Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday, 1 October 2024 - Thursday, 3 October 2024

Virtual Meeting

Name of Registrant:	**Denise Michelle Naylor**
NMC PIN:	91C0137E
Part(s) of the register:	Nursing Part of the Register- Sub Part 1 RNMH: Mental Health Nurse, Level 1 26 March 1994
Relevant Location:	Tameside
Type of case:	Misconduct
Panel members:	Nicola Dale (Chair, Lay member) Pamela Campbell (Registrant member) Margaret Jolley (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Samantha Aguilar
Facts proved:	Charges 1a, 1b, 1c, 1d, 2a, 2b, 2c, 2d, 2e, 3a, 3b, 3c, 3d, 3e, 3f, 4a and 4b.
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Miss Naylor's registered email address by secure email on 22 August 2024.

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

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date (which stated that the meeting would take place on or after 23 September 2024) and the fact that this meeting was to be heard virtually.

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

Details of charges

That you, a registered nurse:

1. Whilst working as a care coordinator for Patient A between 1 December 2021 and 20 May 2022, failed to provide care in line with their care plan and/or clinical needs in that you
    a. failing to undertake fortnightly visits.
    b. failing to escalate and/or act on missed appointments.
    c. failing to take any or any adequate action on the removal of the care package.
    d. Failing to provide a full handover of their care to colleagues.

2. Between 1 December 2021 and 20 May 2022 did not maintain adequate records in respect of Patient A, in that you:
    a. did not make contemporaneous records.
    b. did not record any changes to Patient A's care.
    c. did not record the changes to the care package.

d. did not document the risks associated with the changes to the care package.
e. did not record the any clinical notes on the Trust's PARIS system.

3. Whilst working as a senior nurse practitioner in the Warrington Recovery Team failed to keep accurate records, in that you did not record any contemporaneous notes of:
    a. Patient B's appointment on 4 January 2023
    b. Patient C's appointments on 16, 17 and 18 November 2022
    c. Patient D's appointment on 27 January 2023
    d. Patient E's action plan on 6 February 2023
    e. Patient F's appointment of 24 January 2023
    f. Patient H's appointment 2 February 2023

4. Between 7 November 2022 and February 2023 failed to undertake and/or complete risk assessment forms as required on
    a. Patient B on 4 January 2023
    b. Patient G on 15 February 2023

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

Background

Miss Naylor joined the register on 26 March 1994.

On 17 February 2023, the NMC received a referral from Pennine Care NHS Foundation Trust ("the Trust") regarding the care provided to Patient A. Miss Naylor had been employed at the Trust as a Care Coordinator within the Bury Mental Health Team from 7 May 2021 to 20 May 2022.

Between 1 December 2021 and 20 May 2022, Miss Naylor was the Care Coordinator for Patient A. Patient A had a diagnosis of paranoid schizophrenia. Miss Naylor was required to visit Patient A on a fortnightly basis at their home to undertake care coordinator reviews.

Patient A received domiciliary support from KV Care. This comprised of three visits daily and shopping when necessary. In January 2022, Miss Naylor was informed that KV Care would be discontinuing the care package for Patient A from March 2022 as they no longer had the capacity to deliver this. The care was actually withdrawn at the end of February 2022. KV Care allegedly attempted to speak with Miss Naylor regarding the withdrawal of their services on numerous occasions via phone and email and finally managed to make contact with her the day before care was withdrawn. KV Care advised Miss Naylor they recommended Patient A would require one welfare visit a day.

When KV Care eventually made contact with Miss Naylor, it was alleged that Miss Naylor failed to document the care withdrawal in Patient A's clinical notes or arrange any meeting to discuss future care provisions for Patient A. This information was allegedly further omitted in Miss Naylor's handover when she left the Trust on 20 May 2022, consequently no visits occurred between 20 May 2023 and 23 June 2023.

A Health Care Support Worker attended Patient A's home on 23 June 2023 to conduct a blood test and on receiving no response, contacted the police as they were concerned for Patient A's welfare. Patient A was found to be bedridden and covered in their own faeces, requiring hospitalisation for a lengthy period due to the decline in their physical health.

Upon investigation by the Trust, they found no evidence within Patient A's clinical notes that the fortnightly care coordinator reviews took place whilst Patient A was under Miss Naylor's care. Moreover, there was allegedly a failure to ensure Patient A attended their outpatient appointments, and Miss Naylor allegedly failed to follow up on the reasons for those non-attendances.

Further concerns were raised by Mersey Care NHS Foundation Trust, where Miss Naylor had been employed as a Senior Nurse Practitioner with the Warrington Recovery Team from 7 November 2022 until 3 March 2023. An audit of Miss Naylor's case files raised concerns regarding her record keeping in 7 out of 15 patient files. The concerns related to a failure to make contemporaneous notes and undertake risk assessments.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and the signed context form dated 6 May 2023 from Miss Naylor.

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

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

- Witness 1: Head of Quality for Mental Health Services at Bury for Pennine Care NHS Foundation Trust;

- Witness 2: Advanced Clinical Practitioner (Non-Medical Prescribing) at the Warrington Recovery team for Mersey Care NHS Foundation Trust.

The panel also had regard to written responses from Miss Naylor contained within the signed context form dated 6 May 2023.

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

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

Charge 1

1. Whilst working as a care coordinator for Patient A between 1 December 2021 and 20 May 2022, failed to provide care in line with their care plan and/or clinical needs in that you
    a. failing to undertake fortnightly visits.
    b. failing to escalate and/or act on missed appointments.
    c. failing to take any or any adequate action on the removal of the care package.
    d. Failing to provide a full handover of their care to colleagues.

Charge 1 is found proved in its entirety.

The panel first considered the stem of the charge and whether Miss Naylor had a duty to Patient A when working as a care coordinator. It took into account Witness 1's statement to the NMC dated 25 September 2023:

> *'It is my understanding that Ms Naylor was a Care Coordinator Practitioner, working for CMHT as an agency worker.*
>
> *I believe her main responsibilities in this role were going out into the community, reviewing patients and meeting with patients face to face to assess their mental health. The Care Coordinator would assess the patient and identify any signs of deterioration in their health. She would be expected to consider the whole individual, what was going on for them in relation to their daily life, the people they were seeing and their lifestyle. She would assess the patient against their previous visit, to see if there are any concerns that needed to be escalated to the patient's consultant psychiatrist or acted upon.'*

The panel also had regard to the job description for the Community Mental Health Practitioner at the Trust which outlined the role of a Care Coordinator:

> *'The core purpose of this role is to manage the care of a defined caseload of patients who have a diagnosis of a Serious Mental Illness and/or Complex Mental Health Difficulties and require the support of an identified function*

within the community mental health service with a focus on recovery and social inclusion'

The panel had sight of the meeting minutes from the interview with Miss Naylor on 30 November 2022 which showed that Miss Naylor acknowledged that she was the Care Coordinator for Patient A. She mentioned seeing Patient A on five occasions and described that she last saw him in March 2022 *'checked his cupboards to see if food in* […] *food in cupboard after care was pulled out'.* The panel determined that there was no dispute that Miss Naylor was the nurse looking after Patient A in her capacity as a Care Coordinator.

In considering Charge 1a, the panel took into account the Investigation Report as exhibited by Witness 1 which stated the following:

'[The former Care Coordinator] *RMN handed Patient A's care over to DN* [Miss Naylor] *RMN in December 2021. There was a verbal handover, and they had a three-way handover meeting. Patient A was introduced to DN.* [The former Care Coordinator] *was seeing* [Patient A] *approximately every 2 weeks, sometimes more if needed support with shopping.*

There is no evidence found within Patient A's clinical notes as to rationale for a change in frequency of visits on change of care coordinator'

This was further supported by Witness 1's statement to the NMC dated 25 September 2023 in which she stated that Miss Naylor would have been aware that Patient A required fortnightly visits as part of the handover Miss Naylor received from the previous Care Coordinator.

The panel noted that the Investigation Report also identified the *'Level of contact with care coordinator'* to be one of the issues reviewed:

'Patient A was allocated a new care coordinator in December 2021 and at that time was receiving fortnightly care coordinator reviews, however following the handover period there are no evidence of these visits being

undertaken to this frequency. Only one appointment can be assumed from Patient A's notes in early December from the conversation between DN and the […] *doctor.*

[…]

Within his records there are no notes from visits taken by his allocated care coordinator.

Care coordinator identified dates that visits were undertaken jointly with KV Care, however KV Care were not able to confirm these as had no records and believe they would not have happened as would have been documented within their records for Patient A'

The panel found no evidence to support that Miss Naylor visited Patient A on a fortnightly basis, despite this being part of her role.

Accordingly, the panel found charge 1a proved.

In considering charge 1b, the panel had regard to Witness 1's statement to the NMC dated 25 September 2023 in which she outlined in detail the steps in which a nurse should take in the event that there is no response from a patient and that there was no evidence to suggest that Miss Naylor had carried out those steps.

Furthermore, the Investigation Report provide a list of the appointments that Patient A had and some of which he did not attend. The panel noted that there was no evidence to suggest that Miss Naylor escalated these missed appointments nor made any notes on the electronic patient record system ("PARIS") documenting the outcome, or any action taken as a result of missing these appointments.

The panel also had regard to the context form signed 6 May 2023 by Miss Naylor. She stated:

‘I believe that I was also remiss of just marking his appointments of just DNA rather than escalating this. On reviewing his notes, I noted that he was being seen regularly, O beloved [sic] *two weekly at that time by Clozaril nurses and his activities indicated that he was engaging with them. Historically this non attendance with Care Co-ordinator was well documented. The plan had been to go amd* [sic] *see the patient with that team in order to monitor his mental health* […]*’*

In light of the above evidence, the panel found charge 1b proved.

In considering charge 1c, the panel had regard to Witness 1’s statement dated 25 September 2023:

‘There was a care package put in place by the previous Care Coordinator […] *comprehensive care plan that ensured Patient A’s house was getting cleaned and he was getting a bit of social contact with up to three visits daily from KV care* […]

However, due to service reduction, KV Care had tried to contact Ms Naylor to inform her that they were withdrawing this service […] *KV Care had made numerous attempts to contact Ms Naylor via email and over the telephone to suggest alternative social plans.* […] *there were five attempts from KV Care to contact Ms Naylor. However, they were only able to speak to Ms Naylor the day before Patient A's care package was due to be withdrawn* […]’

The panel understood that the care package from KV Care was not being withdrawn on the basis that it was not needed but rather because KV Care did not have the capacity to continue providing the care. The meeting minutes from the meeting with KV Care on 2 December 2022 recorded that they attempted to contact with Miss Naylor for four weeks and had *‘offered the suggestion to DN that Patient A would benefit from ongoing support of one daily welfare visit plus support weekly with his shopping’.* The panel saw no evidence that Miss Naylor acted on this or put measures in place to assist with the support that was advised.

The panel therefore found charge 1c proved.

In considering charge 1d, the panel took into account Witness 1's statement to the NMC dated 25 September 2023 in that Miss Naylor *'did not identify or flag any concerns in relation to Patient A'* when she left the Trust. The panel found that it was clear from the timeline contained within the Investigation Report that Patient A was visited for bloods to be taken at the end of May 2022 and the next visit was not until 23 June 2022, at which stage concerns were raised for Patient A's welfare and the police were called.

The panel noted that prior to Miss Naylor leaving the Trust, her cases were discussed with the team manager. Witness 1 stated in her letter addressed to the Associate Director of Operations dated 25 January 2023:

> *'Prior to DN leaving, her cases were discussed with the team manager and there were no identified concerns raised nor was the team manager alerted to the fact that in February 2022, KV care had to withdraw Patient A's care package and no replacement support had been put in place'*

The panel therefore determined that a full handover was not provided given that there was no information within Patient A's notes.

The panel also had regard to Miss Naylor's response in the context form signed 6 May 2023 in which she disputed the allegation contained in charge 1d:

> *'At the end of February I was informed that my placement was coming to an end and following discussions, we agreed that my initial date for leaving would be 12th May 2022, but that I could contune* [sic] *for a furtjer* [sic] *two weeks to complete a handover document. I worked from home from 15.05.2022 to 27 05 2022 and completed a full handover on the cases on my caseload of 25 cases.'*

However, the panel has seen sufficient evidence from Witness 1 and the documents before it to conclude that the handover provided by Miss Naylor was wholly

insufficient and this resulted in Patient A not receiving regular visits from a Care Coordinator. In addition, colleagues were not aware that Patient A was no longer receiving daily social care visits resulting in Patient A receiving no care between May and June 2022.

Accordingly, the panel found charge 1d proved.

Charge 2

2. Between 1 December 2021 and 20 May 2022 did not maintain adequate records in respect of Patient A, in that you:
    a. did not make contemporaneous records.
    b. did not record any changes to Patient A's care.
    c. did not record the changes to the care package.
    d. did not document the risks associated with the changes to the care package.
    e. did not record the any clinical notes on the Trust's PARIS system.

Charge 2 is found proved in its entirety.

The panel considered charge 2 as a whole. It noted that part of the fundamental duties of a nurse includes a duty to *'keep clear and accurate records'*. As such, Miss Naylor had a duty to ensure that her records were adequate in respect of Patient A. Miss Naylor demonstrated an understanding of this role in her Curriculum Vitae (CV) when she described her role as including:

> *'Maintaining accurate, contemporaneous clinical records on all service user contact, in accordance with current Trust documentation standards* […]'

The panel had sight of the case records, including the PARIS record for Patient A and the Client Case Notes Report between 17 November 2021 and 30 June 2022. It saw no evidence of any notes made by Miss Naylor regarding Patient A's care between 15 December 2021 and June 2022.

The panel noted that Miss Naylor stated during the local Trust interview on 30 November 2022 that she had some records on a word document in her laptop. The panel did not find this adequate, because Miss Naylor had a two-week window prior to leaving to provide a complete handover of her caseload to the team manager. Miss Naylor could have used this opportunity to ensure that her record notes were visible across all record note systems such as PARIS.

Accordingly, the panel found charge 2 proved in its entirety.

Charge 3

3. Whilst working as a senior nurse practitioner in the Warrington Recovery Team failed to keep accurate records, in that you did not record any contemporaneous notes of:
    a. Patient B's appointment on 4 January 2023
    b. Patient C's appointments on 16, 17 and 18 November 2022
    c. Patient D's appointment on 27 January 2023
    d. Patient E's action plan on 6 February 2023
    e. Patient F's appointment of 24 January 2023
    f. Patient H's appointment 2 February 2023

Charge 3 is found proved in its entirety.

The panel noted that as a Registered Nurse, Miss Naylor had a duty to ensure that she was keeping accurate records in line with the Code of Conduct and the Trust policy.

The panel first considered charge 3a. It bore in mind the context of this charge. An issue had come to light at Mersey Care NHS Foundation Trust and Miss Naylor had been spoken to regarding her record keeping. The Assistant Psychologist had conducted an appointment with Patient B with Miss Naylor present on 4 January 2024. The Assistant Psychologist later found that the notes she had made in respect of Patient B from an appointment conducted on 6 December 2022 had been copied and pasted by Miss Naylor on 6 January 2023 to appear correct for the appointment with Patient B on 4 January

2023. The Assistant Psychologist sent an email to Witness 2 alerting them of the incident on 13 January 2023.

When raised with Miss Naylor, it was alleged that her response (as noted in the auditing notes) was:

> *'DN reported that she did not feel that there had been any changes in the patient's mental heath* [sic] *since assessment on 06/12/22. It was late in the day, and she needed to get the information on the patient record. Discussed this was not acceptable.'*

However, the Assistant Psychologist wrote in her email dated 13 January 2023:

> *'The write up is therefore not reflective of the duty appointment which occurred on the 4th January.'*

The panel found charge 3a proved on the basis that this was not a contemporaneous record and given this was a copied and pasted from a comprehensive review made by the Assistant Psychologist during their visit on 6 December 2022, it therefore could not be an accurate record of the appointment on 4 January 2023.

In respect of Patient C's appointments on 16, 17 and 18 November 2022 (charge 3b), the panel had sight of Patient C's record notes which suggested that Miss Naylor was with Patient C and did not provide a record of that interaction on 16 November 2022. In particular, it noted the following extracts:

- *'Progress Note Date 16 Nov 2022 16:10:00*
  […]

  Note Text: […] *Patient C informed me Denise (Duty nurse) is currently with her* […]'

- *'Progress Note Date 16 Nov 2022 16:30:00*
  […]

Note Text: […] *PLAN Patient C to attend DUTY intervention tomorrow (17th November) via Attend Anywhere at 11am-Text appointment to be sent'*

The panel also noted Patient C's psychology notes dated 17 November 2022 which stated, *'Denise (DUTY nurse) to conduct h/v tomorrow on the 29th November at 2pm- Text reminder to be sent'.* The panel found no evidence of notes or entries made by Miss Naylor of attending these appointments with Patient C or any contemporaneous record of what occurred during those appointments.

Accordingly, the panel found charge 3b proved.

In respect of Patient D's appointment on 27 January 2023 (charge 3c), Miss Naylor was the duty nurse who received the call and made a note on the system on 27 January 2023:

'Spoke with staff who reported that Patient D has been sleeping in the doorway of his room again, home visit booked for 3pm this afternoon'

The panel found no other notes on that day to suggest that Miss Naylor had in fact conducted the visit, and if so, the outcome of her visit.

Accordingly, the panel found Charge 3c proved.

The panel next considered charge 3d which relates to Patient E's action plan on 6 February 2023. The panel had regard to the entry on 6 February 2023 which stated:

'Apt 7.2.23 @ 2.30 […] *Wakefield House requested by duty- Denise to inform Patient E'*

The panel noted that it appears from the record that Miss Naylor was due to inform Patient E of this appointment but had seen no subsequent record regarding that contact. Although, the panel has seen documentary evidence that Patient E attended their appointment as the next entry was from the doctor. The panel took the view that as Miss Naylor was the nurse dealing with Patient E, she had a duty to

ensure that she made contemporaneous notes of Patient E's action plan, particularly as this was an urgent appointment.

The panel therefore found charge 3d proved.

In relation to charge 3e, the panel noted the audit notes which provided a list of patients that Miss Naylor had been allocated to. In respect of Patient H:

> *'Case 13: 2 February 2023- Request for Recovery Team review from crisis line. DN documented in progress note that she contacted and arranged a home visit on the 2 February 2023- assessment not documented'*

The panel was satisfied that Patient H's record shows that Miss Naylor was the nurse on duty on 2 February 2023 and she had *'agreed to home visit appointment'* on that day, this was supported by Witness 2's statement to the NMC dated 30 October 2023.

The panel has seen no other entries which relates to the home visit, and as such, found charge 3e proved.

Charge 4

4. Between 7 November 2022 and February 2023 failed to undertake and/or complete risk assessment forms as required on
    a. Patient B on 4 January 2023
    b. Patient G on 15 February 2023

Charge 4 is found proved in its entirety.

The panel noted that Miss Naylor, as part of her role as a registered nurse, had a duty to undertake and/or complete a risk assessment form. This duty is further reiterated by the Mersey Care NHS Foundation Trust's policies which required the completion of risk assessments form when required. Miss Naylor referred to her understanding of this role in her Curriculum Vitae (CV):

‘Conducting specialist mental health assessments when required and Risk Assessments and devise appropriate care plans and risk management plans’

The panel took the view that whilst Miss Naylor had copied and pasted a comprehensive assessment in respect of Patient B (charge 4a) because she felt that there were no changes to Patient B’s presentation, there was a failure on her part to complete the risk assessment forms. Therefore, she has failed to undertake and/or complete the risk assessment forms as required for Patient B on 4 January 2023.

In respect of Patient G’s risk assessment, the panel has evidence from Witness 2’s written statement to the NMC dated 30 October 2023 attesting that Miss Naylor has not completed the form.

As such, in light of the absence of such form, the panel found charge 4b 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 Naylor's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Representations on misconduct and impairment

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

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Miss Naylor's actions amounted to misconduct. This included section 1, 1.2, 1.4, 3, 3.1, 3.3, 4, 6, 6.1, 8, 8.2, 8.3, 8.5, 10, 10.1, 10.2, 10.3, 20 and 20.1.

The NMC provided the following written submissions:

> *'The areas of concern identified relate to basic nursing skills and practice; involving a failure to safeguard Patient A and to recognise a deterioration in their physical and mental health. Such failure caused actual harm to Patient A, who was found in a poor physical and mental state requiring hospitalization for a lengthy period. Further good record-keeping, care planning, and assessment of are basic fundamentals required by a registered a nurse and a failure to undertake such tasks, are in below the expected standards of a registered professional. Such actions posed a risk to the safety, health and wellbeing of vulnerable patients within Miss Naylor's care. We consider the misconduct serious because the actions of Miss Naylor's fall significantly short of what would be expected of a registered nurse.*
>
> *The NMC invite the panel to find that the charges are a sufficiently serious departure from expected standards to amount to misconduct in that Miss Naylor's actions fell far short of what would be proper in the circumstances in the respect of each charge.'*

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Miss Naylor's fitness to practise impaired. It submitted that limbs a, b and c of Grant are engaged:

> *'Miss Naylor's actions in failing to provide care or adequate care to Patient A, was a failure to safeguard and lead to Patient A suffering actual harm and their mental and physical health, declining to such a degree that they required a lengthy period of hospitalisation. The failure by Miss Naylor to keep contemporaneous clinical records, put patients Miss Naylor's care at serious risk of significant harm. As other professionals would not have*

current information as to the patients' health and as such this could lead to complications. Further, given the vulnerability and medical conditions of patients within Miss Naylor's care, colleagues could also have been at risk of harm, if the current presentation of a patient was unknown.'

The NMC acknowledged that Miss Naylor had put forward [PRIVATE] in that at the time of the events at the Trust, she was experiencing [PRIVATE], and whilst at Mersey Care NHS Foundation Trust, she did not recall receiving an induction.

In addressing the public protection risk and the public interest, the NMC submitted:

'Miss Naylor has displayed limited insight. Miss Naylor put forwards reasons for their actions but has not addressed how they would act differently in the same situation, the impact on the patients concerned, colleagues or the profession as a whole

[…] *Miss Naylor had made some admissions at a local level. However, there is little to no acknowledgement that their actions put patients at risk or any remorse for this. Therefore, the NMC considers the insight is deficient.*

[…] *insight is minimal and unsatisfactory. Miss Naylor has provided no evidence of recent training, learning or how they would act differently in the future. Nor how they would avoid repeating the same conduct, which in this case was across two separate employers, over a significant period.*

Therefore, we are not satisfied that the concerns have been addressed and that the risk of repetition is low.

We consider Miss Naylor has not undertaken relevant training in respect of the issues. The examples of relevant training would be, would be [sic] *safeguarding for adults and children and record-keeping to strengthen Miss Naylor's practice.*

We consider there is a continuing risk to the public due to Miss Naylor's lack of remediation and their limited insight, and failure to demonstrate any meaningful reflection.

There is a significant risk of harm to the public were Miss Naylor be allowed to practise without restriction. A finding of impairment is therefore required for the protection of the public.

[…]

We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Miss Naylor's misconduct engages the public interest because members of the public would be concerned to hear of a nurse failing in such basic nursing practice; not keeping accurate records of the care provided to patients and failing provide care to vulnerable patients, that in turn put them at risk of harm. Such conduct would severely damage and undermine public confidence in the nursing profession and the NMC, as the regulator.'

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 *Remedy UK limited v General Medical Council* [2009] EWHC 2294 (Admin), *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant.*

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

‘1 ***Treat people as individuals and uphold their dignity***

To achieve this, you must

1.2 Make sure you deliver the fundamentals of care effectively.

1.4 Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

2 ***Listen to people and respond to their preferences and concerns***

To achieve this, you must:

2.1 Work in partnership with people to make sure you deliver care effectively.

3 ***Make sure that people’s physical, social and psychological needs are assessed and responded to***

To achieve this, you must:

3.1 Pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages.

3.3 Act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

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.

8.5 Work with colleagues to preserve the safety of those receiving care.

8.6 Share information to identify and reduce risk.

10 ***Keep clear and accurate records relevant to your practice***
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
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 some time after the event.

10.2 Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.

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

13 ***Recognise and work within the limits of your competence***
To achieve this, you must, as appropriate:

13.2 Make a timely referral to another practitioner when any action, care or treatment is required.

20 ***Uphold the reputation of your profession at all times***
To achieve this, you must

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Miss Naylor has demonstrated habitual failings between 2021 and 2023. The mistakes she made at the Trust continued during her subsequent work at Mersey Care NHS Foundation Trust, and there appears to be a consistent theme in her ability to carry out her role to the standards expected of a registered nurse.

The panel found that in respect of Patient A (charges 1 and 2), Miss Naylor's actions amounted to serious misconduct. Miss Naylor was responsible for the care of a vulnerable patient and should have borne a significant role as Care Coordinator in providing him with fortnightly visits to review his wellbeing. Her failure to visit him as instructed in his care notes could have had serious consequences to Patient A's physical and emotional wellbeing. When interviewed about her lack of visitation, Miss Naylor told the Trust during the local investigation that she visited Patient A on five occasions. In her response to the NMC, she said:

> *'I attended the address on numerous occasions where there was no answer despite his blinds being open as they usually were, items were moved in his living room which could be seen through a gap in the blinds which did not raise my concerns'.*

However, Miss Naylor failed to pursue contact with Patient A and on each occasion she left without fulfilling her role as Patient A's Care Coordinator. There are no records to confirm whether these visits took place.

Furthermore, Miss Naylor's failure to escalate and take action regarding the withdrawal of Patient A's care package demonstrated a serious failing on Miss Naylor's part as Care Coordinator. Patient A was a vulnerable individual who was receiving three domiciliary care visits a day and KV Care had advised that he should continue to receive one daily visit, the panel took the view that Miss Naylor would have known that once the care package was stopped by KV Care, the frequent visits would have stopped. This was a significant change in the care provided which heightened the level of risk. Miss Naylor did not record this or ensure that other colleagues were aware. Had Miss Naylor ensured that daily visits or regular contact continued after KV Care withdrew, the horrific and near-death condition that Patient A was found in after being left without a visit of any sort for four weeks could have been avoided.

Additionally, failing to provide a coherent and clear handover amounted to serious misconduct as this increased the risk of harm for Patient A. Miss Naylor's colleagues and other relevant services were unaware that Patient A was not receiving the care he

required, therefore, preventing multiple agencies and services from communicating effectively to deliver care to Patient A.

The panel noted that subsequent to Miss Naylor's work at the Trust, she later secured work at Mersey Care NHS Foundation Trust. At the time of the new work, she would have been made aware of her failings which led to the situation with Patient A, yet failures in her record keeping continued which led to the charges concerning Patients B, C, D, E, F, G and H (charges 3 and 4). Record keeping is a fundamental basic of nursing practice and failure to document activity or findings carries risks, not least of which is that the relevant information is not shared with fellow practitioners who should or do come into contact with the patient. The panel took the view that Miss Naylor's actions fell significantly short individually and collectively and therefore amounted to misconduct.

The panel found that Miss Naylor's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and

the lives of their loved ones. To justify that trust, nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d)* […]*'*

The panel found the limbs a, b and c of *Grant* are engaged. Patient A was put at risk and was caused physical and emotional harm as a result of Miss Naylor's misconduct. Patients B, C, D, E, F, G and H were placed at unwarranted risk of harm given the inadequacy of Miss Naylor's record keeping. Miss Naylor's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel took into account Miss Naylor's response in the context form dated 6 May 2023:

> *'I was extremely disappointed with my performance as I believe I am usually a strong performer and di* [sic] *not entirely understand what was going wrong and affecting my ability. The team at Bury was also particularly helpful in offering help and support which I should have accepted*
>
> […]
>
> *I am truly sorry and quite distressed to hear of how the patient had deteriorated, at no time did I receive any communication regarding this before finally leaving the team on 26/05/2023'*

The panel found that Miss Naylor has demonstrated very limited insight. Whilst she recognised that aspects of her performance as a nurse were *'poor',* she has been unable to demonstrate depth in her reflection of the incidents and a recognition of the serious risk they posed to vulnerable patients. As Care Coordinator, Miss Naylor had a key role in her patients' care, in particular, to advocate for them, communicate with the multidisciplinary team in relation to any changes in care (such as the withdrawal of thrice daily visits from KV Care) and closely monitor the patient's condition to identify any changes that could then be acted on. Contemporaneous record keeping was a fundamental part of this role to record current state and alert others to change and/or potential risk. The panel found that her conduct was further exacerbated by her failure to take responsibility for her actions and inability to reflect and learn from the situation.

The panel determined that whilst the charges found proved may be capable of remediation they would be difficult to remediate due to attitudinal issues which appears to underpin them. Miss Naylor was made aware that she had failed to discharge her duty to Patient A and of the consequences that ensued but nevertheless continued to make a series of similar fundamental errors at her subsequent place of work.

The panel is of the view that there is a high risk of repetition. After leaving the Trust and being informed of the concerns and her failure to carry out and properly record the fortnightly visits to Patient A, Miss Naylor's poor practice continued during her employment at Mersey Care NHS Foundation Trust in respect of Patients B, C, D, E, F, G and H where she again failed to complete patient records and documentation correctly. The panel was not satisfied that Miss Naylor had learned from the incident, particularly since she has not engaged with the fitness to practice process or demonstrated any form of strengthening of practice.

The panel had regard to the assertions put forward by Miss Naylor in which she made references to experiencing [PRIVATE] at the time of the incidents. She outlined a series of [PRIVATE] which she believed led to her conduct. However, the panel has not received any [PRIVATE] to support this. The panel took the view that these failings were to such an extent that it does not mitigate her actions. The incidents involving the patients were not isolated incidents but a series of repeated basic nursing failings during a significant period. 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 addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel took the view that the public, fully apprised of the facts of this case, would be highly concerned had the panel decided that Miss Naylor was not impaired on the grounds of public interest. In the

absence of intervention from Miss Naylor in respect of Patient A, good record keeping and appreciation of risks, the consequences could have been more serious. The panel was of the view that members of the public would undoubtably be concerned. It noted that these incidents could have been avoidable had Miss Naylor undertaken her role conscientiously and to the standard expected. The panel therefore also finds Miss Naylor's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Naylor'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 Naylor off the register. The effect of this order is that the NMC register will show that Miss Naylor has been struck-off the register.

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 22 August 2024, the NMC had advised Miss Naylor that it would seek the imposition of a 12-month suspension order with a review if it found Miss Naylor's fitness to practise currently impaired:

> *'The aggravating factors in this case include:*
> - *Lack of insight into failing*
> - *A pattern of misconduct over a period*
> - *Conduct which puts patients at risk of suffering harm.*
> - *Neglect of a vulnerable patient*
>
> *The mitigating factor appears to be that Miss Naylor was having* [PRIVATE] *at the time of the concerns.*
>
> […]
>
> *Miss Naylor's lack of insight and the concerns particularly in relation to Patient A are serious and may be considered as neglectful or certainly bordering on neglect, this is suggestive of an attitudinal concern. Which is replicated in Miss Naylor's approach to record keeping. The behaviour within the charges is repetitive in nature given that the record keeping concerns was across two separate employers, with limited insight provided. Such behaviour can have a particularly severe impact on public confidence in the*

profession and the ability of the regulator to uphold the standards and values set out within the code and to ensure the safety of those who use the services provided by a nurse, midwife or nursing associate, such behaviour can deter the public from seeking assistance, if it is felt it would not be provided in any event.

This is a case where there has been repeated misconduct on more than one occasion of the same type of record keeping concerns. Given the risk of significant harm to patients and the repetitive nature of the misconduct, the appropriate order would be that of a suspension for a period of 12 months with a review.

[…]

A 12-month suspension order with a review would be sufficient to protect the public and maintain public confidence in the professions. It would also provide Miss Naylor the opportunity to reflect and undertake meaningful reflection and training to provide to a future reviewing panel. Temporary removal from the register is required to uphold nursing standards and maintain confidence in the professions.'

Decision and reasons on sanction

Having found Miss Naylor'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:

- Lack of insight into failings.
- A pattern of repeated failings over a significant period.
- Conduct which placed patients at risk of suffering harm.
- Neglect of a vulnerable patient.
- Underlying attitudinal issues in failing to discharge basic nursing duties.

The panel also took into account the following mitigating feature:

- [PRIVATE] at the time of the incidents.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Naylor'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 Naylor'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 Naylor's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated given the nature of the charges in this case and underlying attitudinal issues. Miss Naylor has not engaged with the NMC in relation to these proceedings, and therefore, there is no evidence to suggest that she would comply with conditions of practice. Furthermore, the panel concluded that the placing of conditions on Miss Naylor's registration would not adequately address the seriousness of this case and would not protect the public.

The panel carefully considered whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

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

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

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

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

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

Miss Naylor's actions were significant departures from the standards expected of a registered nurse are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Naylor's actions were extremely serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

In making this decision, the panel carefully considered the written submissions of the NMC in relation to the sanction that the NMC was seeking in this case. The panel had careful regard to the sanction guidance, SAN-3d and SAN-3e. The panel considered that the charges found proved were serious and not a single incident of misconduct. The panel has seen evidence of repeated breaches of the Code relating to several vulnerable patients within a short period of time following an investigation interview concerning Patient A and a referral to the NMC. The panel determined that there is also evidence of attitudinal issues in what appears to be persistent irresponsible behaviour from Miss Naylor, being an experienced nurse, in overseeing mental health patients. Given her background of 30 years of nursing, Miss Naylor would have been aware of her duties to act in the best interest of her patients and the impact that the withdrawal of daily domiciliary care would have on a vulnerable patient like Patient A.

Miss Naylor has only demonstrated minimal insight regarding the failures in her responsibilities to Patient A which was contained in the original investigation notes and the panel has seen no evidence of insight regarding Patients B to H. The panel noted that there had not been engagement from Mis Naylor in respect of these proceedings to offer her intention regarding her nursing career. In the absence of remorse, remediation and strengthening of practice, the panel determined that a suspension order with review would not meet the public protection and public interest considerations of this case.

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

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

This will be confirmed to Miss Naylor in writing.

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC:

> *'If a finding is made that the registrant's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed, we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
>
> *If a finding is made that the registrant's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registration, we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.'*

Decision and reasons on interim order

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

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

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

That concludes this determination.