Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 15 May – Thursday, 23 May 2024

Virtual Hearing

Name of Registrant:	**Lynnette Ivison**
NMC PIN:	09C0875E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 1 April 2009 Recordable qualifications – V300 Nurse independent/supplementary prescriber – 28 June 2002
Relevant Location:	Blackpool
Type of case:	Misconduct
Panel members:	Darren Shenton (Chair, Lay member) Anjana Varshani (Lay member) Jim Blair (Registrant member)
Legal Assessor:	Graeme Sampson - (15, 16, 17, 21, 20, 22 May 2024) John Bassett - (23 May 2024)
Hearings Coordinator:	Margia Patwary - (15, 16, 17, 21, 22, 23 May 2024) Jumu Ahmed - (20 May 2024)
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Miss Ivison:	Not present and unrepresented at the hearing
Facts proved by admission:	Charges 1b and 1c
Facts proved:	Charge 1a

Facts not proved:	Charge 2
Fitness to practise:	**Impaired**
Sanction:	**Caution order (2 years)**

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

At the outset of the hearing, Mr Edwards made a request that this case be held partially in private on the basis that proper exploration of Miss Ivison's case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to Miss Ivison's [PRIVATE], the panel determined to hold parts of the hearing in private in order to preserve the details of [PRIVATE].

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Ivison was not in attendance and that the Notice of Hearing letter had been sent to Miss Ivison's registered email address on 11 April 2024.

Mr Edwards, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually and, amongst other things,

information about Miss Ivison's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Miss Ivison

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

Mr Edwards referred the panel to the documentation concerning proceeding in absence and summarised Miss Ivison's case chronologically and the recent email dated 30 April 2024. [PRIVATE].

Mr Edwards referred the panel to Miss Ivison's case management form. He invited the panel to consider Miss Ivison's admissions in relation to charges 1b and 1c. He submitted that although Miss Ivison is not present at the hearing, it is clear that Miss Ivison would like the panel to consider her lengthy detailed response in relation to the charges. He further submitted that Miss Ivison has no objection for the information she provided to go before the panel.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with*

the utmost care and caution' as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Miss Ivison;
- Miss Ivison has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses had been warned to attend the hearing to give live evidence, and not proceeding would potentially inconvenience the witnesses, their employer, and for those involved in clinical practice their clients who need their professional services;
- The charges related to events that occurred in 2022 and further delay might have an adverse effect on the ability of witnesses to recall accurately events; and
- There is a strong public interest in the expeditious disposal of the case.

The panel acknowledged some disadvantage to Miss Ivison in proceeding in her absence. However, the evidence upon which the NMC relies will have been sent to her at her registered email address. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited

disadvantage is the consequence of Miss Ivison's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

That you, a registered nurse:

1) Failed to maintain professional boundaries by
   a) giving Patient A your personal mobile phone number on or around 19 February 2018; **[PROVED]**
   b) sending text messages of a personal and/or unprofessional nature from your personal mobile phone to Patient A on numerous occasions between 1 July 2021 and 22 February 2022; **[PROVED BY ADMISSION]**
   c) Delivering gifts of food and alcohol to Patient A on one or more occasions including on 22 December 2021. **[PROVED BY ADMISSION]**

2) Visited one or more of the patients set out in Schedule 1 jointly with Colleague 1 when such visits were not clinically justified and/or were contrary to infection control guidance at that time. **[NOT PROVED]**

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

Schedule 1	
Patient	Date of visit

Patient B	11 June 2020
Patient C	23 July 2020
Patient D	20 August 2020
Patient E	3 September 2020
Patient G	8 September 2020
Patient H	17 September 2020
Patient I	17 September 2020

Background

The charges arose whilst Miss Ivison was employed at Blackpool Teaching Hospital's NHS Foundation Trust (the Trust), in the Community Heart Failure Team (the Team), from September 2015. Miss Ivison commenced employment in the Team as a Band 5 Nurse and was promoted to Band 6 on 18 April 2016. Miss Ivison was responsible for managing a caseload of patients, who they would review and assess to provide specialist heart failure care as required.

…[PRIVATE]…

It is alleged that Miss Ivison failed to maintain professional boundaries with Patient A, including providing Patient A with her personal mobile number on 19 April 2018; exchanging text messages with Patient A and visiting Patient A at the Home in a non-clinical capacity. These concerns arose both during periods when Patient A was on Miss Ivison's caseload, and periods when they were not.

In addition to the concerns regarding Miss Ivison's relationship with Patient A, concerns were also raised with regard to Miss Ivison's failure to safeguard in relation to Covid-19. Additionally, during the course of the NMC investigation, Witness 3, who was Miss Ivison's manager raised concerns about Miss Ivison undertaking joint patient visits, with another member of the Team, on eight separate occasions between June and September 2020,

without clinical justification, and were contrary to infection control guidance in place at the time during the Covid-19 pandemic.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Edwards, who informed the panel that Miss Ivison admitted to charges 1b and 1c as set out in her case management form.

The panel therefore finds charges 1b and 1c proved in their entirety, by way of Miss Ivison's admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Edwards and by Miss Ivison.

The panel has drawn no adverse inference from the non-attendance of Miss Ivison.

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

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

- Witness 1: [PRIVATE].
- Witness 2: [PRIVATE].
- Witness 3: [PRIVATE].

- Colleague 1: [PRIVATE].

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

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

Charge 1a

1) Failed to maintain professional boundaries by
    a) giving Patient A your personal mobile phone number on or around 19 February 2018

This charge is found proved.

In reaching this decision, the panel took into account Patient A's EMIS records and Timeline of Patient A's care.

The panel noted that Miss Ivison does not dispute that she gave Patient A her personal mobile phone number, but the date of when she gave it.

On Patient A's EMIS records, on 19 February 2018 at 16:53, Miss Ivison had inputted the comment:

'given my personal number as day off tomorrow so can discuss with GP'

The panel noted that Miss Ivison has also admitted to charge 1b in that she had sent text messages of a personal and/or unprofessional nature from her personal mobile phone to Patient A on numerous occasions between 1 July 2021 and 22 February 2022.

The panel, therefore, determined, that on the balance of probabilities, it is more likely than not that Miss Ivison failed to maintain professional boundaries by giving Patient A her personal mobile phone number on or around 19 February 2018. The panel, therefore, finds charge 1a proved.

Charge 2

> 2) Visited one or more of the patients set out in Schedule 1 jointly with Colleague 1 when such visits were not clinically justified and/or were contrary to infection control guidance at that time.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 3's oral evidence and documentary evidence including her witness statement and the 'Covid-19 update from the Trust dated 22 May 2020' and Colleague 1's oral evidence. The panel also had regard to Miss Ivison's response on the Case Management Form dated 29 January 2023.

In Witness 3's witness statement, she stated:

> *'10. Ms Ivison was obstructive and I recall at least one incident when they refused to follow policy. Between June and September 2020 a number of incidents arose, during the height of the Covid-19 pandemic when guidance from the Infection Control team was that there was to be no car sharing or joint visits (unless clinically necessary), for infection control purposes. I am unable to provide this specific guidance, and have been advised by Infection Control they are also unable to provide documentary guidance as (at that time) it was changing on a regular basis.* […] *During this period, Ms Ivison continued to carry out joint visits with junior staff on eight separate occasions without approval or justification. I did not directly witness these visits but became aware of them from viewing staff electronic diaries, which showed joint visits taking place. The joint visits took place with* [Colleague 1]

(a Band 4 at the time). I am no longer able to access Ms Ivison's electronic diary, but do have access to [Colleague 1]*'s and upon review have been able to identify eight joint visits that took place between June and September 2020. These joint visits were also documented in the respective patients' notes, and having reviewed I can confirm there is no clinical justification for the visits needing to be conducted by two people.*

11 . When these joint visits were identified they were discussed at our weekly team meetings and we would confirm current Covid-19 infection control guidance to members of the team, so Ms Ivison would have been aware of the guidance that they should not be conducting joint visits unless clinically justified or an alert being in place that the patient or a family member posed a risk to staff. I do recall that when the joint visit issue was raised with Ms Ivison they felt that they were doing nothing wrong despite the management advice about not conducting joint visits. I am no longer able to access copies of the minutes for these meetings as they were sent by email, and I have contacted NHS email who have confirmed that as they have since been deleted the emails cannot be retrieved. This guidance was in place to reduce the spread of Covid-19 via close contact. If either Ms Ivison or [Colleague 1] *had contracted Covid-19 at the same time, which there was a risk of as they were seeing each other, and had to isolate at the time there would have been a considerable impact on the service due to short staff.'*

The panel also had sight of the 'Covid-19 update from the Trust dated 22 May 2020 which was provided by Witness 3. It was of the view that this was a generic update as to what was expected of staff in relation to precautionary activity and social distancing.

The panel took into account Miss Ivison's response in her Case Management Form dated 29 January 2023:

'2. I deny the accusation of joint visits without clinical justification as I was the Case Manager for my areas and all those referrals came to me so it was for me to decide

who was accepted and seen. The service received many inappropriate referrals creating more admin and home visits so we were advised to be more selective on those we planned to see/ add to caseload. Occasionally referrals deemed inappropriate received a telephone call to further assess.

I had been taught to prioritise my workload efficiency. Pre Covid new patients were seen in twos, one nurse one HCA. The process would include a blood test, ECG holistic bundles which were completed by the HCA, then a cardiac assessment by myself, this took 60 minutes depending on the patient. If we did not go as a joint visit, then the HCA would still visit separately, on the odd occasion I could visit alone with ECG again dependent on the patients needs,

At times, I would assess new patients on their own and was the only nurse in the team that used an ECG machine regularly, to reduce footfall. Other factors such as alerts on patients notes and or alcohol / drugs issues warranted double visits. Depending on the referral that came in and on needs of the caseload, I would assess what was the best course of action, when [Colleague 1] *was not with me she would be seeing current patients on my caseload.*

Previously, [Colleague 1] *and I would take turns driving, but during this time we would drive separately to the addresses. I don't want to comment on individual visits and it was 3 years ago and I can only vaguely recall most of the patients and I deny the charge.*

Though I am sure one of the male patients was a 2 per person visit as per emis alert.

Please note the Covid timeline I sent in previous bundle, I was on maternity leave at the height of the pandemic and returned on limited hours due to [PRIVATE]. *I was working as many hours as I could with very little support other than from my partner. I don't think I was working my full hours till the end of the summer.*

Please see email response from mini [PRIVATE] *re closure times due to Covid*

Throughout this period I worked efficiently and did the lamp test twice weekly as per policy, I know other members of the team were not following this policy and pathology records will show this. Covid tests were taken on arrival of each care home visit which followed their infection control policies. I always signed in to the logs then waited for a negative result before entering the main building. On the 22nd Dec I did not take a test or sign in as I was only dropping off goods as his son could not and I explained this to the staff member.

My background is pre / post op care so I am aware of how important hand hygiene and infection control policies are. I have always preserved patient safety as per NMC code in all my roles. I am up to date with all my training on bluestream and [PRIVATE] *assesses my hand hygiene technique and I follow local policy for cleaning clinic rooms I use.* […]'

The panel acknowledged that Covid-19 was a difficult and challenging period and that every member within the medical profession was doing the best they could in an unprecedented and unclear times. The panel heard evidence that, at that time, the guidance and policy was changing on a daily basis. [PRIVATE]. The panel heard evidence from all of the witnesses that joint visits on initial assessment were the most appropriate method for patients to be seen properly and expeditiously as a Health Care Assistant would undertake the intravenous activity and for the nurse to undertake the medical assessment. This was the regular practice prior to the Covid-19 pandemic.

The panel took into account Colleague 1's evidence in which she told the panel that she has had first-hand experience with dealing with Covid-19 and how she felt abandoned by more senior nurses, who did not go out to visit patients in their homes, when she herself had to. Colleague 1 also told the panel that when Miss Ivison and her had a joint visit, they would follow protocols by travelling separately, putting on the personal protective equipment and socially distancing. This was also supplemented with regular covid testing.

The panel was of the view it was clear from Colleague 1 that they were trying to diligently perform their duties, ensuring safety of patients was prioritised.

The panel heard evidence from Colleague 1 that other members of staff also undertook joint visits, albeit much less frequently.

The panel took into account Witness 2's evidence that this was a concern and that this was discussed during the Trust's daily meeting, which dealt with ongoing referrals and the changing restrictions regarding Covid-19 protocols. The panel was not provided any evidence of any notes of these meetings.

[PRIVATE], there was no clear or detailed risk assessment within the policy. The panel noted that joint visits was a clinical judgement made by Miss Ivison and that this was her final clinical decision to make. There was nothing within the guidance which states that this decision needed to be authorised by a manager or another nurse. The panel noted that there was no evidence to demonstrate that joint visits was contrary to infection control guidance at the time.

There was no direct evidence before the panel which demonstrated that the joint visits conducted by Miss Ivison and Colleague 1 were not clinically justified and/or were contrary to infection control guidance at that time.

[PRIVATE], from which it could conclude that Miss Ivison was specifically issued instructions regarding joint visit policy and how they should not be taking place, other than in exceptional circumstances.

The panel had no evidence before it to demonstrate that Miss Ivison's joint visits with Colleague 1 was not clinically justified. In the absence of any clear or corroborated evidence and any evidence which was contrary to infection control guidance, the panel determined that this charge is found not 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 Miss Ivison'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 suitability to remain on the register unrestricted.

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

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

Submissions on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Edwards invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and submitted the

NMC say Miss Ivion's actions amounted to breaches of the Code and fell short of the standards expected of a registered nurse.

Mr Edwards identified the specific, relevant standards where actions amounted to misconduct. He submitted that although there are no concerns in Miss Ivison's clinical practice, it is clear that she breached professional boundaries when she had provided her personal mobile phone number to Patient A. He further submitted that there are hundreds of pages of text messages between Miss Ivison and Patient A within the exhibit bundle, which demonstrates there was communication on a daily basis. This also included times when Miss Ivison was on annual leave.

Mr Edwards submitted that whilst there is evidence of unprofessional relationship via the use of mobile phone, there is no suggestion of inappropriate activity with Patient A. He submitted that Miss Ivison was quite aware that her contact with Patient A was inappropriate. He further referred the panel to Miss Ivison's response bundle which outlines that Miss Ivison acknowledged her communication was inappropriate towards Patient A.

Mr Edwards moved onto impairment and submitted that a finding of impairment is needed both on public protection and public interest grounds. He referred the panel to the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Edwards referred the panel to paragraph 76 of the judgement in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) *(Grant)*, when Mrs Justice Cox approved of the approach formulated by Dame Janet Smith. Mr Edwards submitted that limbs a), b) and c) of the relevant test are engaged, that is, that Miss Ivison breached a fundamental tenet of the profession by failing to maintain professional boundaries and that she brought the profession into dispute by her misconduct. He submitted that Miss Ivison admitted charge 1b and 1c but has not admitted to her fitness to practise being currently impaired by reason of her misconduct.

Mr Edwards submitted that although there was no evidence that actual harm was caused to Patient A, her actions will be harder to remediate as she breached professional boundaries with Patient A over a prolonged period and that there is evidence of some attitudinal issues.

Mr Edwards referred the panel to the NMC guidance on '*Remediation and insight'* to see if the alleged failings have been addressed.

Mr Edwards referred the panel to the NMC guidance which states:

> "*Remediation will usually be central to deciding whether a nurse or midwife's fitness to practise is currently impaired. This is because whether fitness to practise is being considered at a final hearing, or at an earlier stage of our process, the events that led to the nurse or midwife being referred to us will usually have happened some time previously. When assessing remediation, decision makers will need to take into account the following questions:*
>
> - *Is the concern remediable?*
> - *Has the concern been remedied?*
> - *Is it highly unlikely that the conduct will be repeated?*"

Mr Edwards submitted that Miss Ivison has not demonstrated insight into the seriousness of her actions. He submitted that her failings in this case raise a serious concern about her failure to maintain professional boundaries. Mr Edwards submitted that Miss Ivison is liable to repeat her behaviour in the future.

For all of the reasons mentioned above, Mr Edwards invited the panel to make a finding on misconduct and impairment on the grounds of public protection and public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

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 Miss Ivison's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Ivison's actions amounted to a breach of the Code. Specifically:

> ***20 Uphold the reputation of your profession at all times***
> *To achieve this, you must:*
> ***20.1*** *Keep to and uphold the standards and values set out in the Code*
> ***20.6*** *Stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers.*

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

However, the panel found that charges 1a, 1b and 1c amounted to misconduct. The panel was of the view that Miss Ivison's actions in sending text messages from her personal mobile phone to Patient A on numerous occasions was of an unprofessional nature. Further, delivering gifts of food and alcohol to Patient A on one or more occasions is a serious breach of the relevant standards of conduct and falls far below what the public

would expect of a registered nurse. The panel also noted that this behaviour had continued for a long period of time.

The panel found that Miss Ivison'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, Miss Ivison's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional 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. 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 *Grant* in reaching its decision. In paragraph 74, she said:

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

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

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

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

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

d) …

The panel considered that limbs b) and c) were engaged as Miss Ivison brought the profession into disrepute and that she had breached one of the fundamental tenets of the nursing profession, maintaining professional boundaries. The panel noted that although this impacted on a former patient, there was no clinical harm caused, nor any defects in her clinical practice.

In terms of public protection, the panel noted that Miss Ivison had taken steps to develop her insight and remediated her actions, and this is shown through her response on the Case Management Form dated 29 January 2023. The panel found that Miss Ivison did not respond to Patient A’s inappropriate messages and there was no evidence of Miss Ivison acting in a predatory manner. The panel found that Miss Ivison did not abuse her professional position in relation to Patient A’s vulnerability, but at a difficult time in her personal life she blurred her professional role in respect of Patient A, who she later considered a friend.

The panel noted that Miss Ivison had shown remorse about the incident and how it had impacted on her life. The panel noted that since the incident, no concerns have been raised and that this can be regarded as an incident isolated to one patient. It further had sight of detailed 360-degree workplace feedback from January 2024, references from previous employer, managers and colleagues, all of whom spoke positively to her commitment to nursing and safe care of her patients.

[PRIVATE], Miss Ivison has comprehensively engaged with the regulatory process, and provided considerable documentation in support of her case and comment on the material disclosed to her by the NMC.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not she had undertaken steps to remediate her conduct. The panel took into account that Miss Ivison addressed the conduct during her detailed reflective pieces and in her monthly supervisory meetings that were referenced in a management testimonial. The panel also noted the considerable amount of CPD training that Miss Ivison had undertaken since subject to these proceedings which demonstrated her ongoing commitment to the nursing profession.

For the reasons set out above, the panel considered it to be highly unlikely that Miss Ivison will repeat the misconduct. The panel therefore decided that a finding of impairment is not necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. It was of the view that members of the public would be alarmed by the actions of a nurse who had breached professional boundaries with a patient under their care, over a prolonged period. The panel also noted that there is

no doubt that well informed members of the public would be concerned at such behaviour on the part of a nurse.

The panel was of the view that this was a case which fell within that spectrum of cases identified by Mrs Justice Cox in Grant, namely:

> *'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'*

Having regard to all of the above, given the particular circumstances of this case, the panel determined that a finding of current impairment of Miss Ivison's fitness to practise was necessary to uphold professional standards and maintain public confidence in the profession.

Sanction

The panel considered this case very carefully and decided to make a caution order for a period of two years. The effect of this order is that Miss Ivison's name on the NMC register will show that she is subject to a caution order and anyone who enquires about her registration will be informed of this order.

Submissions on sanction

Mr Edwards submitted that the NMC sanction bid for Miss Ivison's case is a striking off order.

Mr Edwards outlined the mitigating and aggravating features in Miss Ivison's case.

Mr Edwards referred the panel to the NMC's guidance on *'Serious concerns which are more difficult to put right'* reference: FTP-3a. He also referred the panel to a document regarding '*clear sexual boundaries between healthcare professionals and patients, responsibilities of healthcare professionals'* issued by the Council for the Regulatory Excellence (CHRC). He submitted that as Miss Ivison has breached professional boundaries it may not be easy for her to put right. He submitted that the incident occurred over a long period of time and although there was no patient harm, there was a vulnerable patient involved.

Mr Edwards submitted that Miss Ivison's conduct is serious and that it at least warrants temporary removal from the register. He referred the panel to the NMC's guidance on *'Striking-off order'* reference: SAN-3e.

Mr Edwards submitted that the only appropriate sanction in Miss Ivison's case is a striking off order and that it is the only sanction which will be sufficient to protect patients and members of the public.

Mr Edwards submitted that if the panel are of view that a striking off order is either unnecessary or disproportionate, he invited the panel to consider the NMC's guidance on *'Suspension order'* reference: SAN-3d where a checklist was provided.

Mr Edwards submitted that Miss Ivison's conduct was not a single incident but had taken place over an extended period and as she had taken no action to stop the communication this may be indicative of a deep-seated attitudinal concern. He stated that Miss Ivison had accepted the misconduct and whilst there was evidence of some remediation, she had not displayed full insight. He further stated there has been no evidence of repetition of the behaviour and there were no clinical concerns, but that the panel may consider that the matter was so serious that a short period of suspension without a review may be appropriate.

Mr Edwards submitted that no order or a caution order would be insufficient in Mr Ivison's case given the seriousness of her case.

Mr Edwards submitted that there are no workable or practicable conditions that can be formulated and/or that can be imposed through a conditions of practice order as the panel made a finding of impairment on the grounds of public interest.

For these reasons, Mr Edwards submitted that a striking-off order would adequately protect the public.

Decision and reasons on sanction

Having found Miss Ivison'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:

- [PRIVATE]

The panel considered Mr Edwards submission that there was a risk that Patient A was placed at an emotional risk of harm and that the patient was vulnerable. However, the panel found no evidence before it to support this. Whilst the age of Patient A may be a factor in assessing vulnerability the panel considered that this alone was not determinative. Indeed, when it considered all the witness evidence and the available documentary text messages, it was clear that Patient A was an articulate and intelligent individual, albeit in the latter stages of his life.

The panel also noted that it is the NMC's submission that Miss Ivison lacked insight. However, the panel considered that Miss Ivison had demonstrated significant insight in terms of the failings in her actions, throughout the Trust investigation and engagement of the regulatory process up to this hearing.

The panel identified the following mitigating features:

- Early admissions to the regulatory charges;
- Miss Ivison accepted her inappropriate behaviour during the initial Trust and NMC investigation;
- No concerns in relation to Miss Ivison's clinical practice prior to or since the incident;
- Miss Ivison has kept up to date with her clinical practice and associated training requirements;
- Evidence of significant insight;
- [PRIVATE]; and
- Workplace issues, including lack of supervisory support and alleged bullying requiring workplace mediation.

The panel considered the relevant guidance referred to in the submissions of Mr Edwards. It gave particular consideration to the guidance on *'seriousness'* and the associated document from the CHRC in respect of sexual boundaries. It noted that its primary focus was in the context of a registrant acting inappropriately to a patient rather than vice versa.

It did consider the paragraph regarding *'when a patient or carer is sexually attracted to a healthcare professional'* and the recommendation that the healthcare professional should seek advice from colleague or professional body. The panel reminded itself of the evidence of Witness 3, who herself had received comments that were inappropriate and contained sexual innuendo from Patient A, and the hearsay statements of Healthcare Assistant 1 and Healthcare Assistant 2 at the care home – both of whom comment on the

character of Patient A and how he would engage in such behaviour. Additionally, it reflected on the evidence from Miss Ivison and the content of the text messages. The panel noted that when such messages were sent by Patient A, there was no encouragement or engagement from Miss Ivison to continue this tone of conversation. Indeed, there were instructions from her to *'stop'* or periods where she ignored the messages.

This panel consequently concluded that this case did not fall within the category of cases referred to in NMC's guidance FTP-3a.

The panel first considered whether to take no action but concluded that this would be inappropriate given that Miss Ivison had breached professional boundaries. The panel considered that taking no further action would not adequately mark the public interest in this case nor uphold proper professional standards and maintain confidence in the nursing profession.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states:

> *"A caution order is only appropriate if the Fitness to Practise Committee has decided there's no risk to the public or to patients requiring the nurse, midwife or nursing associate's practice to be restricted, meaning the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise Committee wants to mark that the behaviour was unacceptable and must not happen again."*

The panel, having found impairment solely on public interest grounds, then went on to consider whether a caution order would adequately address the public interest concerns in Miss Ivison's case.

The panel concluded that this case was at the lower end of the spectrum of impaired fitness to practise given the strong set of mitigating features. The panel wished to mark that the behaviour was unacceptable and must not happen again. The panel was therefore of the view, taking into account all the features of this case, that a caution order would be appropriate and proportionate to mark the public interest in this case.

The panel noted that Miss Ivison has shown insight into her conduct. The panel noted that she made admissions and provided extensive documents showing evidence of genuine remorse. Miss Ivison has engaged with the NMC since referral. The panel has been told that there have been no adverse findings in relation to Miss Ivison's practice either before or since this incident.

The panel also considered the public interest in the retention of an otherwise competence nurse in the workplace, who had continued to deliver effective care without repetition of the behaviour, or any complaint since these matters coming to light.

The panel considered whether it would be appropriate or proportionate to impose a more restrictive sanction. It first considered a conditions of practice order, but was of the view that as there were no concerns relating to Miss Ivison's clinical practice, a conditions of practice order would not address the misconduct found. It concluded that no useful purpose would be served by a conditions of practice order.

The panel further considered that a suspension order would be disproportionate due to this case being at the lower end of the spectrum of impaired fitness to practise and it would be unduly punitive as an order was not required to protect the public.

The panel decided that a caution order would adequately mark the seriousness of the misconduct and meet the public interest. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of 2 years would be the appropriate and proportionate response. For the next 2 years, Miss Ivison's employer - or any prospective employer - will

be on notice that her fitness to practise had been found to be impaired and that her practice is subject to this sanction. Such an order would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered nurse.

At the end of this 2 year period the note on Miss Ivison entry in the register will be removed. However, the NMC will keep a record of the panel's finding that her fitness to practise had been found impaired. If the NMC receives a further allegation that Miss Ivison's fitness to practise is impaired, the record of this panel's finding and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to Miss Ivison in writing.

That concludes this determination.