Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 17 September – Friday 4 October 2024

Virtual Hearing

Name of Registrant:	**Louise Miller**
NMC PIN:	86H0063S
Part(s) of the register:	Registered Nurse Sub part 1: RN3: Mental Health Nurse, Level 1 (13 October 1989)
Relevant Location:	Glasgow
Type of case:	Misconduct
Panel members:	Catherine Devonport (Chair, registrant member) Elaine Biscoe (Registrant member) Saiqa Shaffi (Lay member)
Legal Assessor:	Lucia Whittle-Martin
Hearings Coordinator:	Rene Aktar
Nursing and Midwifery Council:	Represented by Elin Morgan, Case Presenter
Miss Miller:	Not present and unrepresented
Facts proved:	1a, 1b, 2a, 2b, 3a, 3b, 4, and 5
Facts not proved:	6 and 7
Fitness to Practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Miller was not in attendance and that the Notice of Hearing letter had been sent to Miss Miller's registered email address on 14 August 2024.

Further, the panel noted that the Notice of Hearing was also sent to Miss Miller's representative on 14 August 2024.

Ms Morgan, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (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, including instructions on how to join and, amongst other things, information about Miss Miller's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In light of all the information available, the panel was satisfied that Miss Miller had 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 Miller

The panel next considered whether it should proceed in the absence of Miss Miller. It had regard to Rule 21 and heard the submissions of Ms Morgan who invited the panel to continue in the absence of Miss Miller. She submitted that Miss Miller had voluntarily absented herself.

Ms Morgan also submitted that there had been no engagement at all by Miss Miller with the NMC in relation to these proceedings and, as a consequence, there was no

reason to believe that an adjournment would secure her attendance on some future occasion.

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).

The panel decided to proceed in the absence of Miss Miller. In reaching this decision, the panel considered the submissions of Ms Morgan, and the advice of the legal assessor. It 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 had been made by Miss Miller;
- Miss Miller had not engaged with the NMC and had not responded to any correspondence sent to her about this hearing;
- There was no reason to suppose that adjourning the hearing would secure her attendance at some future date;
- Six witnesses had been warned to attend to give live evidence at this hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2021;
- Further delay may have an adverse effect on the ability of the witnesses to accurately to recall events; and
- There was a strong public interest in the expeditious disposal of the case.

The panel noted that there would be some disadvantage to Miss Miller in proceeding in her absence. Miss Miller had made no response to the allegations. Due to her absence, she would not be in a position to challenge the evidence relied upon by the NMC in person and would not be able to give evidence on her own behalf. However, in the panel's judgement, this could be mitigated. The panel could make allowances for the fact that the NMC's evidence would not be tested by cross-examination and, of its own volition, could explore any inconsistencies in the evidence. Furthermore, any disadvantage was the consequence of Miss Miller's decision to absent herself from the hearing, and to not provide evidence or make submissions on her own behalf.

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

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

At the outset of the hearing, Ms Morgan made a request that this case be held partly in private on the basis that proper exploration of Miss Miller'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 references to [PRIVATE], the panel determined to hold parts of the hearing referencing [PRIVATE] in private in order to preserve the confidential nature of such matters raised. [PRIVATE].

The panel was satisfied that these considerations justified conducting part of the hearing in private and outweighs any prejudice to the general principle of hearings being held in public.

Details of charge in unamended form

'That you, a registered nurse:

1. On the night shift of 10/11 April 2021 attended Flemington Care Home to work and
   a. [PRIVATE]
   b. failed to sigh one or more Medication Administration Charts (MAR) charts for residents as set out in schedule 1

2. Attended work at Mossvale Care Home on one or more occasion [PRIVATE]

a. 12 October 2021
b. 13 October 2021

3. On 13 October 2021 left a shift without
   a. Authorisation
   b. completing a handover to other staff

4. On or before 12 October 2021, on application and/or at interview with Mossvale Care Home, did not disclose you were subject to an NMC investigation.

5. Your conduct at charge 4 was dishonest in that you knew you were subject to an NMC investigation.

6. On or around 19 July 2021, told the NMC that Mossvale Care Home were aware of the NMC investigation.

7. Your conduct at charge 6 was dishonest in that you told the NMC that you had disclosed the details of the investigation when you knew you had not done so.

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

Schedule 1

i. Patient A
ii. Patient B
iii. Patient C

Decision and reasons on applications to amend the charges

At the outset of the hearing, Ms Morgan applied to add the words "*when you knew or ought to have known*" to the stem of charges 1 and 2. She made a further application to amend, after the evidence had commenced, but before she closed her case, namely, to change the word "*attended*" to the words "*were in attendance*" in charges 1 and 2. [PRIVATE].

It was submitted by Ms Morgan that the proposed amendment would provide clarity and more accurately reflect the evidence. Charges 1 and 2 in their amended form would therefore read as follows:

'That you, a registered nurse:

1. On the night shift of 10/11 April 2021 **you were in attendance at** Flemington Care Home to work when **you knew or ought to have known that you**
   a. [PRIVATE]
   b. failed to ~~sigh~~ **sign** one or more Medication Administration Charts (MAR) charts for residents as set out in schedule 1

2. **Were in attendance** at Mossvale Care Home on one or more occasion when **you knew or ought to have known that you** [PRIVATE]

a. 12 October 2021
b. 13 October 2021

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel heard that Miss Miller had been notified of the proposed amendments mid hearing and had not submitted any objection to them. The additional requirement to prove that she knew or ought to have known that [PRIVATE], was to her benefit, not to her detriment, and it was clearly in the interests of justice for the NMC to prove that Miss Miller knew or ought to have known about her condition at the relevant time.

The proposed amendments regarding her attendance had been made after Ms Morgan opened the case, but in her opening, Ms Morgan had stated that the NMC was not in a position to prove [PRIVATE]. The panel learnt that the original wording, "*attended*", had been chosen to convey the fact that Miss Miller was in attendance for the benefit of patients. In those circumstances the panel concluded that the words "*were in attendance*" clarified the case that had been brought. The panel concluded that no injustice would be caused to either party by the proposed amendments. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Background

It is alleged that on the night shift of 10 and 11 April 2021, Miss Miller was working as an agency nurse at Flemington Care Home ('Flemington') [PRIVATE].

It is further alleged that there were medication administration charts for three different patients which were not signed by Miss Miller on 10/11 April 2021 when they should have been.

Miss Miller was subsequently dismissed by Initial Healthcare Limited (the nursing agency) who employed her. Miss Miller was referred to the NMC on 16 April 2021 by Witness 4, Director at the nursing agency. This referral resulted in an investigation by the NMC.

In July 2021, Miss Miller started a new role at Mossvale Care Home ('Mossvale').

On 12 October 2021 while on day shift, Miss Miller was interviewed by Mossvale, her employer, about the NMC investigation that she had not disclosed to them. On the following day, 13 October 2021, Miss Miller was again interviewed by her employer and was also interviewed by the Police. It is alleged that Miss Miller was in attendance at Mossvale on both days and [PRIVATE].

It is further alleged that when the Police interview concluded at Mossvale, Miss Miller left work without authorisation and without conducting a handover.

It is further alleged that Miss Miller did not disclose the NMC investigation on her job application form to Mossvale or at her job interview and that this was dishonest.

It is further alleged that on 19 July 2021, Miss Miller emailed the NMC making them aware of her new post at Mossvale and added, *"I have made them fully aware of my situation".* It is alleged that this email was dishonest because Miss Miller had not informed Mossvale of the investigation.

Decision and reasons on application to admit hearsay evidence

The panel received oral submissions from Ms Morgan to admit the evidence of Ms 1, Mr 1 and Ms 2 as hearsay evidence under Rule 31.

Ms Morgan submitted that the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) makes clear the need for a panel to undertake a careful balancing exercise before admitting hearsay evidence, especially in a case where the evidence is the sole or decisive evidence on an allegation. The key issue in all cases is one of relevance and fairness. Ms Morgan submitted that if the panel were

to admit the hearsay evidence, then the panel can determine what weight to attach to that evidence.

Ms Morgan submitted that since the service of this material, it was known to Miss Miller that such evidence would be relied upon, and Miss Miller had provided no challenge to this.

Ms Morgan submitted that there is nothing to suggest that any of the three individuals had fabricated their evidence.

Ms Morgan acknowledged these are serious charges and could have an adverse impact on Miss Miller. However, she submitted that neither Ms 1, Mr 1 or Ms 2 provided the sole and decisive evidence for this case.

Ms Morgan submitted that it would be relevant and fair to admit this material.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included reference to Rule 31, which requires the panel to consider the issues of relevance and fairness, and to the principles set out in *Thorneycroft*.

<u>Decision relating to Ms 1</u>

The panel decided that the evidence provided by Ms 1 is relevant. Her evidence consisted of a short witness statement provided for the internal investigation at Flemington, signed and dated 11 April 2021, in which she said:

> *[PRIVATE]*

The panel concluded that Ms 1 did not provide the sole or decisive evidence in this case. Miss Miller had not provided any formal challenge to it. There was no suggestion that this had been fabricated. Ms Morgan had informed the panel that attempts had been made to call Ms 1 as a witness, but that she no longer worked at Flemington and her contact details were unknown. The panel took account of the

seriousness of the charge and the impact that an adverse finding might have on Miss Miller's career. However, the panel concluded that this was outweighed by the other factors set out in *Thorneycroft* and that it would not be unfair to admit the evidence provided by Ms 1 into evidence.

The panel therefore decided to admit the hearsay evidence of Ms 1 into evidence.

Decision relating to Mr 1

Mr 1 was a Regional Director at Mossvale. The material provided by him consisted of a short email dated 16 November 2021 in which he stated:

> *"[PRIVATE] When we went to find her to discuss this with her she had already left the building, however management were not informed of this. [PRIVATE]."*

The panel concluded that Mr 1 did not provide the sole or decisive evidence in this case. Miss Miller had not provided any formal challenge to it. There was no suggestion that this had been fabricated. Ms Morgan had informed the panel that no attempt had been made to call Mr 1 as a witness as it was believed by the NMC that this would be disproportionate. The panel took account of that, together with the seriousness of the charge and the impact that an adverse finding might have on Miss Miller's career. However, the panel concluded that those factors were outweighed by the other factors set out in *Thorneycroft* and that it would not be unfair to admit the evidence provided by Mr 1 into evidence.

The panel therefore decided to admit the hearsay evidence of Mr 1 into evidence.

Decision relating to Ms 2

Ms 2 was a Support Manager for Care Concern Group. She attended Mossvale on 12 and 13 October 2021 to support the Home in the sickness management and recruitment. The relevant material was a description of what occurred when Miss Miller was interviewed on 13 October 2021 by Witness 6 and the immediate aftermath. This included the following:

[PRIVATE].

The panel concluded that Ms 2 did not provide the sole or decisive evidence in this case. Miss Miller had not provided any formal challenge to it. There was no suggestion that this evidence had been fabricated. Ms Morgan had informed the panel that no attempt had been made to call Ms 2 as a witness as it was believed by the NMC that this would be disproportionate. The panel took account of that, together with the seriousness of the charge and the impact that an adverse finding might have on Miss Miller's career. However, the panel concluded that those factors were outweighed by the other factors set out in *Thorneycroft* and that it would not be unfair to admit the evidence provided by Ms 2 into evidence.

The panel therefore decided to admit the hearsay evidence of Ms 2 into evidence.

Decision and reasons on facts

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 Morgan on behalf of the NMC.

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

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 took account of the fact that Miss Miller is of good character.

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

- Witness 1: Home Manager at Flemington Care Home

- Witness 2: Staff Nurse at Flemington Care Home
- Witness 3: Care Assistant at Flemington Care Home
- Witness 4: Company Operations Director at Initial Healthcare
- Witness 5: Clinical Lead at Abbey Healthcare Homes
- Witness 6: Regional Support Manager at Care Concern Group Ltd

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

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

Charge 1a

1. On the night shift of 10/11 April 2021 were in attendance at Flemington Care Home when you knew or ought to have known that you

a. [PRIVATE]

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1, 2, 3 and 4, the notes of the interview meetings held with Miss Miller on 24

April 2021 and on 30 April 2021, Miss Miller's own statement prepared by her for the local investigation, alongside all of the documentary evidence put before it.

Before making any findings, the panel recognised the notes of the interview meetings were handwritten notes of the interviews between Miss Miller and Witness 4 completed by an administrator and are not a verbatim record. The panel had no information to confirm that Miss Miller agreed with the contents of the documents, and she was not at the hearing to dispute the accuracy of them. However, the panel had the benefit of hearing from Witness 4 who was present at the interviews and did not dispute the accuracy of the interview notes.

The notes of the interview dated 24 April 2021 included the following passage:

[PRIVATE].

The notes of the interview dated 30 April 2021 included the following passages:

[PRIVATE].

The panel also took into account Miss Miller's own statement where she stated:

[PRIVATE].

The panel took into account that this evidence was supported by eyewitnesses, Witness 2 and Witness 3 in their oral evidence, and the CCTV footage.

[PRIVATE].

The CCTV footage included a passage, timed 06:28 – 06:43 on 11 April 2021. [PRIVATE].

In the course of her internal interview, Miss Miller suggested that [PRIVATE].

The panel determined that there was sufficient evidence to prove on the balance of probabilities that Miss Miller [PRIVATE] on the night shift on 10/11 April 2021 when in attendance at Flemington and that she knew or ought to have known that [PRIVATE] at the time.

The panel therefore found this charge proved.

Charge 1b

a. failed to sign one or more Medication Administration Charts (MAR) charts for residents as set out in schedule 1

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1, and the notes from the interview meeting dated 24 April.

The panel noted from the MAR charts that Patients A, B and C were residents in the Cedar unit. The panel also noted from Miss Miller's interview with Witness 4 in the local investigation that she was responsible for administering medication in the Cedar unit on 10/11 April 2021. The panel also heard evidence from Witness 1 where it was stated that Miss Miller was responsible for signing the MAR charts. The panel was therefore satisfied that Miss Miller ought to have signed the MAR once the medication had been given to the patients.

The panel went on to consider the MAR charts and noted there were gaps within Patient A and B's charts where medications were due to be given but were not signed for. The panel also noted that this issue was put to Miss Miller in her local investigation interview. The panel in particular noted the following exchanges between Witness 4 and Miss Miller:

"Why did you miss out signature on Pnt B
You missed out 3 signatures
Overlooked them, only thing I can think of"

In relation to Patient C, the panel concluded that there were no missing signatures in relation to 10/11 April 2021.

The panel decided that there was sufficient evidence to prove that Miss Miller was responsible for administering the drugs to patients on the Cedar ward and was responsible for signing the MAR charts yet failed to sign one or more MAR charts for Residents A and B.

On that basis, the panel found this charge proved.

Charge 2a

2. Were in attendance at Mossvale Care Home on one or more occasion when you knew or ought to have known that [PRIVATE]
    a. 12 October 2021

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 6, alongside all of the documentary evidence put before it.

The panel noted from Witness 6's evidence that Miss Miller was on day shift between 7:45am and 8pm at Mossvale on 12 October 2021. The panel was therefore satisfied that Miss Miller was on duty at the relevant time.

The panel further noted that whilst on duty, Miss Miller was interviewed by Witness 6 and Ms 2 in respect of the NMC investigation. In her statement to the NMC dated 22 March 2023, (first statement) Witness 6 stated as follows:

[PRIVATE].

[PRIVATE].

[PRIVATE].

On that basis the panel determined that there was sufficient evidence to prove on the balance of probabilities that [PRIVATE] on the day shift on 12 October 2021 when in attendance at Mossvale and knew or ought to have known that [PRIVATE].

The panel therefore found this charge proved.

Charge 2b

b. 13 October 2021

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 6, and written evidence of Ms 2 and Ms 3, alongside all of the documentary evidence put before it.

The panel noted from Witness 6's evidence that Miss Miller was on day shift between 07:45 and 20:00 at Mossvale on 13 October 2021. The panel was therefore satisfied that Miss Miller was on duty at the relevant time.

The panel noted that Miss Miller was interviewed by Witness 6 and Ms 2 on 13 October 2021 whilst Miss Miller was on shift. The panel took into account Witness 6's first statement where she described Miss Miller's behaviour during that interview:

[PRIVATE].

Miss Miller was subsequently interviewed by Police Scotland on the same day. The interviewing officer described Miss Miller's behaviour on the day:

[PRIVATE].

The panel also took into account the hearsay evidence of Ms 2 in which she stated:

[PRIVATE].

[PRIVATE].

On that basis the panel determined that there was sufficient evidence to prove on the balance of probabilities that [PRIVATE] on the day shift on 13 October 2021 when in attendance at Mossvale and knew or ought to have known that [PRIVATE].

The panel therefore found this charge proved.

Charge 3a

3. On 13 October 2021 left a shift without
    a. Authorisation

This charge is found proved.

In reaching this decision, the panel took into account the hearsay evidence of Mr 1 and Ms 2, the written and oral evidence of Witness 5 and 6, alongside all of the documentary evidence put before it.

The panel had already established at charge 2b that Miss Miller was on duty on 13 October 2021.

The panel took into account the email correspondence between Mr 1 and the NMC Case Officer, dated 16 November 2021 where he stated:

> *"[PRIVATE]. When we went to find her to discuss this with her she had already left the building, however management were not informed of this."*

The panel also took into account Witness 6's first statement where she stated:

> *"[PRIVATE], but [Witness 5] told us that Louise had left the building already of her own accord."*

In her second statement to the NMC dated 31 May 2023, Witness 6 stated:

"Louise didn't let anyone know that she was leaving the shift early, following her interview with the police… [Ms 2] was managing the service on this date, and we only became aware of her absence when we tried to locate her [PRIVATE]."

The panel determined that it was more likely than not that Miss Miller had left sometime in the afternoon as the police interview was carried out during her shift in the morning. The panel considered the evidence which suggested that when staff tried to locate Miss Miller, it was discovered that she had already left the building. This evidence was later confirmed by Witness 6 in her oral evidence. When asked who would have authorised Miss Miller to leave, Witness 6 responded, *"it would have been [Ms 2] as interim manager, [Mr 1] or me".* When asked *"did you authorise Miss Miller to go home"*, Witness 6 replied: *"No we were all shocked. None of us authorised her."*

In her hearsay evidence, Ms 2 stated that Miss Miller contacted Mossvale on the telephone later that day and stated that the Police had told her to go home. However, in evidence from Witness 6 the panel heard that Police Scotland stated this was not the conversation they had with Miss Miller.

In addition, further evidence from Witness 6 stated that later that day, Miss Miller called the Home and stated that she was sorry she left the shift as she had never done this in the past.

The panel decided that there was sufficient evidence to prove that Miss Miller, on 13 October 2021, left a shift without authorisation.

The panel therefore found this charge proved.

Charge 3b

b. completing a handover to other staff

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Mr 1 and Ms 2 and Witness 6, alongside all of the documentary evidence put before it. The panel established that Miss Miller was scheduled to be on shift that day between 07:45 and 20:00.

The panel took into account Mr 1's email dated 16 November 2021 where he stated:

> *"When we went to find her to discuss this with her she had already left the building, however management were not informed of this."*

The panel also took into account Witness 6's written statement dated 26 March 2023:

> *"We had gone to locate LM to inform her of our decision and was informed she had left the building, we were shocked as no handover had taken place and no medication had been administered, another nurse was within the service and completed LM's shift."*

In her second statement to the NMC, Witness 6 stated:

> *"Louise did not let anyone know that she was leaving the shift early, following her interview with the Police, and didn't hand over to any other member of staff before she left*
> *…*
> *If any nurse left any shift early for any reason, full handover must be given, the same as it is given at the beginning and end of a shift."*

The panel considered that during the call Miss Miller made to Mossvale that afternoon, she had the opportunity to inform Witness 6 that she had handed over to a colleague, if indeed she had done so. The panel determined that a registered nurse would know that they had a responsibility to handover when leaving a shift.

The panel decided that there was sufficient evidence to prove that Miss Miller did not complete a handover to other staff.

The panel therefore found this charge proved.

Charge 4

4. On or before 12 October 2021, on application and/or at interview with Mossvale Care Home, did not disclose you were subject to an NMC investigation.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Witness 5, the job application form completed in July 2021 and the job interview notes conducted on 15 July 2021.

The panel first considered the application form, which was completed in handwriting and signed by Miss Miller in July 2021. In this form, Miss Miller was asked reasons for leaving her previous employer. Regarding Initial Healthcare Agency, Miss Miller stated that her employment was terminated. Miss Miller went on to give the following details: *"[PRIVATE] but this situation is something I would prefer to discuss face to face if fortunate enough to come for interview."* At no point in her application form did Miss Miller disclose that she was subject to an NMC investigation.

Regarding the job interview on 15 July 2021, the panel noted that Miss Miller was interviewed by Witness 5 and another Care Home Manager. In her oral evidence, Witness 5 stated that Miss Miller did not disclose the NMC investigation although to her recollection, Miss Miller was not asked whether there had been any such investigation. She added that if Miss Miller had said something, she would have written it down due to its importance. Witness 5 stated that at the end of job interview, Miss Miller did mention an incident that occurred but that *"everything was fine and sorted."* Witness 5 stated that she then told Miss Miller they would be checking her NMC PIN.

The panel decided that there was sufficient information to prove that on or before 12 October 2021, on application and interview with Mossvale Care Home, Miss Miller did not disclose that she was subject to an NMC investigation.

The panel therefore found this charge proved.

Charge 5

5. Your conduct at charge 4 was dishonest in that you knew you were subject to an NMC investigation

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 6, Miss Miller's email, alongside all of the documentary evidence put before it.

The panel recognised that neither the application form nor the job interview included a specific question requiring the applicant to disclose the existence of any ongoing investigation into their Fitness to Practise. However, the panel concluded that as a registered nurse, Miss Miller owed a duty of candour to any prospective employer and she should have, but did not, disclose the existence of the NMC investigation on the application form or at interview.

In oral evidence Witness 6 stated that she would expect an applicant to disclose an NMC referral on the job application form. When it was raised with her that there is no specific question on the form, she said that in her experience, nurses attach a supplementary page with details of referrals and conditions of practice.

The panel concluded, on the balance of probabilities, that Miss Miller knew both at the time of completing the application form and at the time of her interview with Mossvale that she was subject to an NMC investigation and had a duty to disclose it but chose not to do so.

The panel concluded that a reasonable member of the public would regard this as dishonest.

Accordingly, the panel found this charge proved.

Charge 6

6. On or around 19 July 2021, told the NMC that Mossvale Care Home were aware of the NMC investigation.

This charge is found NOT proved.

This charge relied on an email from Miss Miller to the NMC Screening Case Officer dated 19 July 2021 which stated:

> *"I am emailing to let you know I have secured a staff nurse post at Mossvale Care Home in Glasgow. I have made them fully aware of my situation. I am to start this week, tomorrow infact, on three days induction."*

The panel noted that the email demonstrated there was an ongoing NMC investigation. However, the panel's position was that the contents of the email did not specifically state that Miss Miller had made Mossvale aware of the NMC investigation. Therefore, there was insufficient evidence that Miss Miller had told the NMC that Mossvale was aware of the NMC investigation.

The panel therefore found this charge NOT proved.

Charge 7

7. Your conduct at charge 6 was dishonest in that you told the NMC that you had disclosed the details of the investigation when you knew you had not done so.

This charge is found NOT proved.

In light of its findings on charge 6, the panel found charge 7 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 Miller'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 Miller'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.'*

Ms Morgan 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 (2018' (the Code) in making its decision.

Ms Morgan submitted that Miss Miller's actions fall short of the standards expected of a registered nurse. She submitted that she is in breach in several areas of the Code. This includes 8.2, 8.6, 10.1, 11.2, 13.4, 16.3, 20.9.

Submissions on impairment

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

Ms Morgan submitted that these are serious charges.

Ms Morgan submitted that there is no evidence of any improvements to Miss Miller's practise and/or attitude. She submitted that Miss Miller has acted dishonestly and is liable to act dishonestly in the future.

Ms Morgan submitted that Miss Miller's fitness to practise is impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *CHRE v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927(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 Miller's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Miller's actions amounted to a breach of the Code. Specifically:

> ***'8 Work co-operatively***
> *To achieve this, you must:*
> *8.2 maintain effective communication with colleagues*
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *To achieve this, you must:*
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event*
>
> ***11 Be accountable for your decisions to delegate tasks and duties to other people***
> *To achieve this, you must:*
> *11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care*
>
> ***13 Recognise and work within the limits of your competence***
> *To achieve this, you must:*
> *13.4 take account of your own personal safety as well as the safety of people in your care*
>
> ***16 Act without delay if you believe that there is a risk to patient safety or public protection***
> *To achieve this, you must:*
> *16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can*

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.9 maintain the level of health you need to carry out your professional role'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that these are serious concerns.

In respect of charges 1a and 2, the panel decided that Miss Miller's behaviour fell seriously below the standards expected of a registered nurse. She had a duty of care to the residents [PRIVATE], she had put residents at risk of harm. The panel noted that Miss Miller had the responsibility to administer medication to patients which included controlled drugs. It noted that Miss Miller had put medications for one of the patients out twice and although there was no harm caused by reason of this, that was only due to the vigilance of a junior member of the team on that shift.

In respect of charge 1b, Miss Miller had failed to sign one or more MAR charts for Residents A and B which was a serious falling short of the standards expected of her in that it placed patients at risk of medication administration errors. It also represented a serious safety issue as it left other nursing staff unsure of whether these medications had ever been given.

In respect of charge 3, Miss Miller was the only registered nurse for the unit and yet she left without authorisation or completing a handover to other staff. Important clinical matters may have been missed without being relayed to other members of staff and this would have potentially put patients at risk.

In respect of charges 4 and 5, the panel noted that Miss Miller had a duty of candour to disclose to her employer that she was subject to an NMC investigation and concluded that this failure to disclose amounted to a serious falling short.
It was the judgement of the panel that fellow members of the profession would find Miss Miller's conduct deplorable.

Accordingly, the panel found that each of its findings of fact found proven amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Miller'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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

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

The panel found that residents were put at risk of harm as a result of Miss Miller’s misconduct in charges 1, 2 and 3. Miss Miller’s misconduct had breached fundamental tenets of the nursing profession and had brought its reputation into disrepute. Miss Miller’s behaviour in charge 4 had been dishonest. Accordingly, the panel found all four limbs were engaged in the *Grant* test.

In terms of limb *a* being engaged, the panel found that [PRIVATE], failure to complete MAR chart and leaving without authorisation and giving a handover left patients at unwarranted risk of harm.

In terms of limbs *b* and *c* being engaged, being able to practise safely is a fundamental tenet. [PRIVATE]. [PRIVATE].

In terms of limb *d*, the panel had found that Miss Miller had acted dishonestly in the past and in the absence of any insight or other remediation it was the judgement of the panel that there was a risk that she would do so again.

The panel considered that Miss Miller's actions are remediable. However, the panel took into account that there was no evidence of any such remediation. Miss Miller had provided no evidence of her awareness of the seriousness of events, or lessons learnt from previous mistakes. To the contrary, in relation to charge 2, she had repeated the behaviour found proved in charge 1a.

In all the circumstances, the panel concluded that there is a real risk that Miss Miller will repeat her behaviour. By reasons of its findings in charges 1, 2 and 3, the panel considered that Miss Miller would pose a risk of harm to patients if permitted to practise unrestricted. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 light of the panel's findings in relation to charges 1, 2 and 3, together with its finding of dishonesty in relation to charges 4 and 5, the panel concluded that public confidence in the profession, and the maintenance of standards, would be seriously damaged if a finding of impairment were not made in this case and therefore also finds Miss Miller's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, it was the judgement of the panel that Miss Miller'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 Miss Miller off the register. The effect of this order is that the NMC register will show that Miss Miller 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.

Submissions on sanction

Ms Morgan submitted that the aggravating features in this case include a direct risk to multiple vulnerable residents in the care of Miss Miller, repetition of the misconduct and dishonesty. Ms Morgan submitted that the mitigating feature in this case is Miss Miller's good character.

Ms Morgan submitted that the only appropriate sanction in this case would be a striking-off order.

Ms Morgan submitted that taking no further action or the imposition of a caution order would not protect the public and would be inappropriate given the serious nature of the concerns.

Ms Morgan submitted that a conditions of practice order may be appropriate in a case where there are clinical concerns and where there is no evidence of any deep-seated attitudinal problems. Ms Morgan submitted that this was not the case here. She also submitted that a conditions of practice order would be unlikely to address the dishonesty concerns in this case. Ms Morgan also submitted that as Miss Miller had not engaged with these proceedings, there was no evidence before the panel that Miss Miller would comply with any conditions of practice imposed by the panel. For these reasons, Ms Morgan submitted that a conditions of practice order is not appropriate.

Ms Morgan submitted that following her dismissal from Flemington, Miss Miller did not learn from the events. Although dismissed from Flemington, this had little or no impact on her conduct and Miss Miller went on to repeat the behaviour six months later at Mossvale. She also said that this conduct indicates a risk of further repetition and therefore a suspension order would not be sufficient to protect the public.

Ms Morgan submitted that Miss Miller's behaviour was fundamentally incompatible with remaining on the register given the proven misconduct and breaches of the Code and [PRIVATE] which placed residents and staff at risk of harm, Miss Miller also left a shift without authorisation and handover, exposing residents and colleagues to potential harm. Miss Miller's conduct demonstrated dishonesty in which she misled her employers regarding the NMC investigation, and this raised serious questions about her professional standards. She also submitted that due to Miss Miller's lack of engagement, the NMC would find it difficult to work with her in the future. Ms Morgan therefore submitted that a striking-off order was appropriate.

Decision and reasons on sanction

Having found Miss Miller'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 heard and accepted the advice of the legal assessor.

The panel took into account the following aggravating features:

- Risk of harm to multiple vulnerable residents in the care of Miss Miller
- Repetition of misconduct
- No evidence of insight into failings
- Miss Miller was the senior nurse in charge

The panel also took into account the following mitigating features:

- No previous regulatory concerns
- [PRIVATE]

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection concerns identified. 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 Miss Miller'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 Miss Miller'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 Miss Miller's registration would be a sufficient and appropriate response. The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Miller's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel took into account that in this particular case, there had been repetition of the misconduct [PRIVATE]. There had been a lack of insight and remorse over a period of three and a half years since the original referral. This was compounded by the dishonesty that had been found proved. Miss Miller had not engaged with the NMC other than one brief email. Miss Miller had ample opportunity to engage with the investigatory process and provide evidence that she had learnt from her mistakes and that she understands the seriousness of the issues.

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?*

The panel determined that Miss Miller's actions amounted to a significant departure from the standards expected of a registered nurse and were fundamentally incompatible with her remaining on the register. Her actions and attitude overall placed residents and colleagues at a significant risk of harm and the panel had no evidence of learning or remediation. In those circumstances the panel concluded that the risk that she would repeat her misconduct [PRIVATE] was high as she had repeated her behaviour at Flemington when attending a second Care Home, Mossvale, [PRIVATE], having been dismissed for the very same thing six months earlier.

The panel was of the view that Miss Miller's actions [PRIVATE], accompanied by a complete lack of remorse and remediation, were so serious that to allow her to continue to practise as a nurse would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body. The panel concluded that removal from the register was the only appropriate sanction in those circumstances. Further, her misconduct [PRIVATE] at two consecutive Care Homes was compounded by her dishonesty on her application form and in her interview for employment at Mossvale.

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 significant risk of repetition and the need to protect the public and the effect of Miss Miller'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 protect the public, to mark the importance of maintaining public confidence in the profession and the regulator, 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 Miss Miller 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 is in Miss Miller's own interests until the striking-off order takes effect.

The panel accepted the advice of the legal assessor.

Submissions on interim order

Ms Morgan submitted that, given the panel's reasons for imposing the striking-off order, an interim suspension order of 18 months is necessary to protect the public and also in the public interest. She submitted that public confidence in the profession would be seriously damaged if Miss Miller were allowed to practise without restriction during the appeal period. Ms Morgan submitted than an interim order of 18 months was required to allow sufficient time for any appeal lodged to conclude.

Decision and reasons on interim order

The panel is satisfied that an interim order is necessary for the protection of the public and in the public interest. It had regard to the seriousness of the case, risk of repetition, and the reasons set out in its decision on sanction.

The panel concluded that an interim conditions of practice order would not be appropriate in this case, for the reasons set out in its decision on sanction. The panel therefore imposed an interim suspension order for a period of 18 months to allow

time for any possible appeal, in order to protect the public and to maintain public confidence in the profession and in the NMC as its regulator.

The panel is satisfied that this order for this period is necessary and proportionate and fairly balances the need to protect the public and the public interest with any effect on Miss Miller.

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

That concludes this determination.