mrs Chester stated:

> '*Samples sent off for forensics separate document attached onto Docs. DP appeared* [PRIVATE] *and understood the procedure which was done. DP also gave consent'.*

Furthermore, whilst Mrs Chester conducted the NEWS assessment and NEWS scored Person B as 0, Mrs Chester failed to complete a [PRIVATE] which would have involved assessing and recording Person B's blood sugar levels.

Mrs Chester handed over Person B's care to Witness 2 who came on for the day shift. It is alleged that Mrs Chester did not mention Person B's [PRIVATE] during handover or that Person B would require medical review. Person B's [PRIVATE] went unchecked until the night shift of 26/27 June 2020 when Witness 3 came on for the night shift and between 01:00 and 03:00 when reviewing all custody records. Witness 3 noticed that Person B was [PRIVATE], and that there was no record of [PRIVATE] checks being conducted on Person B despite MA (medical attention) being noted next to Person B's name on Athena.

It was noted that Witness 2 had advised that Person B had already been seen by Mrs Chester the previous night and that nothing had been handed over to him apart from the intimate swabs being taken by Mrs Chester at approximately 05:20 the previous morning.

It is said that Witness 3 was concerned that Person B could be unwell, so she informed the Custody Sergeant, Witness 1, and requested access to Person B's cell. Witness 3 conducted a blood sugar check on Person B the result was 19.7mmol/L which was very high. Witness 3 requested a urine sample from Person B, and this indicated the presence of ketones and had traces of blood. Witness 3 then reported that Person B began vomiting large amounts in the cell and was sweating profusely. It was alleged that Person B had [PRIVATE] therefore, Witness 3 called an ambulance. Person B was admitted to [PRIVATE] due to missed insulin doses. He was admitted to the Acute Medical observation Unit (the Unit) until he was discharged back into custody at Colchester Police Station on 28 June 2020.

Following the incident with Patient B, CRG commenced a local investigation into Mrs Chester's conduct which was led by Witness 4. During the investigatory meeting on 1 July 2020, it is said that Mrs Chester made several statements which were alleged to be dishonest.

Mrs Chester allegedly stated that she had booked [PRIVATE] review for Person B to be carried out by the next nurse coming on shift because Person B appeared subdued and withdrawn, and that she allegedly requested the next nurse take a repeat blood sugar test post food, despite her not taking Person B's blood sugar, because she had said that [PRIVATE] was not clinically indicated. When the FME record was checked by Witness 4 it was found that Mrs Chester had not booked a repeat blood sugar test for the next shift. It is alleged that Mrs Chester also stated in her interview that after she had left Person B in the cell, she checked the risk assessment on the custody record which stated [PRIVATE]. When Witness 4 asked Mrs Chester why she did not return to Person B to obtain blood sugar levels, Mrs Chester stated that she handed this over to the next nurse coming onto the day shift.

In relation to the regulatory concerns, which at the time included:

1. *'Failed to provide adequate care to Person A, in that you left him unsupervised in the medical room with a 90ml bottle of prescription methadone.*
2. *Falsely recorded on Athena that you had administered 60mls of methadone to Person A at 14:29 and 30mls at 16:33.*
3. *Your conduct at 2 above was dishonest, in that you knew that Person A had consumed the content of the methadone bottle.'*

Mrs Chester, via her representative at the time, provided a written response to the Case Examiners where she accepted regulatory concerns 1 to 3 with caveats. The letter goes on to say that Mrs Chester expressed '*that she is deeply sorry for the errors she has made and that she is very committed to ensuring they do not repeat'*.

An email was then received from Mrs Chester's representative on 15 January 2024 confirming that Mrs Chester did not intend on attending a substantive hearing. An email from Mrs Chester was then received on 29 January 2024 confirming that she will not be '*going ahead now to do an appeal'* and that she will be leaving nursing. She also notes in the email that CRG were the '*worst unprofessional company'* she has ever worked for.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC. It noted the communication from Mrs Chester, dated 29 January 2024, and her email response via email to the NMC, dated 16 April 2024. However, she has not responded in detail to all of the Charges put forward to her by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Custody Sergeant at Colchester Police Station on 26 June 2020 at the time of Person B's detention.

- Witness 2: Health Care Professional at the CRG and Registered Nurse. Care of Person B handed over to Witness 2 on 26 June 2020 by Mrs Chester.

- Witness 3: Enhanced Care Practitioner with CRG on 26/27 June 2020.

- Witness 4: Enhanced Care Practitioner at the CRG and led the local investigation report against Mrs Chester.

- Witness 5: Custody Sergeant at Colchester Police Station on 28 November 2019 at the time of Person A's detention.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The legal assessor also referred the panel to the relevant case law which included *Ivey v Genting Casinos UK Limited* [2017] UKSC 67. The panel also considered the documentary evidence provided by the NMC which included comments and documents from Mrs Chester.

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

Charge 1

1. On 28 November 2019:
    a. Left a bottle of prescription methadone unattended with Person A.

b. Recorded that you had administered 60mls of methadone at 14:29 to Person A when he had in fact taken all 90mls of methadone.

This Charge is found proved in its entirety.

The panel had regard to the following documentary evidence in respect of Charge 1a. At the time of the incident involving Person A, Witness 5 was the Custody Sergeant at the Police Station. In Witness 5's account to the NMC dated 17 May 2021, he stated:

> *'When I later spoke to the Registrant, she said that when she was in the medical room with Person A, she left the open bottle of methadone on the table in front of Person A. Realising that she needed to decant 60mls from the bottle so that he had the correct dose, she had walked a few steps away to the other side of the room with her back to Person A to get a syringe from the cupboard. When her back was turned, Person A had grabbed the bottle. The Registrant asked him for the bottle, but he refused to hand it over. She did not shout for help, nor press the panic alarm which is installed in the medical room. Person A consumed the entire contents of the bottle.'*

This was supported by the Custody Detention Log entry on 28 November 2019 which was entered by Mrs Chester at 16:33:

> *'Medication Entry made by External* […] *Chester.* […]
> *Medication was prescribed as 1 x 60mls of Methadone* [Person A] *took the whole bottle ending up to be 90 mls'*

Witness 5 further provided an email dated 30 November 2019:

> '[Mrs Chester] *was sitting at her desk and the DP* [Person A] *was sitting on the examination bench to her left and slightly behind her. The DP had previously been very difficult and agitated / cross because he had apparently been promised that he would be given his methadone at 9:15am by the night medic. He was still being difficult and she felt under considerable pressure from him, but she did not think to call for help. "I didn't want to bother you*

because you were busy". The bottle of methadone was on the desk to her left, just in front of the telephone. She tells me that she realised that the label indicated that the bottle contained two doses (60ml and then 30ml in the evening). So, without saying anything to the DP, she got up and turned to the right, turning her back on the DP, to get a syringe from the cupboard to decant the correct dose. Whilst she was standing, the DP stood up, and grabbed the bottle. He refused to give it back to her and her training/guidance is NOT to try to grapple with detainees for fear of there being an allegation of assault. She asked him to return the bottle "so I could check what the label said" but he refused and downed the whole lot.""

During the course of Witness 4's local investigation as commissioned by CRG, Witness 4 provided the NMC with his findings:

'At 16:32, the Nurse then recorded on Person A's Detention Log (AP10), that "Medication was prescribed as 1x60mls of Methadone DP took the whole bottle ending up to be 90mls". This was a correction to the Nurse's earlier 14:29 and 14:30 entries in the Detention Log in which they recorded that only 60mls Methadone had been prescribed and given. At 16:33 the Nurse recorded in the custody record that 30mls had been prescribed to Person A at 14:29. This was a retrospective entry.'

The panel also noted Mrs Chester's account, detailed in her email dated 16 April 2024, which stated:

'On the 29th 2019 I was on the other side of the room when a [sic] *assistant police officer came in when I was no were* [sic] *near the table putting the methadone down on the table which was left unattended. By the time I walked over to the medication, person A had already took hold of the medication and started drinking it. I had to tell person A to stop drinking the medication. They* [sic] *was a small amount left in the bottle which was given in he* [sic] *afternoon. I was unsure to how much was in the bottle due to being unable to measure the amount. So yes on reflection* [PRIVATE] *me to say yes I did guess the amount in the bottle. I'm truly sorry* [PRIVATE].*'*

The panel found Witness 5's evidence to be credible and reliable. As the Custody Sergeant on 28 November 2019, the panel noted that he had a particular duty of care to Person A which relates to the health and welfare of the suspect in police custody and these duties require considerable vigilance and focus on any events of relevance. As such, the panel placed some weight to his account, which was further supported by the email dated 30 November 2019 to his Senior Officer, which set out the chronology of the events, and the Detention Log.

The panel considered Mrs Chester's account was not consistent with the other documentary evidence before it. On the balance of probabilities, the panel found Witness 5's evidence to be more credible than Mrs Chester's, as it aligned closer with other evidence and was not self-serving, and therefore, it was objective and independent. Accordingly, the panel found Charge 1a proved.

The panel next considered the documentary evidence which relates to Charge 1b. The panel took into account the Custody Detention Log entry by Mrs Chester entered at 14:29 on 28 November 2019:

> *'Medication was prescribed as 1 x 60 mls of Methadone.*
> *Medication entry made by External* […] *Chester. See National Medical Form'*

The panel also considered the following entry at 16:33, entered by Mrs Chester on the same date and almost 2 hours later:

> *'Medication Entry made by External* […] *Chester.* […]
> *Medication was prescribed as 1 x 60mls of Methadone* [Person A] *took the whole bottle ending up to be 90 mls'*

Witness 5 stated in his account to the NMC dated 17 May 2021:

> *'It was only at 16:33 that the registrant made an entry to record the extra 30mls had been taken at 14:29. This is shown by the Medication Prescribed and Given log which I attached as Exhibit* […] *and the in on-screen version of*

the detention log. At this the same time that the ambulance, having been called for his chest pains following his fall.'

The panel also noted Mrs Chester's account, detailed in her email dated 16 April 2024 above. The panel determined that this account was inconsistent with the events recorded in the Custody Detention Log.

The panel determined that it is clear from the Custody Detention log entry by Mrs Chester at 14:29 on 28 November 2019, that she has recorded that she administered 60ml of methadone to Person A. Witness 5 then subsequently attested that Mrs Chester made a retrospective entry to record that the *'extra 30mls'* had been taken by Person A at *'14:29'.* The panel therefore found that there was contemporaneous evidence entered by Mrs Chester to prove that she did in fact enter onto the system that she administered 60ml, when Person A had in fact taken the full 90ml. The panel therefore found Charge 1b proved.

Charge 2

2. On 26 June 2020, in relation to Person B:
    a. Failed to obtain and/or record a medical history from him.
    b. Failed to handover to Colleague 1 [PRIVATE].
    c. Failed to indicate at handover that Person B would require a medical review.

This charge is found proved in its entirety.

In considering Charge 2a, the panel took into account the Detention Log dated 26 June 2020 entered at 05:05:

'HCP was requested by Police, Reason Requested: Detainee is [PRIVATE] *and also requires intimate samples to be taken for* [PRIVATE]*.*
A medical call out was made on 26/06/2020 at 05:02 and Crg Medical was spoken with. The call out was answered.'

The panel also had regard to the Self-Assessment form dated 26 June 2020 at 01:56 as exhibited by Witness 1 in his statement to the NMC (16 April 2021), in which it stated the following:

> *'*[…]*. Provide any additional comments here.:* [PRIVATE]
>
> […] *Describe the indications/ further comment here.: WMS for* [PRIVATE] *but will not disclose any information*
>
> *Question & Answers for Self assessment*
>
> […]
>
> *Do you have any Medical conditions?: Yes*
>
> *What are your medical conditions?:* [PRIVATE]
>
> *Have you had or are you receiving treatment for medical conditions? Yes*
>
> *Treatment for medical conditions.: Insulin- due next time eats* […]

The panel also had sight of the Officer Assessment of Person B on 26 June 2020 at 05:05 (Exhibit TR/9) which stated:

> *'Detainee is an* [PRIVATE] *and also requires intimate samples to be taken for a sexual offence.'*

The panel also noted Witness 3's statements dated 10 May 2021 in which she explained the duty falling upon Mrs Chester as follows:

> '[…] *the Detention Officer will log onto the Athena system that a medical call out (MC) to the CRG was made. This will be seen by the HCP in the medical room of the custody suite who will respond accordingly by opening up a custody record and looking at the risk assessment of the detainee. The*

record will help the HCP determine what equipment they will need to take to the detainee in their cell to perform their assessment.'

The panel considered carefully the comments from Mrs Chester that Person B did not inform her of [PRIVATE]. Additionally, the panel considered her statement on 16 July 2020 wherein she stated that this was her eight detainee and that her shift was running out and that she was due to finish at 7am. She also stated that the detainee arrived in police custody around 1am and that she was in a *'busy shift'.* She also stated that she asked the detainee verbally *'if he had any medical issues that I needed to document. He replied, quite clearly that he did not, and that he just wanted to get on* [PRIVATE] *or he was on medication'.*

The panel also noted Mrs Chester's account, detailed in her email dated 16 April 2024, which stated:

'On the 26th June Person B
I did obtain what was given to me verbally from the person B, I did ask Person B if they had a medical issues which they denied. BP was taken and I had documented to my knowledge that he appeared to be Subdude [sic] *and looked very unwell. My mistake was yes I should of* [sic] *documented more down. But it was unfortunate due to* [PRIVATE] *I did not documented* [sic] *everything. I relise* [sic] *now I should have listened* [PRIVATE] *know my limitations. It was unfortunate I had handed over other detainees* [PRIVATE] *that morning but not Detainee B. On my way home I had realised this and called the member of staff on duty that morning on his private mobile saying could he review person B has* [sic] *he needed a proper review has* [sic] *I had mainly done the samples which was started the early hours of six am but with* [PRIVATE] *I had not let him know. The manager* […] *was aware of* [PRIVATE] *has* [sic] *I was waiting for an appointment from* [PRIVATE] *services to email me with an appointment which the Manager had told me this had been done. This was hopefully to reduce my hours and to discuss* [PRIVATE]*. I had not incorrectly told the investigatory meeting that the person B denied having any medical or mental health conditions. Person B had denied this, I had handed this over to the morning staff.'*

The panel considered that there was sufficient information before Mrs Chester to prompt her to obtain and/or record a medical history from Person B given that the contemporaneous records consisting of the Custody Detention Record, Self-Assessment, Officer Assessment and Medical Record-Officer Visual Assessment, all indicate that he had [PRIVATE]. Also, the panel took note of Witness 1's statement (16 April 2021), wherein he said, *'he mentioned that Person B* [PRIVATE]. The panel also had sight of the Excellicare record completed by Mrs Chester in which there was no record made of medical history [PRIVATE].

Accordingly, the panel found Charge 2a proved.

The panel next considered Charge 2b and 2c. It had regard to Witness 2's statement to the NMC signed 25 April 2021 who received a handover from Mrs Chester:

> '*On 26 June 2020 I came onto shift at 07:00 at the Station and received a handover from the Nurse.*
> […]
> *There was no discussion between the Nurse and I that Person B was* [PRIVATE] *and needed insulin administrated, so I was not asked to see Person B*. […] *Person B's* [PRIVATE] *was not mentioned to me. The Nurse did not book a* [PRIVATE] *review or request a* [PRIVATE] *for Person B. I am not aware of any record of these bookings taking place. If the Nurse had booked a* [PRIVATE] *for person B, this was usually recorded in the daily handover sheet'*

In Witness 4's statement to the NMC dated 30 June 2021, he stated:

> *'The Nurse denied recalling Person B, after prompting and the Nurse looking through their book in which they record all persons seen do they recall Person B. The Nurse could not recall if they checked the police's risk assessment. The Nurse declared that Person B did not mention their* [PRIVATE] *to them. The Nurse said Person B appeared clammy and quiet and that they thought this was because Person B* [PRIVATE] *and not the result of a medical condition. The Nurse said they had not booked a review of*

Person B because there was no medical condition. The Nurse then said that they had booked a [PRIVATE] *review through the call centre for 08:00 for the next HCP as Person B appeared withdrawn. There is no record of this booking being made. After explaining that Person B suffered from* [PRIVATE] *the Nurse could not fully explain what a DKA is and did not understand that it was a medical emergency. The Nurse claimed that Witness 1 told them to ignore the medical history, when I spoke to Witness 1 they stated that this was untrue'*

The panel next considered Mrs Chester's undated account of the incident on 26 June 2020:

'I did tell the day medic that the detainee had not had a proper welfare check, only samples taken. It was not written in the hand over sheet has [sic] *I had run out of time. This detainee was apparently not seen all day till the night medic checked on him, but this is not my responsibility.'*

The panel noted the comments by Mrs Chester dated 16 July 2020, wherein, she stated that at no relevant time did she know that Person B was [PRIVATE]. In her statement on the incident dated 16 July 2020, she said *'the detainee arrived in custody around 01:20am and not once was I informed, during my busy shift, that this detainee was* [PRIVATE] *or had medication in custody'.* Mrs Chester also indicated that she had handed over appropriately two other [PRIVATE] suspects that night and that she told the day medic that Person B had not had a proper welfare check.

The panel also considered the account provided by Mrs Chester, as detailed in her email, dated 16 April 2024.

The panel took the view that there was sufficient evidence before it to find Charge 2b and 2c proved. The panel found Witness 2's account to be clear in that he spoke directly to Mrs Chester upon his attendance at the police station, that he received no information in the handover that Person B was [PRIVATE] and required monitoring. The panel noted that had Mrs Chester carried out the relevant checks as required in her role, that she may have been able to identify that Person B did in fact have [PRIVATE] which would require a

review, notwithstanding that Witness 1 stated that he had told her specifically of Person B's [PRIVATE] There was no documentary evidence of a medical history or assessment being undertaken or request for further healthcare review by Mrs Chester in the CRG health record. Accordingly, the panel found Charges 2b and 2c proved on the balance of probabilities.

Charge 3a

3. Incorrectly told an investigatory meeting on 1 July 2020 that:
    a. Person B denied having any medical and/or mental health conditions.
    b. […]
    c. […]

This charge is found NOT proved.

The panel found Charge 3a not proved, given its decision to exclude the hearsay evidence of Person B. Whilst it considered the rest of the documentary evidence, it found no other material to support this charge.

Charge 3b and 3c

3. Incorrectly told an investigatory meeting on 1 July 2020 that:
    a. […]
    b. You booked a [PRIVATE] review and/or a repeat blood sugar test for Person B.
    c. Person B's [PRIVATE] had been handed over to the nurse coming on shift.

Charges 3b and 3c are found proved.

In respect of Charge 3b, the panel took into account Witness 4's account to the NMC dated 30 June 2021:

> *'The Nurse could not recall if they checked the police's risk assessment. The Nurse declared that Person B did not mention* [PRIVATE] *to them.* […] *The Nurse said they had not booked a review of Person B because there was no medical condition. The Nurse then said that they had booked a* [PRIVATE] *review through the call centre for 08:00 for the next HCP as Person B appeared withdrawn. There is no record of this booking being made.'*

Witness 4 exhibited (AP/22) the notes for the Investigatory Meeting with Mrs Chester dated 1 July 2020 including in paragraph 6:

> *'VI. Did you feel it necessary to book a review for the morning HCP?*
> - *No as the DP denied any medical problems.*
>   - *Angie then said that she booked a* [PRIVATE] *review with the call centre for next HCP as the DP appeared subdued and withdrawn. Angie requested that the next HCP took a repeated blood sugar post food.* ***Angie didn't take a blood sugar at her review.***
>   - *Angie said that the review was booked for 8am. I have checked FME and this review was never made.*
>   - *I then raised with Angie why she thought a* [PRIVATE] *review was required when she has already said that a blood sugar was not*

clinically indicated and as the DP hadn't stated any previous medical problems. Angie then became [PRIVATE]*.*

[…]'

Regarding Charge 3b, the panel also had regard to the Management Plan recorded by Mrs Chester dated 26 June 2020, which indicated that no healthcare review was required, and that the only noted action during the date in question was *'Samples taken and sent off for forensics'.*

In Mrs Chester's email to the NMC on 16 July 2020 about the incident on 26 June 2020 in respect of Person B, she stated that, *'As my visual assessment was telling me that there was no medial* [sic] *issue. I concentrated on completing the sampling procedure'.*

Witness 4 stated that Mrs Chester initially denied knowing that Person B had a medical condition. She then later claimed that a [PRIVATE] review was booked through a call centre for the next HCP, but no record of this booking was found. Further, the panel considered the Management Plan recorded by Mrs Chester on 26 June 2020 was a contemporaneous record of the incident. It noted that Mrs Chester did not make any documentary record that referred to a subsequent [PRIVATE] review for Person B or a blood sugar test. The panel found that there was sufficient evidence before it to suggest that Mrs Chester had been incorrect in her answers at the investigatory meeting on 1 July 2020, when she said she had booked a [PRIVATE] review and a repeat blood sugar test.

As such, the panel found Charge 3b proved.

In respect of Charge 3c, the panel took into account Witness 2's statement to the NMC signed 25 April 2021:

'*On 26 June 2020 I came onto shift at 07:00 at the Station and received a handover from the Nurse.*

[…]

There was no discussion between the Nurse and I that Person B was [PRIVATE]*, so I was not asked to see Person B*. […] *Person B's* [PRIVATE] *was not mentioned to me. The Nurse did not book a* [PRIVATE] *review or*

request [PRIVATE] *for Person B. I am not aware of any record of these bookings taking place. If the Nurse had booked* [PRIVATE] *for person B, this was usually recorded in the daily handover sheet'*

The panel also noted the notes of the Investigatory Meeting (AP/22) with Mrs Chester dated 1 July 2020 including in paragraph 6:

- *'I then stated to angie; so when you realised that the DP was* [PRIVATE] *why did you not go back to the DP's cell and obtain his blood sugar level? Angie said she handed this over to the next HCP.*
- *I have obtained a statement from the next HCP* [Witness 2] *and this was never discussed during verbal or written handover'*

Witness 3 supported this account in her statement to the NMC dated 10 May 2021:

'During the handover, I noticed that there was an MC on Athena for a detainee ("Person B"). An MC marker means that a medical call out has been made […] *I questioned* [Witness 2] *about this, and they stated that when they received the handover from the Nurse at 07:00 the same day, the Nurse mentioned that forensics had been taken from Person B due to their arrest for an offence of rape. The Nurse said nothing else that needed assessing with Person B. As a result,* [Witness 2] *had not seen Person B during their shift as they believed that there was no action that needed to be taken because of what the Nurse handed over.'*

The panel has already noted at Charges 2b and 2c the statements made by Mrs Chester that she did not know that Person B [PRIVATE]. Witness 2 provided relevant evidence, as he was the HCP on shift relieving Mrs Chester. He claimed that he did not receive information that Person B was [PRIVATE], needed insulin administrated and must be reviewed. This was supported by the account of Witness 3, who directly received the handover for Person B from Witness 2. The panel therefore found that there was sufficient evidence before it to prove that Mrs Chester had incorrectly told an investigatory meeting on 1 July 2020 that Person B's [PRIVATE] had been handed over to the Nurse coming on shift.

The panel therefore found Charge 3c proved.

Charge 4

4. Your actions at charge 1b above were dishonest in that you deliberately sought to represent that Person A hadn't consumed the whole bottle of methadone at around 14:29.

This charge is found proved.

The panel considered Witness 4's account to the NMC dated 30 June 2021 during the course of their local investigation for CRG:

> *'The Nurse initially tried to hide this incident by depositing the methadone bottle into Person A's possession bag even though it was empty and recording that 60ml was administered at 14:29. The Nurse had booked in a review for 16:00 with the description "next pain relief due"* […]. *The Nurse then made an entry at 16:33 that 30mls was administered at 14:29. This is shown by the Medication Prescribed and Given log* […]*. These entries recorded by the Nurse are false, because they knew that the entire contents of the 90ml methadone bottle were consumed by Person A when the Nurse had their back turned in the medical room. The Nurse tried to cover this up by recording in the custody record that they had administered 60ml dose at 14:29 and then the final 30ml dose at 16:35.'*

The panel also took into account the documentary evidence referred to above in Charges 1a and 1b. It bore in mind the legal advice when considering the dishonesty of this charge and the case of *Ivey v Genting Casinos UK Limited* which provides:

- What was the defendant's actual state of knowledge or belief as to the facts; and
- Was the conduct dishonest by the standards of ordinary decent people?

The panel considered the content of the Custody Detention log in which Mrs Chester recorded that 60mls of methadone was given at 14:29 and did not record that full 90mls was given until 16:33.

The panel further considered Witness 5's witness statement, which said that Mrs Chester told him that she had sought further medical advice and that their advice was the extra 30ml was unlikely to cause any adverse effect. An email from the doctor concerned dated 2 December 2019 stated that they remember Mrs Chester contacting them about this incident where the twice daily dose was taken in one go and they had advised that this one-off incident should not have major clinical significance. The panel was unable to identify a timeline for this.

The panel also considered Witness 4's witness statement, which stated:

> *'… the nurse had a duty to record on Person A's detention log and medical assessment log exactly what had happened. Everybody makes mistakes and although this was a large error by the nurse it was important that they recorded what had happened immediately onto Person A's notes. This is because the other members of staff working with Person A needed to be aware that person A had consumed the entire 90mls of methadone. If person A had an adverse reaction to the 90mls of methadone, the records need to be accurate so that the appropriate people could see what had been consumed and provide Person A with appropriate care.'*

The panel therefore found that Mrs Chester had acted dishonestly by the standards of ordinary decent people. Although she allegedly contacted the doctor for medical advice on the incident, she did not record that Person A had taken the full bottle at 14:29 or informed police colleagues. The panel determined that Mrs Chester sought to conceal her actions by failing to disclose this in a timely manner, as such, it found Charge 4 proved.

Charge 5 (only in respect of 3b and 3c)

5. Your actions at charge […] 3b and/or 3c above were dishonest in that you deliberately sought to conceal that you had overlooked that Person B was [PRIVATE].

This charge is found proved.

The panel took into account the Investigatory meeting with Mrs Chester dated 1 July 2020:

'VI. Did you feel it necessary to book a review for the morning HCP?

- *No as the DP denied any medical problems.*
  - *Angie then said that she booked a* [PRIVATE] *review with the call centre for next HCP as the DP appeared subdued and withdrawn. Angie requested that the next HCP took a repeated blood sugar post food.* ***Angie didn't take a blood sugar at her review.***
  - *Angie said that the review was booked for 8am. I have checked FME and this review was never made.*
  - *I then raised with Angie why she thought a* [PRIVATE] *review was required when she has already said that a blood sugar was not clinically indicated and as the DP hadn't stated any previous medical problems. Angie then became tearful again and became anxious.*

  […]
  - *I then stated to angie; so when you realised that the DP was* [PRIVATE] *why did you not go back to the DP's cell and obtain his blood sugar level? Angie said she handed this over to the next HCP.*
  - *I have obtained a statement from the next HCP* [Witness 2] *and this was never discussed during verbal or written handover'*

The panel also noted the relevant comments in Mrs Chester's email, dated 16 April 2024, wherein she stated that she, '*called the member of staff on duty that morning on his private mobile saying that could he review person B has he needed a proper review*' and that she had '*not incorrectly told the investigatory meeting that the person B denied having any medical or mental health conditions. Person B had denied this, I had handed this over to the morning staff'*.

In considering Charge 5 in respect of 3b and 3c, the panel bore in mind the legal advice when considering the dishonesty of this charge and the case of *Ivey v Genting Casinos UK Limited* which provides:

- What was the defendant's actual state of knowledge or belief as to the facts; and

- Was the conduct dishonest by the standards of ordinary decent people?

The panel found Mrs Chester's answers during the Investigatory Meeting held by Witness 4 to be inconsistent. The panel found that Mrs Chester was dishonest when she said that she booked a [PRIVATE] review and/or a repeat blood sugar test for Person B and that Person B's [PRIVATE] had been handed over to Witness 2. There was sufficient information before the panel, referred to above, which indicated that Mrs Chester did not book a [PRIVATE] review and/or a repeat blood sugar test for Person B and nor did she handover to Witness 2 that Person B has [PRIVATE]. The panel determined, on the balance of probabilities, that Mrs Chester should have been aware that Person B was [PRIVATE] and had overlooked this. Her responses at the Investigatory Meeting (as above) indicated that she was deliberately attempting to conceal this fact.

Accordingly, found Charge 5 in respect of Charges 3b and 3c proved.

Decision and reasons on considering additional information from the new exhibits received on 30 May 2024

On 30 May 2024, the panel received additional papers whilst it was deliberating. The papers received are as follows:

- An email from Mrs Chester to the NMC, dated 16 April 2024; and
- A final impairment bundle.

The panel heard and accepted the advice of the legal assessor, who drew the panel's attention to considerations of relevance and fairness.

The panel determined that it would be fair to take into account Mrs Chester's email, dated 16 April 2024, as well as the outcome of Mrs Chester's performance review letter (Exhibit AP/9), dated 30 May 2020, when reaching its decision. However, as there is no evidence that Mrs Chester had an opportunity to read or contradict the evidence against her in the new bundle, the panel decided that it would be unfair to Mrs Chester to consider this evidence in their decision.

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 Chester'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 Chester's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The panel considered the NMC's Statement of Case on misconduct:

16. *'It is submitted that the facts amount to misconduct.*

17. *Whether the facts found proved amount to misconduct is a matter entirely for the panel's professional judgment. There is no burden or standard of proof (per Council for the Regulation of Health Care Professionals v (1) General Medical Council (2) Biswas [2006] EWHC 464 (Admin)).*

18. *The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:*

'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of 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'.

As may the comments 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'.

Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Nursing and Midwifery Council's Code of Conduct.

On the basis of the charges being found proved, we consider the following provision(s) of the Code: Professional standards of practice and behaviour for nurses and midwives (2015) ('the Code') have been breached in this case;

10 Keep clear and accurate records relevant to your practice
To achieve this, you must:
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 records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times,
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

19. *It is submitted that Mrs Chester's conduct as detailed in the charges above have fallen far short of what is and would have been expected of a registered professional. Her conduct would be seen as deplorable by her fellow practitioners and would damage the trust that the public places in the profession.*'

On impairment, the NMC stated:

20. *'It is submitted that Mrs Chester fitness to practise is impaired by reason of her conduct on both public interest and public protection grounds.*

[…]

24. *Mrs Chester has clearly brought the profession into disrepute by the very nature of the conduct she has displayed. Nurses occupy a position of trust and must act with and promote integrity at all times. Integrity and the professional duty of candour are fundamental tenets of the profession that have been breached in this case. The public has the right to expect high standards of registered professionals. The seriousness of Mrs Chester's conduct is such that it calls into question her professionalism in the workplace, this therefore has a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute.*

25. *Mrs Chester* [sic] *conduct is fundamentally incompatible with being a registered professional because the qualities required of Mrs Chester have been significantly undermined and compromised.*

26. *With regard to future risk, it may assist to consider the comments of Silber J in Cohen v General Medical Council [2008] EWHC 581 (Admin) namely (i) whether the concerns are easily remediable; (ii) whether they have in fact been remedied; and (iii) whether they are highly unlikely to be repeated.*

27. *We consider that Mrs Chester has not provided a substantive response to the regulatory concerns except to say that she accepts regulatory concerns 1 to 3 so it cannot be said that Mrs Chester is demonstrating full insight and that there is no risk of her repeating the behaviour.*

28. *We consider there is a continuing risk to the public due to the severity of the concerns and the fact that these concerns are more difficult to put right. Our guidance states that generally, there are certain concerns that are more difficult to put right and often mean that the nurse, midwife or nursing associate's right to practice needs to be restricted.*

29. *In cases where concerns involve breaches of the professional duty of candour these concerns are amongst the most serious category of concerns. Within our guidance on seriousness, we list breaches of the professional duty of candour as serious concerns which are more difficult to put right. Mrs Chester has breached this duty as she was dishonest on more than one occasion to cover up her mistakes which resulted in Person B suffering real harm as a direct result of her actions and he ended up in hospital. It can be said that had the nurse that took over not noticed that Person B was a* [PRIVATE] *the consequences could have been much more severe.*

30. *A finding of impairment is thus also essential to maintain public confidence in the profession. In light of this and the fact that her conduct could seriously damage the reputation of the profession, it is submitted that a finding of impairment is necessary on public interest and public protection grounds*.'

The panel heard and accepted the advice of the legal assessor, who drew the panel's attention to the '*The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code")*, the NMC's Statement of Case on misconduct and impairment, as well as the contextual information provided by Mrs Chester. The legal assessor referred the panel to the cases of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin)*, General Medical Council v Meadow* [2007] 1 All ER 1 and *Cohen v General Medical Council* [2008] EWHC 581 (Admin). He reminded the panel that whilst 'impairment' is not defined, it should consider whether a nurse can practise kindly, safely and professionally, whilst considering all factors, including mitigating factors, involved in the case.

Decision and reasons on misconduct

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

The panel was of the view that Mrs Chester's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Chester'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:

8.2 maintain effective communication with colleagues

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk.

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.4 take all steps to keep medicines stored securely

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.'

The panel noted the NMC's written submission on Code 20.3 and concluded that it does not apply in this case. With regard to Code 10.2 and 10.3, the panel determined that Charges 1a) and 2a) apply to the former, and Charge 1b) applies to the latter.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered Mrs Chester's actions in Charge 1. With regard to Charge 1a), the panel acknowledged that leaving medication unattended was a serious error, in itself, which could have merely been a negligent error. However, the panel considered the facts relevant within Charge 1b), which addresses the same incident, and concluded that Charge 1a) amounted to misconduct as Mrs Chester's later falsifying of documents exacerbated the situation and placed Person B at risk of harm. With regard to Charge 1b), the panel determined that falsifying records is a serious breach of the Code and amounted to misconduct.

With regard to Charge 2 taken as a whole, the panel considered that Mrs Chester appeared to have identified and handed over other patients appropriately, but determined that she had not done so with Person B. The panel also considered the pressures of working in the Custody Suite that night, Mrs Chester's [PRIVATE] as well as the delays surrounding waiting for consent and bags for samples to arrive. However, the panel determined that Person B was an extremely vulnerable patient, and her failure to make the necessary record checks to ascertain Person B's health status, as outlined in the charge, amounts to misconduct. The panel determined that this failure fell below the standards expected of a nurse caring for a vulnerable patient, despite the pressures she was facing and her personal circumstances at the time and led to the admission of Person B to hospital.

On Charge 3 taken as a whole, the panel considered that nurses have a professional duty of candour. The panel determined that Mrs Chester breached that duty of candour and openness, and this is serious misconduct, as Mrs Chester was not candid in the investigation, which undermined confidence in the profession.

With regard to Charges 4 and 5, read together, the panel determined that Mrs Chester's dishonesty fell far below the standards expected of a nurse. With regard to Charge 4 specifically, the panel determined that Mrs Chester could have been honest regarding her error, albeit it was a serious error, but had chosen to be dishonest. Accordingly, the panel found that Mrs Chester's dishonesty in both Charges 4 and 5 amount to serious misconduct.

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

Decision and reasons on impairment

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

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

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

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) 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 determined that all four limbs of *Grant* are engaged in this case.

With regard to the first limb, the panel finds that patients were put at risk and Person B was caused physical harm as a result of Mrs Chester's misconduct. On the second and third limb, Mrs Chester's misconduct had breached the fundamental tenets of the nursing profession – particularly the duty of candour – and has therefore brought its reputation into disrepute. Furthermore, the panel was also satisfied that confidence in the nursing profession would be undermined if its regulator did not treat charges relating to dishonesty extremely serious.

Regarding insight, the panel considered all relevant documentation before it, including documentation submitted by Mrs Chester. The panel noted her undated reflection, which stated:

> *'My role is* [PRIVATE]*, but I have never neglected my role. I have just completed my PIP further training which was due to an incident the year before. I passed the PIP training with a high mark, so I know that my professional standard of work is high. Now I am being told I was neglectful to this detainee by the new ECP, who looked after the detainee and said he had gone into a hyper and was sent to the A/E dept. Apparently, since then, he has recovered and was returned to custody.'*

The panel also considered an email from Mrs Chester, dated 19 September 2019, which stated:

> *'On reflection I can see what areas I have to improve on and to trust my intuition more […] I need to also not let the police pressurise me at times on shifts and take my time more not to rush when sometimes its non-stop…'*

Whilst the panel noted this email predated the incidents, the panel considered that Mrs Chester was reflecting on the nature of her role, and how she can manage it.

The panel further considered an email from Mrs Chester's representatives at the Royal College of Nursing (RCN), dated 1 October 2021, which stated:

> *'Our member does not propose to make any further comments at this stage, other than to express to the NMC that she is deeply sorry for the errors she has made and that she is very committed to ensuring they do not repeat.'*

The panel considered that '*errors'* is not elaborated on in this email, and Mrs Chester does not specify the exact concerns she is referring to.

The panel also considered Mrs Chester's response regarding the incident involving Person A, which was, according to Witness 5, *"peppered with 'There was nothing I could do' and*

‘It’s not my fault”. The panel determined that this indicated that Mrs Chester failed to demonstrate insight into her actions at the time, when asked about it.

The panel took into account the email sent by Mrs Chester to the NMC, dated 29 January 2024, which stated:

> *‘… I will be leaving nursing now* [PRIVATE] *it was my dream to be a nurse, have many positive memories. The company CRG we’re the worst unprofessional company I have ever worked for.’*

The panel also considered the email sent by Mrs Chester to the NMC, dated 16 April 2024, as quoted above.

Taking into account all the above, the panel determined that Mrs Chester demonstrated some remorse for her actions. However, the panel concluded that Mrs Chester has demonstrated limited insight into her actions. The panel determined that Mrs Chester did not take full responsibility for her actions and sought to blame CRG. The panel also noted that, in her reflection, she sought to blame others for her misconduct through contextualising the environment. Whilst the panel acknowledged that it was a busy shift and Mrs Chester had [PRIVATE], the panel concluded that Mrs Chester did not sufficiently reflect on her role in the misconduct.

Furthermore, the panel also considered Mrs Chester’s reflection on her training on [PRIVATE]. However, the panel concluded that this demonstrated limited insight, given that the misconduct related to her failure to follow the correct procedures in the identification of [PRIVATE], rather that the management of [PRIVATE] in itself.

The panel also carefully considered the evidence before it in determining whether or not Mrs Chester has taken steps to strengthen her practice. The panel took into account the training certificates Mrs Chester had provided the panel, and the panel concluded that these certificates primarily relate to mandatory induction training, rather than additional training which Mrs Chester has undertaken since the incidents. The panel also considered the comments in Mrs Chester’s email, dated 16 April 2024, that ‘*I have trained in many skills the last few years which guided me in being a professional practice nurse’*. The panel

concluded that there is no further evidence before it to suggest Mrs Chester has taken steps to strengthen her practice.

The panel is of the view that there is a risk of repetition, given that Mrs Chester has not demonstrated adequate insight or taken steps to strengthen her practice since the incident. The panel also considered that this case involves dishonesty, and it determined that it is difficult to remediate dishonesty. The panel therefore decided that a finding of impairment is necessary on the ground 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.

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, in light of the seriousness of the charges. In particular, the panel determined that Mrs Chester's breach of her duty of candour is a public interest concern, and a breach of a fundamental tenet of nursing. Therefore, the panel also finds Mrs Chester's fitness to practise impaired on public interest grounds.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Chester off the register. The effect of this order is that the NMC register will show that Mrs Chester has been struck-off the register.

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 the NMC's Statement of Case on sanction, which stated:

'

31. We consider the following sanction is proportionate:

32. A Striking off order

[…]

35. Mrs Chester has not provided any substantive responses to the charges she faces except to say she accepts the regulatory concerns 1, 2 & 3. Mrs Chester was dishonest when trying to cover up her mistakes on two separate occasions which resulted in Person B suffering real harm and as a result of Mrs Chester's failures Person B was admitted to hospital. Despite this Mrs Chester continued to be dishonest when the matter was investigated at local level and maintained that she had booked a [PRIVATE] *review for Person B to be carried out by the next nurse coming on shift despite the FME record not recording this had been booked and that she did not return to take blood sugar levels as she had handed this over to the next nurse coming on day shift when she knew she had not.*

36. This therefore raises fundamental questions about Mrs Chesters professionalism. It has a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute and a striking off order is the only sanction which will be sufficient to maintain the professional standards and protect the public.

37. Considering each sanction in turn starting with the least restrictive:

a. Taking no further action would not adequately deal with the seriousness of the concerns in this case and would not meet the wider public interest or public protection.

b. *A Caution Order again would be insufficient to maintain public confidence within the profession and would be inadequate to mark the seriousness of the conviction and conduct displayed in this case.*
c. *A Conditions of Practice Order would be inappropriate because there are no conditions that would be sufficient to maintain confidence within the profession and conditions would not address the dishonesty and attitudinal concerns displayed by Mrs Chester.*
d. *A suspension order would be inappropriate as there is evidence of deep-seated attitudinal and personality problems and this is not a case where it was a single instance of misconduct.*

38. *The appropriate and proportionate sanction is one of a striking off order. Mrs Chester has brought the profession into disrepute and trust and confidence in the profession is likely to be seriously eroded by the fact that Mrs Chester's behaviour raises fundamental questions as a registered professional and is incompatible with continued registration. The concerns are difficult to address or put right and constituted a very serious breach of the professional duty of candour.*

39. *A striking off order is the only order that would adequately meet the public interest by declaring such behaviour as unacceptable for a registered professional*.'

Decision and reasons on sanction

Having found Mrs Chester'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 adequate insight into failings;
- Conduct which put patients at risk of suffering harm and of suffering actual harm;
- Mrs Chester was in a position of trust, and was working as a sole practitioner with vulnerable patients in a custodial environment.

The panel also took into account the following mitigating features:

- It was a busy environment on the shift on 26 June 2020, and the panel noted that Mrs Chester has appropriately handed over two other [PRIVATE] patients on the same shift;
- Mrs Chester attempted to mitigate the harm caused to Person B by seeking medical advice with an offsite doctor;
- Mrs Chester was [PRIVATE].

The panel also noted Mrs Chester's criticism of CRG in her email to the NMC, dated 29 January 2024, and how she felt unsupported by the organisation. The panel also had sight of the concluding remarks in the outcome of the Performance Improvement Plan, dated 30 May 2020.

The panel also considered the NMC Guidance '*Considering sanctions for serious cases'* (SAN-2). The panel determined that this case involved a deliberate breach of the professional duty of candour regarding the recording of the administration of methadone to Person A, and Mrs Chester's dishonesty at the investigatory meeting. The panel also considered, as outlined in the aggravating factors above, that Mrs Chester was in a position of trust, caring for vulnerable detainees, in which she was the only nurse the detainees could access. The panel determined that, in her misconduct, there was a direct risk of harm to the detainees, including actual harm on Person B.

The panel considered that Mrs Chester did not have personal financial gain from the breach of trust in her conduct. The panel acknowledged that although the clinical concerns may, in themselves, form separate isolated incidents, Mrs Chester's dishonesty indicated a pattern.

Accordingly, the panel bore in mind its above considerations on seriousness when imposing a sanction.

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 Chester'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 Chester's misconduct was not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Chester's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, as Mrs Chester has not engaged with the NMC adequately to indicate whether she would comply with a conditions of practice order. The misconduct identified in this case involved Mrs Chester's dishonesty, and the panel determined that her dishonesty was not something that can be addressed through retraining or conditions of practice. Furthermore, the panel concluded that the placing of conditions on Mrs Chester's registration would not adequately address the public interest concerns identified.

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

- *No evidence of repetition of behaviour since the incident;*
- *There is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Chester's actions is fundamentally incompatible with Mrs Chester remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

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

On the first point above, the panel concluded that Mrs Chester's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel considered that both Mrs Chester's actions and her dishonesty regarding those actions – namely to misrepresent her recordings on methadone, as well as her dishonest account at the Investigatory Meeting – fell far short of the standards expected of a nurse, as it concerned breach of the professional duty of candour and failings in the fundamental tenets of nursing. The panel acknowledged Mrs Chester's remarks on the pressures she was facing on the shift, but it concluded that her misconduct raises fundamental questions about her professionalism.

Furthermore, the panel was of the view that the charges found proved, demonstrate that Mrs Chester's actions were serious, and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mrs Chester's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was 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.

This will be confirmed to Mrs Chester in writing.

Interim order

As the striking-off 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 Chester's own interests until the striking-off sanction takes effect.

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

Representations on interim order

The panel took account of the NMC's written submission on interim orders:

> *'If a finding is made that the registrant's fitness to practise is impaired on a public protection basis and a restrictive sanction imposed, we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest…*'

Decision and reasons on interim order

The panel considered the guidance on interim orders (INT-1). 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 suspension order is consistent with its finding on sanction.

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 to cover any appeal period.

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

That concludes this determination.