Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday 13 – Tuesday 14 November 2023, Thursday 16 – 17 November 2023, Monday 20 – Tuesday 21 November 2023, Monday 27 November 2023, Friday 27 September – 2 October 2024, and 14 November 2024

Virtual Hearing

Name of Registrant:	Ms Doreen Angela Sutherland
NMC PIN	99C1224E
Part of the register:	Registered Nurse- 19 March 2003
Relevant Location:	Birmingham
Type of case:	Misconduct
Panel members:	Lucy Watson (Chair, Registrant member) Tracey Chamberlain (Registrant member) David Hull (Lay member)
Legal Assessor:	Tracy Ayling KC (13-14, 16-17 and 20 November 2023) Robin Ince (21 November 2023) Robin Hay (27 November 2023, 27 September – 2 October 2024 and 14 November 2024)
Hearings Coordinator:	Monsur Ali (13-14 and 16-17 November 2023, 27 September – 2 October 2024, and 14 November 2024) Sophie Cubillo-Barsi (20 – 21 November 2023)
Nursing and Midwifery Council:	Represented by Lucie Danti, Case Presenter
Ms Sutherland:	Present and represented by Timothy Akers, instructed by Royal College of Nursing (RCN)
Facts proved:	Charges 1a, 2 and 3
Facts not proved:	Charges 1b(i), b(ii), b(iii),
Fitness to practise:	Stage not reached

Sanction: Stage not reached

Interim order: Interim suspension order (12 months)

Details of charges

That you, a Registered Nurse:

1. On 24 March 2021, whilst working at Parklands Care Home, following Resident A having sustained a fall failed to:

   a) undertake a proper clinical assessment and/or complete the Top to Toe Assessment before Resident A was moved from the floor;

   b) complete and/or update the following records:

      i) An Accident/ Incident Form;

      ii) A body map;

      iii) A Falls checklist.

2. Made an application to the NMC for revalidation of your registration as a midwife dated 1 March 2018, in which you indicated that you had completed 450 hours of registered midwifery practice in the previous three years, when you had completed less than 450 hours or no hours of registered midwifery practice in the previous three years.

3. Your actions at charge 2 above were dishonest in that you intended to mislead the NMC about your eligibility for revalidation.

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

Submissions on application to adduce hearsay evidence

The panel heard an application made by Ms Danti under Rule 31 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules), to allow the statement and evidence exhibited by Witness 2 into evidence. She said that there are four exhibits that this application relates to which are exhibited by Witness 2. The first is Exhibit [Witness 2]/02 and this is Ms 1's, (a healthcare assistant) local statement

dated 26 March 2021. The second is Exhibit [Witness 2]/07 which is an excerpt from Resident A's electronic care notes taken on 24 March 2021 and this is in relation to comments made by Ms 1. The third is Exhibit [Witness 2]/11 which are minutes of a local interview conducted by telephone with Ms 1 dated 31 March 2021, and finally, [Witness 2]/13 which is a Comprehensive Root Cause Analysis report dated 19 April 2021. Ms Danti stated that all these documents relate to Charge 1 and their associated sub charges.

Ms Danti asked the panel to consider the relevant principles from paragraph 56 of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) in making its decision.

Ms Danti submitted that these documents were not the sole or decisive evidence in support of Charge 1. She told the panel that it will hear oral evidence from Witness 2 in relation to this charge and Witness 2 can be challenged during her oral evidence.

Ms Danti submitted that the nature and extent of the challenge to the contents of the evidence was clear, and there had been no suggestion that Ms 1 had fabricated the evidence as there had been no indication of any underlying tension between you and Ms 1. She submitted that the charges against you are serious.

Ms Danti submitted that there has been no engagement by Ms 1 despite numerous attempts to contact her. She referred the panel to a bundle of documents which contained the record of the attempts made by the NMC to secure Ms 1's attendance at this hearing. Ms Danti stated that there was suggestion that Ms 1 had been unwell and more recently the NMC was informed that Ms 1 no longer works at the Care Home. She stated that there was no response to any of the attempts to make contact with Ms 1. She said that there were a total of five communications sent to Ms 1 with no response received from her. On 6 December 2021 it was decided not to pursue any further attempts to contact Ms 1 and by this time a number of attempts had been made over the course of four and a half months. Ms Danti submitted that in these circumstances there have been reasonable steps taken to secure the attendance of Ms 1.

Ms Danti submitted that the requirements of fairness are satisfied in this case and invited the panel to allow these four categories of documents into hearsay evidence as produced in Witness 2's witness statement.

Mr Akers submitted that he does not take issue with Exhibit [Witness 2]/07 which is the entry of various updates on Resident A's electronic personal care record. However, he asked the panel to consider whether in all of the circumstances it is really fair to admit the evidence of this absent witness.

In relation to Exhibit [Witness 2]/02, Mr Akers submitted that the evidence the NMC seeks to admit is, a) hotly contested by you, and b) is highly emotive. He directed the panel to certain parts of the statement where it is stated that *'no checks were carried out'* and submitted that these parts are vehemently disputed by you. He also submitted that there are parts of the statement that are highly emotive and again they are strongly disputed by you. He submitted that Ms 1's statement is a gross misrepresentation of what really took place.

In relation to Exhibit [Witness 2]/11, Mr Akers submitted that the information on this document is hotly contested in terms of who carried out the Top to Toe assessment. He said that it has your name on the Top to Toe check and submitted that it would be grossly unfair to allow such untested evidence into these particular proceedings.

Mr Akers submitted that [Witness 2]/13, the Root Cause Analysis investigation report, was completed on the back of unreliable evidence from Ms 1.

Mr Akers stated that he agrees with Ms Danti's submissions that Ms 1's evidence is not the sole or decisive evidence in relation to Charge 1. However, he asked the panel if it is fair to admit weak and unreliable evidence in order to bolster the NMC's case in these proceedings.

Mr Akers submitted that the panel may well deem that Ms 1 has a reason either to fabricate or exaggerate her evidence in these proceedings. She was working as a care

worker on the night in question and by placing the blame on you, she is, by the same token, exculpating herself in effect.

Mr Akers submitted that these proceedings could have a profoundly adverse effect upon your career. He therefore asked the panel to consider whether there really is a good reason for the non-attendance of Ms 1. He said that there is a reference to Ms 1 being unwell but it seems that reference did not even come from herself and it is hearsay of the most dangerous kind because it came from the manager of the Care Home.

Mr Akers submitted that the questions of fairness and the credibility of the evidence cannot be tested without Ms 1 being cross examined and questioned before the panel. He therefore opposed the application to admit Exhibit [Witness 2]/02, [Witness 2]/11 and [Witness 2]/13 as hearsay evidence.

Decision and reasons on application to adduce hearsay evidence

The panel accepted the legal assessor's advice on the issues it should take into consideration in respect of this application, which included reference to *Thorneycroft*, *NMC v Ogbonna [2010] EWCA Civ 126, R (Bonhoeffer) v GMC [2011] EWHC 1585 (Admin)* and *Manseray v NMC* [2023] EWHC 730 (Admin).

Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

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

In relation to the question of fairness, the panel had particular regard to the guidance set *out at paragraph 56 of Thorneycroft,* which states:

> *"56. The decision to admit the witness statements despite their absence required the Panel to perform careful balancing exercise. In my judgment, it was essential*

in the context of the present case for the Panel to take the following matters into account:

> *(i) whether the statements were the sole or decisive evidence in support of the charges;*
> *(ii) the nature and extent of the challenge to the contents of the statements;*
> *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
> *(v) whether there was a good reason for the non-attendance of the witnesses;*
> *(vi) whether the Respondent had taken reasonable steps to secure their attendance; and*
> *(vi) the fact that the Appellant did not have prior notice that the witness statements were to be read."*

Having carefully considered the application and applied the principles of *Thorneycroft*, the panel determined that the evidence the NMC seeks to admit is not sole and decisive. It was of the view that whilst it was not sole or decisive, it is important and corroborative evidence of Witness 1. However, the panel noted that you will not be able to challenge that corroborative evidence and therefore the panel was of the view that this was likely to cause detriment to your case and could therefore be unfair. For example, any allegation of joint fabrication or even inadvertent influence of one witness on another could not be dealt with.

The panel determined that there appears to be no reason for Ms 1 to fabricate any of this evidence.

The panel also took into account the seriousness of the allegations and noted that this is a misconduct case where the outcome could have significant impact on your career.

The panel next considered whether there is a good reason for the non-attendance of Ms 1. It determined that whilst some efforts were made by the NMC to secure her attendance, sufficient effort has not been made since October 2021. Nevertheless, that is not the sole reason for the panel's findings but something which it took into account.

The panel had not heard evidence as to why Ms 1 was not attending as a witness and had not provided a witness statement. Accordingly, the panel was not satisfied there was a good reason for the non-attendance of Ms 1.

The panel was satisfied that prior notice had been given that the evidence from Ms 1 would be submitted.

In relation to Exhibit [Witness 2]/02 and [Witness 2]/11, the panel determined that it would not be fair to admit these into evidence as it cannot test the veracity of these documents without the witness being questioned and cross-examined. The panel decided that taking all of these matters into account cumulatively, it would be unfair to admit this evidence.

However, in relation to Exhibit [Witness 2]/07, the panel concluded that this could be dealt with by questioning of Witness 2. The panel therefore determined that it is relevant and fair to admit [Witness 2]/07 because that is documentary contemporaneous evidence as it is the electronic record of Resident A's care notes. It therefore determined to admit this evidence.

In relation to [Witness 2]/13, the panel noted that it will hear oral evidence of Witness 2 who is the author of this document and can answer any questions about it. It therefore determined to admit this evidence.

Background

You have been working as a registered nurse since 19 March 2003. There are two linked cases in this matter. The first case, reference 083717/2021, relates to poor

patient care. The second case, reference 084371/2021, relates to failing to act with honesty and integrity when revalidating your midwifery registration.

In relation to the first case (083717/2021), you were referred to the NMC on 20 May 2021 by the Clinical Service Manger (Witness 2) at Parklands Care Home (the Home). Charge 1 and the sub charges relate to this matter alone. At the time of referral you were working as an agency nurse at the Home and the circumstances giving rise to Charge 1 relates to a single resident, Resident A.

You were working a night shift on 23 March 2021 at the Home. The incident happened early in the morning of 24 March 2021.

Resident A had significant care needs and these included the assistance of two care staff for all personal care and the use of equipment, including a hoist. At one point, Resident A was brought to the communal lounge in a chair and subsequently fell whilst he was attempting to move from the chair. The allegation is that you failed to conduct the appropriate checks on Resident A before he was hoisted and lifted back into his chair from the floor. Secondly, you failed to complete and/or update records following Resident A having had this fall.

In relation to the second case (084371/2021), Charges 2 and 3 relate to this matter. This was an internal referral made on 30 June 2021 by the panel of the investigating committee under NMC Article 22 (6), following an incorrect/fraudulent entry hearing. The hearing took place on 19 February 2020 in respect of your midwifery revalidation. You admitted at the hearing that your entry was made incorrectly but not that you had acted dishonestly.

Decision and reasons on application of no case to answer

On the NMC closing its case, the panel considered an application from Mr Akers that there is no case to answer in respect of Charge 1a. This application was made under Rule 24(7) of the Rules. Mr Akers submitted that the NMC has not presented sufficient

evidence in order for there to be a case to answer. He referred the panel to the case of *R v Galbraith* [1981] 1 WLR 1039 which states:

> *'Where there is no evidence upon which an allegation could be proved, the panel should allow the application on behalf of the Registrant.*
>
> *Where there is some evidence but where that evidence is so unsatisfactory or unsound, or is so weak, tenuous or insufficient that the panel, relying on that evidence, can not properly conclude that the allegation can be proved, it should also allow the application.*
>
> *Where the evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability and where, on one possible view of the facts, there is evidence on which the panel could properly come to the conclusion that the allegation can be proved, then it should not allow the application.'*

Mr Akers submitted that limb two of *Galbraith* is engaged because the NMC's case taken at its highest is such that the panel could not properly find the facts proven. Mr Akers referred the panel to the evidence of Witness 1 and submitted that the factual foundation of Charge 1a is solely or decisively reliant upon the evidence of this witness whose evidence, as a whole, came across as forgetful, inherently inconsistent, and intrinsically unreliable. He said that there were clear and substantial inconsistencies in Witness 1's evidence. For example, in her local written statement, she stated that *'around 2:30 we went to the resident's room, when we came back, we found Resident A on the floor.'* He said that there is a clear inference that Resident A's fall was not witnessed and that he was found there on the floor. Mr Akers said that this contrasts with what Witness 1 says in her written witness statement to the NMC which states *'I could see Resident A clearly as the light in the lounge was on. I ran towards him in order to get him to sit back down and said 'no [Resident A], you will fall'. He then fell before I could reach him.'* Mr Akers stated that Witness 1's evidence drastically changed as time passed, thus he submitted that such inconsistencies simply cannot form the basis of reliable witness testimony.

Furthermore, Mr Akers submitted that Witness 1 stated in cross examination that you did not touch Resident A until he had been moved back to his room. Mr Akers said that this is in total contrast to what you said in your written statement dated 12 December 2021 where it is stated, *‘The registrant kneeled to the ground, towards Resident A, and placed her hand on his hip and said ‘are you okay?’*. Mr Akers submitted that such inconsistencies strike at the heart of Charge 1a, seriously undermining any potential factual basis that would be necessary in order to find the NMC’s case on this charge proven.

Mr Akers submitted that the only two witnesses who can speak to your conduct at the material time, are the ‘discredited witness’ evidence of Witness 1 and your own evidence. He said that this charge is all about what you did immediately after the fall of Resident A.

Mr Akers submitted that it is not asserted by the NMC that you failed to complete the Top to Toe assessment form before Resident A was moved. He said that it is clear that what is alleged is that you failed to undertake a proper clinical assessment and/or complete the Top to Toe assessment before Resident A was moved from the floor. He said that there is no mention of failing to complete the Top to Toe assessment form. He said that in that way, perhaps Charge 1a could be distinguished from Charge 1b where 1b explicitly relates to an alleged failure to update the relevant records, whereas Charge 1a refers to a clinical assessment and/or completing a Top to Toe assessment. He submitted that a Top to Toe assessment form was completed by you and can be found within the exhibit bundle.

Mr Akers further stated that the evidence of Witness 2 adds nothing to the evidential weight of this specific charge given the substance of her evidence is based upon, now clearly, unreliable evidence of Witness 1 and hearsay evidence of Ms 1 which the panel has deemed would not be fair to admit into the evidence. He submitted that the evidence adduced in respect of Charge 1a has been unreliable and inherently weak and in accordance with Rule 24 (7) this charge should proceed no further.

Ms Danti submitted that the argument that there is lack of strength and that there are weaknesses in the evidence of Witness 1 is not something to be considered at this stage. She said that the question at this stage should be, is there evidence that could properly result in a fact being found proved and submitted that there is sufficient evidence. Ms Danti said that whilst the panel is being invited by Mr Akers to find that the foundation of charge 1(a) is solely and decisively reliant upon the evidence of Witness 1, what he suggests is simply not true.

Ms Danti submitted there is sufficient evidence. Witness 1's statement, taken on 6 April 2021, was taken from a WhatsApp message. This evidence was not inconsistent with the clear oral evidence that Witness 1 stated that she witnessed Resident A's fall and that he had not simply been found on the floor. When Witness 1 was cross examined by Mr Akers, she repeatedly disagreed with him when it was put to her that she had not witnessed the fall. Ms Danti said that the allegation has nothing to do with whether or not Witness 1 saw the fall but it is to do with whether or not you undertook a proper clinical assessment and/or completed the Top to Toe assessment before Resident A was moved from the floor. She said that there is ample evidence that the panel can take into account and when that evidence is taken into consideration properly, it can find that this charge is proved.

Ms Danti referred the panel to your evidence in the exhibit bundle and submitted that there is no suggestion that any examination of Resident A was undertaken whilst he was on the floor and before he was moved.

Ms Danti submitted that it is clear from the charge that the completion of the Top to Toe assessment involved completing the form as this is clearly set out on the form itself. It is the Top to Toe assessment form that is to be completed, in paper form, beside the resident before they are moved, to ensure any potential risk of injury is minimised. Ms Danti said that this form had been filled out following an examination carried out on the bed in Resident A's room and it was not, based on your evidence, a clinical assessment by any stretch of the imagination that constituted a clinical assessment required to discharge the duty set out in that form. Ms Danti submitted that this was the Top to Toe

assessment that was required to be completed for the purposes of the allegation and by your own evidence this was not completed until Resident A had been moved.

Ms Danti submitted that it simply is not right that the evidence of Witness 2 in itself adds nothing to the evidential allegation in relation to Charge 1a. Witness 2 is a registered nurse and was able to explain to the panel that a clinical assessment should be undertaken following a fall, before moving the patient. Witness 2 said that this was not done before Resident A was moved.

The panel took account of the submissions from both parties and accepted the advice of the legal assessor.

In reaching its decision, the panel carefully assessed the relevant evidence in relation to this application. It considered whether there is any evidence upon which a properly directed panel could find the alleged facts proved in relation to Charge 1a.

The panel considered the first limb of Galbraith which states '*Where there is no evidence upon which an allegation could be proved, the panel should allow the application on behalf of the Registrant.'* It noted that there is no suggestion that there is no evidence and therefore determined that the first limb of Galbraith does not apply.

The panel then considered the second limb of Galbraith which states *'Where there is some evidence but where that evidence is so unsatisfactory or unsound, or is so weak, tenuous or insufficient that the panel, relying on that evidence, can not properly conclude that the allegation can be proved, it should also allow the application'.* The panel determined that, although there were inconsistencies, there was also evidence provided by Witness 1 which was capable of being credible and consistent. The panel noted that Witness 1 at times said that she could not remember but there were other times during her oral evidence when she was very clear and consistent. In particular, she was clear and consistent when she referred to Resident A's pain and that he was calling out for medication when he was on the floor and that this was unusual, and her evidence that she had seen him fall.

The panel also considered that Witness 1's evidence was not the sole and decisive evidence in relation to charge 1(a) and that there was other documentary evidence in the form of [Witness 2]/04, [Witness 2]/05 and [Witness 2]/06, [Witness 2]/07, [Witness 2]/17.

The panel then went on to consider limb three of *Galbraith, 'Where the evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability and where, on one possible view of the facts, there is evidence on which the panel could properly come to the conclusion that the allegation can be proved, then it should not allow the application.'* The panel also took into account that it has been over two years since the incident in question, therefore, it is reasonable that witnesses may not remember some details of the events. However, it does not mean the evidence is inaccurate in the things they do remember. Witness 1 was very clear about seeing Resident A fall and that he was calling for medication. Further, Witness 1 was equally clear that the local statement dated 6 April 2021 was a brief WhatsApp message sent to her agency. Witness 1 admitted that there was unreliability in terms of the timing of the incident in this statement but the panel took account of the fact that this was an informal message rather than the more formal approach taken in providing the statement to the NMC in December 2021.

The panel also considered that there was other relevant documentary evidence as already referred to that could enable it to reach a decision on whether Charge 1a could be found proved. Having taken all of the above into account, the panel dismissed the application.

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

During your evidence, Mr Akers made a request that parts of your hearing be held in private on the basis that proper exploration of your case involves reference to the health of family members. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Danti submitted that she supported the application.

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 reference may be made to the health of your family member, the panel determined to go into private session as and when such issues arise. It considered that the right to privacy in relation to these matters outweighed the public interest in holding those parts of the hearing in public.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Akers, that you made a full admission to Charge 2.

The panel therefore found Charge 2 proved by way of your admission.

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

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

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

- Witness 1: An agency care worker for Mere Green agency and worked shifts at the Home.

- Witness 2: Clinical Service Manager at the Home.
- Witness 3: Associate Professor and Course Leader for Return to Midwifery Practice at Birmingham City University.

The panel also had considered the written witness statements of the following witnesses:

- Witness 4: Employed by BMI Healthcare as Ward Sister at the Priory Hospital since 2011.
- Witness 5: Registered Nurse. Employed by BMI Healthcare as Director of Clinical Services at the Priory Hospital.
- Witness 6: Managing Director of Careat for the last ten Years.
- Witness 7: Registered Nurse. Employed by Sandwell and West Birmingham Hospitals NHS Trust as a Senior nurse for the Trust Bank since 1999.

The panel also heard evidence from you under affirmation.

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

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

In relation to Charge 1a, the panel considered the points raised by Ms Danti, who argued that Charge 1a, specifically the wording *'failed to complete the top-to-toe assessment,'* referred to the completion of a form.

Mr Akers, countered that this interpretation would effectively change the wording of the charge.

In reviewing the language of Charge 1a, the panel found that the charge referred to a comprehensive clinical assessment, specifically a top-to-toe examination, rather than the completion of any form. The panel was satisfied that the intent of Charge 1a was focused on the proper conduct of a clinical assessment, ensuring it had been completed before lifting the patient from the floor.

The panel considered the duties required of a registered nurse when a patient has fallen to the floor. The panel recognised that you had several years of experience as a registered nurse and that you knew or ought to have known that you had a duty to undertake a proper clinical assessment to ensure that the patient is safe and to minimise any further risk of harm before lifting the patient off the floor, in accordance with the NMC's Code of Professional Standards.

Charge 1

> *"On 24 March 2021, whilst working at Parklands Care Home, following Resident A having sustained a fall failed to:*
>
> *a) undertake a proper clinical assessment and/or complete the Top to Toe Assessment before Resident A was moved from the floor;"*

This charge is found proved.

Panel considered the written and oral evidence and particularly the e-mail statement from you to Ms 2 dated 26 March 2021 in which you stated:

> *'In the above night in mention the 23.03.2021 aprox 03.00am [Resident A] who was asleep in the lounge stood up and fell to the floor out of his chair. I did not witness this fall. He was assisted back into his chair taken to his room where I examined him. No obvious cuts or bruised were seen. I took his observations which were all normal. I asked if he had any pain and he complained about his right leg. I gave him 20mls of paracetamol. Made comfortable left safe.'*

The panel also considered the evidence of Witness 1, who was very clear about instances where she could not recall events, as well as those she did remember. She specifically confirmed that you knelt beside Resident A when he had fallen, placed your hand on his hip, and asked if he was okay. However, she was equally clear that a proper assessment was not conducted until after Resident A was moved to his bed.

Witness 1 further stated that once Resident A was in his room, you went to the office to retrieve the observation equipment and review his care plan. You also acknowledged in your statement for the local investigation that you collected the observation equipment only after Resident A was in his room.

Further, you made two entries in the PCS electronic record system, both of which document the assessment as being performed on the bed. Neither entry indicates that any assessment was conducted while Resident A was still on the floor.

Based on this evidence, the panel concluded that although you performed a brief initial check while Resident A was on the floor, a proper clinical assessment was not carried out until he had been hoisted back into his chair and then hoisted onto his bed.

The panel therefore determined that this charge is found proved.

Charge 1

"b) complete and/or update the following records:

i) An Accident/ Incident Form;

ii) A body map;

iii) A Falls checklist."

This charge is found NOT proved.

In reaching this decision, the panel took into account your evidence and that of Witness 2. Witness 2 had commenced employment at the Home a day prior to the incident. Witness 2 had undertaken a root cause analysis investigation into the incident in question when Resident A had fallen and was subsequently admitted to hospital with a fractured neck of femur.

You said that you were working at the Home as an agency nurse and did not have full access to all the Home's electronic systems. New electronic systems, specifically the Radar Incident Reporting System (Radar) and the PCS electronic record system, were introduced during your time at the Home.

Witness 2's evidence was that, in her view, you would have had access to these systems. and that the Falls Checklist is found on Radar. She said that training for use of Radar is included in the induction for agency nurses. She further said that she could not be sure whether or not you received training on Radar and the PCS electronic record system as she was not employed by the Home at that time.

Your evidence was that you had not received training on the Radar system. Although you were provided with a login for the PCS electronic record system, you could not now remember whether you received any initial training when this system was introduced. However, you did not receive any training updates. You had access to the PCS electronic recording system on a hand held mobile device but this did not provide

access to the Radar system. No induction records or internal training documentation from the Home were before the panel which would indicate training in the use of these electronic systems.

You described how you secured assistance from a permanent nurse on another ward who helped you access and complete forms you were unable to access. You explained that this permanent staff member had an iPad, whereas you had only a mobile phone with limited access to the electronic systems in the Home. You also said that the Radar system was accessible on a computer, kept in an office, for which the permanent staff member had the key, whereas as an agency member of staff, you did not. Witness 2 also said that the Radar system is held on a separate computer and staff had to go to the office to log incidents on the computer. As a result, the panel concluded that it was likely that this nurse helped you complete the necessary forms. However, no statements from this staff member were submitted in either the local investigation or the NMC investigation to verify this assistance.

Although the panel was satisfied that you had a duty to complete these forms, it may not have been possible for you to do so. Therefore, it determined that you did not fail to complete them but rather were prevented from doing so, despite having sought assistance from another registered nurse.

The panel therefore determined that this charge is found not proved.

Charge 2

> 2. *"Made an application to the NMC for revalidation of your registration as a midwife dated 1 March 2018, in which you indicated that you had completed 450 hours of registered midwifery practice in the previous three years, when you had completed less than 450 hours or no hours of registered midwifery practice in the previous three years."*

This charge is found proved.

Although this charge is proved by way of your admission, the panel nonetheless did consider the wider circumstances, as Charge 3 is dependent upon Charge 2. The panel determined that there was no evidence provided in the application form you submitted for the Return to Practice Midwifery Course in September 2018 to indicate that you had practiced as a midwife within the past three years or longer. At interview for the course, Witness 3 determined that it was unclear when you had last worked as a midwife but it appeared that your last midwifery post was in 2010. A revalidation requirement for practitioners who are dual qualified is that they complete 450 hours of practice in each speciality. The NMC Revalidation Guidance for dual registered practitioners is clear that any nursing hours cannot be credited as midwifery hours.

Although, you completed 450 hours of registered nursing practice, you agreed with Witness 3 that you had not completed the required 450 hours of registered midwifery practice in the preceding three years to March 2018, as set out in the NMC revalidation guidance for revalidation. In fact, you had completed no hours of midwifery practice in this period. Despite this, you had entered on your revalidation form that you had worked 450 hours as a registered midwife and revalidated for this role.

Charge 3)

> *3. "Your actions at charge 2 above were dishonest in that you intended to mislead the NMC about your eligibility for revalidation."*

This charge is found proved.

The panel found the transcript of the Investigative Committee hearing in February 2020 particularly useful, as it was closer in time to your revalidation. During that hearing, you stated that you had completed continued professional development (CPD), including several training days and seminars and midwifery evidence based study days, believing they would count towards your practice hours, and also assumed that some of your nursing hours would transfer to midwifery hours. You explained that, based on this understanding, you mistakenly declared completion of 450 hours of midwifery practice.

The panel also reviewed evidence you submitted at this hearing, including your revalidation documents. You said that you had completed five reflective pieces and organised a reflective discussion and confirmation with a colleague. The panel appreciated that, as an agency nurse, this process might have been more challenging, as you had to seek support from a colleague rather than from an employer.

In addition, the panel considered the mitigating factors you presented. [PRIVATE] You mentioned that the revalidation was an entirely new, digital process, which may have added to the challenge. The panel recognised that all nurses at the time were adapting to this system, with substantial guidance available from the NMC and other professional bodies.

You said that as a result of these mitigating factors, at the time of the revalidation application, you had not fully reviewed the revalidation guidance and thus did not clearly understand the requirement for separate midwifery practice hours at the time of the Investigative Committee hearing.

However, the panel determined that you did review the revalidation guidance sufficiently, as evidenced by your completion of five reflective statements, using the NMC templates, your arrangement of a reflective confirmation, and your completion of relevant CPD. The panel therefore did not accept that you would have misunderstood the requirements for dual registration, which clearly indicate that professionals registered as both nurse and midwife must complete 450 hours in each role. You told the panel that you had not intended to revalidate as a midwife at all and had in fact ticked that box in error.

When considering whether your actions might have been unintentional, the panel had regard to your reflective discussion with Witness 4, where you discussed your future plans for midwifery practice, as well as the steps you had taken toward CPD for midwifery. The panel concluded this was further evidence of your intention to revalidate as a midwife prior to returning to midwifery practice and also further demonstrated your knowledge of revalidation requirements at the point of your revalidation application.

Although the panel acknowledged [PRIVATE] you faced, it was aware that revalidation is a priority for registered professionals, with ample time allotted for its completion. At the time of this revalidation, registrants received prior notice of the requirements well in advance.

The panel considered whether your actions could have been slapdash or careless, but had regard to the fact that you had appropriately and correctly downloaded a reflective pieces template from the NMC website and completed them with relevant material. You had also provided evidence that you had compiled relevant material for your CPD over a period of time. This all demonstrated a well informed understanding of the revalidation requirements at the time.

The panel determined that you had applied to complete a Return to Practise midwifery course to meet the required hours and standards to practise as registered midwife. Also, you consistently said that you would not have taken a job as a midwife until you had undertaken a return to midwifery course due to the length of time since you had last practised.

The panel therefore determined that you were well aware that your declaration in regard to the hours worked as a midwife was untrue.

The panel concluded that this charge is found proved.

Interim order

As this case now due to be adjourned, the panel, in accordance with Rule 32(5), has considered whether to impose an interim order.

The panel accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Danti. She stated that there is no interim order currently in place. However, a finding of dishonesty was made by a Conduct and Competence Committee in 2012, and a five-year caution order was imposed.

Mr Aker said that although the caution order from 2012 has some degree of relevance to the panel's decision, the key point, as highlighted by Mr Hay's legal advice, is proportionality.

Mr Akers said that Ms Sutherland's caution dates back 14 years, to 2012. Moreover, the dishonesty found by the panel in this case relates to events that occurred over six and a half years ago. Given the amount of time that has passed and the specific findings made by the panel in this case, it may be the panel's assessment that imposing an interim order would not be a proportionate response to any potential risk to the public.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. In reaching its decision, the panel had regard to the serious nature of the facts found proved, in particular, the finding of dishonesty. The panel also had regard to the previous findings in 2012 of dishonesty, apparently similar in nature and to the fact that the caution order then imposed expired relatively soon before the current act of dishonesty now found proved.

The panel therefore concluded that an interim conditions of practice order would not be appropriate or proportionate, due to the serious and repeated nature of findings of dishonesty. The panel therefore imposed an interim suspension order for a period of 12 months. It was satisfied that such an order is proportionate in the circumstances for the protection of the public and to address the wider public interest and maintain confidence in the profession.