Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 30 July 2024 – Tuesday, 13 August 2024
Tuesday 22 October 2024 – Wednesday 30 October 2024

Virtual Hearing

Name of Registrant:	**Julia Ann Nixon**
NMC PIN	09H1870E
Part(s) of the register:	Registered Nurse – Sub Part 1 RNA: Adult nurse L1 – September 2009 V300: Nurse independent / supplementary prescriber – May 2015
Relevant Location:	Staffordshire
Type of case:	Misconduct
Panel members:	Tracy Stephenson (Chair, Lay member) Jane Louise Jones (Registrant member) Seamus Magee (Lay member)
Legal Assessor:	Gillian Hawken
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by Claire Stevenson (Counsel), Case Presenter (30 July 2024 – 13 August 2024); Uzma Khan (22 October 2024 – 30 October 2024)
Mrs Nixon:	Present and represented by Andrew Richmond, Anderson Strathern
Facts proved:	2, 3a, 3b, 4 and 5
Facts not proved:	1a(i), 1a(ii), 1a(iii), 1b, 1c, 6, 7
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (12 months)**

Interim order:	**Interim conditions of practice order (18 months)**

Details of charge (as read)

That you, a registered nurse, on 13 December 2019 in respect of Patient A:

1) Having been advised by them and/or Mr A that Patient A was experiencing chest pain and/or back pain and/or shortness of breath/breathlessness:

    a) Failed to record in Patient A's records that they were experiencing:
        i) Chest pain;
        ii) Shortness of breath/breathlessness;
        iii) Back pain.

    b) Failed to undertake/refer for an electrocardiogram ("ECG").

    c) Failed to escalate/onward refer them to secondary care that day for assessment.

2) Failed to discuss clinical red flag warning signs.

3) Failed to advise Patient A that if they experience any worsening symptoms and/or have any concerns then they should:
    a) contact out of hours/111.
    b) seek further medical advice/review.

4) Recorded in Patient A's notes that you had discussed clinical red flag warning signs with them when you had not.

5) Recorded in Patient A's notes that you had advised them that if they had any concerns at all they should seek review and/or provided details for out of hours/111 when you had not.

6) Your actions at charge 4 above were dishonest in that you deliberately sought to represent you had discussed clinical red flag warning signs when you knew you had not.

7) Your actions at charge 5 above were dishonest in that you deliberately sought to represent you had advised them that if they had any concerns at all they should seek review and/or provided details for out of hours/111 when you knew you had not.

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

Decision and reasons on application to admit further evidence (Day 8)

Ms Stevenson on behalf of the Nursing and Midwifery Council (NMC) provided the panel with written submissions and referred to them in her oral submissions.

Ms Stevenson made an application under Rule 31 of The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (the Rules) to admit further evidence, namely, Ms 1's (Patient A's daughter) Witness Statement dated 7 August 2024, and corresponding WhatsApp text messages dated 14 December 2019 between Ms 1 and Patient A and to call Ms 1 as a witness.

Ms Stevenson acknowledged that Ms 1 had observed some of this hearing since the outset.

Ms Stevenson referred the panel to Rule 22(6) which states:

> *'(6) No witness as to fact may observe the proceedings until she has given evidence or been formally released by the Committee.'*

Notwithstanding this, she invited the panel to take a purposive approach in this matter.

She drew the panel's attention to: NMC guidance 'Case management during hearings' CMT-9, last updated 01/07/2022) ("Guidance"); Rule 24(1) which provides the panel with a discretion as to how a hearing conducted. She referred the panel to the guidance set out in CMT-9 which provides the process that should be followed if a new issue arises after someone has finished giving their evidence. In such circumstances, the panel should think very carefully about whether the individual needs to be recalled or whether the panel can either explore the issue with witnesses who remain in session, others who have not yet given evidence, or by considering the evidence they have already heard.

Ms Stevenson submitted that Ms 1's WhatsApp text messages and her evidence were relevant. She told the panel that the WhatsApp text message, dated 14 December

2019, was written the day after the consultation had taken place between Patient A, Witness 1 and you. She submitted that the WhatsApp message between Patient A and Ms 1 dated 14 December 2019 was a further contemporaneous record and made an observation about how Patient A was feeling which was similar to that previously recorded in her diary. In the text message, Patient A stated that she was *'having quite painful pains in her chest'* and also detailed the outcome of the consultation she had with you.

Ms Stevenson submitted that the issue in this case revolved around the conflicting accounts of Witness 1 and you. She submitted that the text message evidence was consistent evidence which could assist the panel's deliberation as to whether it could rely on Witness 1's account as to its credibility, reliability and consistency. She submitted that it was clearly relevant to the allegations in this case.

In relation to fairness, Ms Stevenson submitted that it was fair to admit the text messages and evidence of Ms 1. She submitted that Ms 1's witness statement explained why it was only now that it had been brought to the NMC's attention. She further submitted that it provided information in relation to the provenance of the text messages. As to the reasons why it was only now that these text messages had been brought to NMC's attention, Ms 1 explained in her witness statement:

> *' I have been observing the case against Ms Nixon and have heard that there has been a lot of questions about my mum's diary. I was working yesterday (Tuesday 6 August 2024) and during my lunchbreak thought I'd just go back to my messages to see what was said. I heard that the surgery had recorded my mum's symptoms as chest tightness, but my mum said in her message to me sent at 10:36 on 14 December 2019 that it was chest pain, I thought this could be relevant.*
>
> *I was speaking to my dad in my lunchbreak and we discussed the content of the Whatsapp messages. He thought it would be relevant to send to the NMC, so he spoke to the NMC about it yesterday.*
>
> *As noted above, I thought the message could be relevant because of what's been said during the case about my mum's diary. I used to get her a diary every*

Christmas. She loved writing and would make lengthy notes about things. I know for some people that might seem odd, but she always made detailed notes about things. Any kind of things went in there, small things as well as medical things. As she put medical things in there, my dad gave extracts from her diary to the Coroner days after my mum's death.'

Ms Stevenson submitted that the NMC was not previously aware of the text messages until it was raised by Witness 1 on the 6 August 2024. She submitted that the evidence does not factually prove or disprove the matter, it was not the sole or decisive evidence in support of the charges, but it was further contemporaneous and consistent evidence of Witness 1's account.

She submitted that you have made it clear that you disputed Witness 1's account. However, this evidence was not so substantial that it would require a significant amount of time for instructions to be taken. Furthermore, it does not cause any inconvenience to any witnesses, as all witnesses had now given their evidence.

Ms Stevenson submitted that this case was serious not only taking into account the impact that any findings may have on your career, but also taking into account the impact of Patient A's death and the proceedings upon her family. Ms Stevenson submitted that the panel should not only consider fairness to you, but fairness to the NMC, whose overarching objective was the protection of the public.

Mr Richmond on your behalf opposed the application in its entirety. He submitted that Rule 22(6) was clear that no witness as to fact may observe the proceedings until they have given evidence and had been formally released by the committee. He submitted that the purposive approach was not the correct approach to be taken in this case. He submitted that the purposive approach could be taken where the rule in question was ambiguous or unclear.

Mr Richmond referred the panel to the case of *Hill v The Institute of Chartered Accountants* [2013] EWCA Civ 555, which states:

'...that when one is dealing with bye-laws and regulations of professional

disciplinary bodies one cannot expect every contingency to be foreseen and provided for. The right question to ask of any procedure adopted should therefore be not whether it is permitted but whether it is prohibited... It must, of course, still be fair and that to my mind is the critical issue in this appeal.'

He submitted that Rule 22(6) clearly does prohibit and does not provide the panel with discretion in this matter.

Mr Richmond submitted that Ms 1 had observed the hearing for seven days and had therefore benefitted from the opportunity of hearing other witnesses give evidence before she gave evidence. He submitted that this was clearly at odds with Rule 22(6). Further, in reference to Rule 24(1) he submitted that it was also at odds with the express provisions of Rule 22(6).

In relation to relevance, Mr Richmond raised the issue of provenance of the material and submitted that it could be a matter for cross-examination in due course.

In relation to fairness, Mr Richmond submitted that a balance does have to be struck by the panel in the interest of the public, along with your interest. He submitted that to allow Ms 1 evidence would be unfair and prejudicial to you in this case. He submitted that this could and ought to have been brought to the attention of the NMC by Witness 1 or Ms 1 well before now.

Mr Richmond submitted that we were now at day eight of eleven and it was clearly unfair and prejudicial to you for this evidence to be introduced at this late stage.

The panel accepted the advice of the legal assessor. This included reference to Rules 31 and 22(6) of the Rules. She also reminded the panel of its primary function - to protect, promote and maintain the health and safety of the public - and the need to balance fairness to you with the public interest in the panel reaching a correct decision in relation to the allegations. The legal assessor addressed the panel in relation to the judgment in *Professional Standards Authority (PSA) v Nursing and Midwifery Council (NMC) (Lembethe and Mkhize)* [2019] EWHC 3326 (Admin).

The panel considered the relevance of the text messages and determined that they contained information in relation to symptoms Patient A was presenting with at that time:

> *'Had to have an urgent appt with nurse practioner [sic] yesterday got appt within the hour. Was having quite painful pains in my chest thought it was the remains of the flu virus thing I've been having. She gave me a good examination. She says I have got costochondritis which I have never heard of before. She gave me naproxen and lansoprazole for it. Says there's no infection on chest or in ear so don't need antibiotics.'*

The panel also noted the reference to having the *'flu virus thing'* which had not been raised previously. The panel determined that the text messages provided relevant contemporaneous context and background and required further exploration.

In relation to fairness, the panel decided that it would be fair to both parties to further explore the reference to *'flu virus thing'* in the text message in determining the facts in due course. The panel bore in mind that the NMC were unaware that these text messages existed until 6 August 2024. The panel acknowledged that these were received late and that you perceived there was unfairness and prejudice to you. This would, in the panel's view, be mitigated by your representative having the opportunity to challenge this new evidence in any cross-examination of Ms 1.

The panel had regard to Ms 1's proposed witness statement in relation to the reason for providing the text messages at this late stage of the hearing:

> *'As noted above, I thought the message could be relevant because of what's been said during the case about my mum's diary. I used to get her a diary every Christmas. She loved writing and would make lengthy notes about things. I know for some people that might seem odd, but she always made detailed notes about things. Any kind of things went in there, small things as well as medical things. As she put medical things in there, my dad gave extracts from her diary to the*

Coroner days after my mum's death.'

The panel determined that it should admit the text messages into evidence for further exploration and afford you and your representative the requisite time to consider and address this new material. This would, in the panel's view, mitigate the stated prejudice that you were concerned about, as your representative would have the opportunity to challenge this new evidence in any cross-examination of Ms 1. The panel balanced any potential delay to your hearing, as a result of you needing additional time to consider this new evidence, and the consequent prolonged uncertainty that could be caused to you in the event that the hearing did not conclude in the current listing. It balanced such prejudice with the public interest and the interests of justice in what the panel considered to be potentially important evidence being explored. In the particular circumstances of this case, the panel was of the view that the public interest weighs more heavily and tips the balance in terms of its deliberations around fairness.

The panel bore in mind the provision of Rule 22(6). However, in these particular circumstances it had taken an unusual step by admitting the supplementary evidence. The panel came to this decision in light of its overarching duty to protect the public and act in the public interest. The panel balanced its primary function to protect, promote and maintain the health and safety of the public with the need for fairness to all parties. The panel concluded that in the interest of justice, it would be fair to accept into evidence the WhatsApp text messages and written statement of Ms 1. However, the panel would give the appropriate weight to this evidence once it had heard and evaluated all of the evidence before it.

Application for Special Measures (Day 9)

Ms Stevenson made an application under Rule 23 of the Rules for you and Ms 1 to have your cameras switched off while Ms 1 gave evidence. [PRIVATE] due to distressing nature of the subject matter [PRIVATE].

Mr Richmond submitted that he had no objection to you having your camera switched off whilst Ms 1 gave evidence. However, he objected to Ms 1 having her camera switched off while giving her evidence. Mr Richmond submitted that it would be in all parties' interest to assess Ms 1's demeanour. He submitted that it would be of assistance to the panel in making any determination in placing weight upon your evidence to be able to see Ms 1 during examination, cross examination, as well as during panel questions.

The panel accepted the advice of the legal assessor, who referred it to NMC guidance on Reference CMT-12 'Supporting people to give evidence in hearings'.

The panel carefully considered the application. It noted its duty in CMT-12 to make witnesses as comfortable as possible without being unfair to either party before it. The panel therefore granted the first part of the application that your camera be switched off during the evidence of Ms 1. However, the panel was of the view that Ms 1's camera should remain switched on while giving evidence. The panel was of the view that Ms 1 could be reassured by the fact that the panel would facilitate any breaks she required. The panel also enquired as to the allocated NMC witness liaison officer's availability and was reassured that she would be available to attend the hearing to provide support to Ms 1 while giving evidence.

In these circumstances, the panel application for you to have your camera switched off was granted and the application in relation to Ms 1 to give evidence with her camera off was refused.

Background

The charges arose whilst you were employed as a Nurse Practitioner by Wolstanton Medical Centre (the Surgery). You were referred to the Nursing and Midwifery Council (NMC) by Witness 1 (Patient A's husband) on 15 August 2021, who raised concerns in relation to his wife, Patient A.

On 13 December 2019, Patient A was alleged to have been suffering with chest and back pain, nausea and breathlessness, which increased as the day progressed. Witness 1 telephoned the Surgery on Patient A's behalf to request a doctor's appointment, but no appointments with a GP were available. However, Witness 1 explained that Patient A's had a heart condition and he was then able to make an urgent appointment to see a nurse specialist a short time later. You saw Patient A with her husband at the appointment.

You undertook various checks and then diagnosed Patient A with costochondritis. You explained to Witness 1 and Patient A what the condition was and you allegedly said that Patient A would experience mild to severe pain for three or four days, maybe even a week. You prescribed Patient with Naproxen and Lansoprazole and administered the flu vaccination.

Witness 1 alleged that he asked you about whether it would be worth doing an electrocardiogram test (ECG) in view of Patient A's heart condition or getting another opinion. You allegedly replied that you did not think that this was necessary and you did not perform an ECG. Witness 1 and Patient A did not seek any further medical advice after 13 December 2019 due to your diagnosis and the alleged reassurances given by you. Witness 1 alleged that you had not given any 'red flag' warnings and your advice was that the issue would improve after a week or so.

On 14 December 2019, Patient A recorded in her diary that she was still suffering with chest pains, that she was feeling weak and that it was too much effort to do anything. Patient A continued to feel unwell until 17 December 2019. On that date Witness 1 left the house to do the shopping for Patient A. Upon his return he found Patient A had

suffered a heart attack. Witness 1 tried to resuscitate her for 20 minutes whilst waiting for the ambulance. Patient A passed away on 17 December 2019.

The hearing resumed on 22 October 2024.

The panel heard closing submissions on facts from Ms Khan on behalf of the NMC and submissions provided in writing and referred to in oral submissions by Mr Richmond on your behalf.

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 Stevenson and Ms Khan on behalf of the NMC and those made by Mr Richmond on your behalf.
The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged or is more likely than not to be true.

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

- Witness 1: Husband of Patient A
- Witness 2: Practice Manager at the Surgery, at the material time
- Witness 3 Expert Witness; Registered General Nurse and Advanced and Emergency Nurse Practitioner
- Witness 4 Doctor/Partner at the Surgery, at the material time

- Ms 1 Daughter of Patient A

The panel also heard evidence from you under affirmation.

The panel heard and accepted the advice of the legal assessor. This included reference to the NMC guidance DMA-6 on 'Evidence', DMA-8 on 'Making decisions on dishonesty charges and the professional duty of candour', as well as relevant legal authorities found in the cases of *Khan v GMC* [2009] EWHC 535 (Admin), *Dutta v GMC* [2020] EWHC 1974 (Admin), *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 and *Re-B Children* [2009] AC 11.

Before making any findings on the facts, the panel considered all of the witness and documentary evidence provided on behalf of the NMC and those from Mr Richmond on your behalf.

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

Charges 1a(i), 1a(ii), 1a(iii)

That you, a registered nurse, on 13 December 2019 in respect of Patient A:

1) Having been advised by them and/or Mr A that Patient A was experiencing chest pain and/or back pain and/or shortness of breath/breathlessness:

    a) Failed to record in Patient A's records that they were experiencing:

        i) Chest pain;
        ii) Shortness of breath/breathlessness;
        iii) Back pain.

These charges are found NOT proved.

The panel had before it: Patient A's medical notes detailing the consultation on 13

December 2019; an audit trail of the interactions with Patient A; a booking note made by the receptionist who booked the appointment for Patient A; complaint letters dated 7 February 2020 and 8 December 2020 from Witness 1 to the Surgery; Patient A's diary entries for 13 and 14 December 2019 and WhatsApp text messages dated 14 December 2019 exchanged between Patient A and Ms 1; your written reflective pieces provided to the NMC and your oral evidence; Witness 1's oral evidence and Witness 4's oral evidence.

The panel first considered the stem of charge 1:

1) *'Having been advised by them and/or Mr A that Patient A was experiencing chest pain and/or back pain and/or shortness of breath/breathlessness:'*

The Surgery's records showed that a telephone call was made to the Surgery at 12.37 on 13 December 2019. The reason recorded by the receptionist for the appointment was *'ongoing chest inf* [infection]'. Witness 1 in his oral evidence said that at no time did he ever inform the receptionist that Patient A had an ongoing chest infection. The record showed that Patient A arrived at 13.01 and was seen by you at 13.16. The consultation lasted for 13 minutes and Patient A left at 13.30. The Surgery operated a care navigation system and in their oral evidence both Witness 4 and Witness 2 referenced the fact that all reception staff were trained to use the system. The receptionist on duty when the call was made was not called to give evidence or provide a witness statement. As a result the panel was unable to explore what was discussed between the receptionist and Witness 1. The panel also heard that calls to the Surgery were not recorded at the time this incident occurred.

The notes of the consultation between you and Patient A were recorded by you as follows:

'Problem	***Costochondral joint syndrome** (First)*
History	*had abx a few weeks ago for sinusitis, says seems to have settled this but now has ears that feel blocked and her chest feels tight. not expectorating any phlegm, feels nauseous and week. has vomited*

phlegm

Examination O/E – tympanic temperature 36.6 degrees C . O/E – pulse rate 72 beats/min. Blood oxygen saturation 98% . O/E – blood pressure reading 164/95mmHg looks a little pale but well perfused. not sob (short of breath) and speaking in full sentences. Ears are clear, left TM (tympanic membrane) is perforated, old perfoiration [sic], right intact. throat nad (nothing abnormal discovered). chest is clear, air entry throughout, no wheeze, no creps and no pleural rub. no increased work of breathing. tender++ on palpation of sternoclavicular joint

Medication *Lanzoprazole 15mg gastro-resistant capsules One To Be Taken Each Morning 28 capsule [sic] Naproxen 250mg tablets One To Be Taken Twice A Day 56 tablet [sic]*

Comment *advised analgesia and any concerns at all review, ooh-111. Discussion about clinical red flag warning signs...'*

Following the consultation, Patient A made the following entry in her diary on 13 December 2019:

'Started with chest pains in the morning. Got worse later on. got [Witness 1] to call GP surgery and managed to get an appt with nurse practitioner.
1.15pm
Had an appt with [YOU] nurse practitioner
She gave me a good examination sounded my chest and back
Looked in my ears and throat
Said the pain I was having in my chest and back was something called Costochondritis
Which is inflammation of cartilage that joins your ribs to your sternum.
...said it could last for days or even longer – great!!'

The following day, the 14 December 2019, Patient A made a further diary entry which stated:

> *'still suffering with the chest pains and feeling weak'. Too much effort to do anything.'*

On 14 December 2019 at 10.36, Patient A in response to a WhatsApp message from Ms 1 stated:

> *'...had to have an urgent appt with nurse practitioner yesterday got appt within the hour. Was having quite painful pains in my chest thought it was the remains of the flu virus thing I've been having. She gave me a good examination. She says I have got costochondritis which I have never heard of before. She gave me naproxen and lansoprazole for it. She says there's no infection on chest or in ear so don't need antibiotics...'.*

The panel heard two conflicting accounts of what happened during the consultation from Witness 1 and you.

Witness 1 in his complaint letter to the Surgery dated 7 February 2020, some seven weeks after the appointment, stated:

> '*I told [you]...had been struggling with back and chest pain and breathlessness and that I was concerned because she had a heart problem'.*

At the time the complaint was made Witness 1 had not had sight of Patient A's medical records. A year later on 8 December 2020, following receipt of Patient A's medical records, Witness 1 wrote a further letter of complaint to the Surgery in which he raised concerns about discrepancies between what he recalled being said at the appointment and what you had recorded in the notes. In oral evidence Witness 1 highlighted what these discrepancies were and said there was no record of chest pain in the records. However, he agreed that reference was made in the notes to Patient A's chest feeling tight. He said there was no mention of breathlessness even though he said at times his

wife had been gasping for breath. He told the panel that she had been short of breath for some time and this was discussed with you during the consultation.

Witness 1 told the panel that he had told you that Patient A had been suffering with chest pain, back pain, breathlessness and nausea. He said that he was *'100%'* sure about what they had discussed during the consultation and stated he had *'no doubt whatsoever in my mind'.*

In Witness 1's oral evidence, he told the panel that Patient A answered most of the questions herself. When asked what Patient A had said, Witness 1 stated: *'I know she mentioned breathlessness'.* Witness 1 went on to explain in more detail the specifics of what Patient A said in the consultation. He stated: *'I think my wife described what sort of pain it was and I think she was saying she's trying to get a deep breath and she was having problems because of the pain'.* Witness 1 told the panel that you told Patient A *'you will have pain because you've got costochondritis'.* Witness 1 further described what was said about Patient A's breathing and pain, and stated '*all I can remember...is that fact that my wife told her that she was having problems when she was trying to breathe in and that caused the pain'*. Witness 1 in his oral evidence, when questioned about the note stating *'not sob' [short of breath],* agreed that Patient A was talking in sentences. However, he said they were short sentences and that he had answered some questions on her behalf.

You maintained in your written documentation submitted to the NMC and oral evidence that *'Patient A did not complain of experiencing any chest pain',* and you stated *'I recorded what I was told at the time'.* When questioned during oral evidence, you gave a more detailed account relating to Patient A's chest pain and stated *'she didn't present with cardiac sounding chest pain'* and *'at no point was cardiac sounding chest pain ever mentioned'.* When questioned by Mr Richmond whether chest pain and back pain had been mentioned to you, you answered *'not back pain, no',* and went on to explain that Patient A '*didn't come in and say I've got pains in my chest, just it felt tight...Didn't say it was painful, but it was painful...which I documented'.* You confirmed that you had palpated Patient A's sternum and that this had reproduced the pain Patient

A had been experiencing. The panel noted that *'tender ++ on palpation of sternoclavicular joint'*.

When asked about the consultation and notes, Witness 4 in his oral evidence, stated: *'...chest pain had been accepted, but it had been attributed to a non cardiac condition'.*

The panel then went on to consider your record keeping in respect of Patient A's appointment. In an undated reflective account that you sent to the NMC for your revalidation, you stated: '...*I am also aware on this occasion my documentation has left me open to criticism. I have learnt a very hard lesson from this and have improved my documentation since'* and also *'On reflection, I accept that I should have documented this in more detail and explained more clearly my reasons for discounting a cardiac cause.'*

In oral evidence, you confirmed that your documentation could have been completed in more depth and you said you should have included in the notes why you had ruled out cardiac pain.

Witness 3, the expert witness, in her oral and written evidence stated that it would have been prudent of you to have recorded details of the onset of the symptoms. In response you accepted that your notes should have been in more detail. You said '*but what I wrote down is what I was presented with at the time'.*

The panel having considered all of the evidence, determined that it was more likely than not that there had been some discussion and assessment during the consultation relating to Patient A having some difficulty breathing and also experiencing some pain in the chest wall area when breathing. This was confirmed when you palpated the sternum and the pain was reproduced. Therefore, the panel went on to consider charges 1a(i) and 1a(ii).

The panel determined that there was insufficient evidence to find that it was more likely than not that back pain had been advised, as set out in the stem of charge 1. As such, the panel did not go on to consider charge 1a(iii).

In relation to charge 1a(i), the panel determined that the exact term *'chest pain'* was not recorded in Patient A's notes. However, there was a clear record in the notes to '*tender++ on palpation of sternoclavicular joint'* which the panel determined was a description of pain in the chest area. The diagnosis was confirmed as costochondral joint syndrome. Witness 3, the expert witness explained the syndrome as follows: '*Signs and symptoms - when the costochondral joint becomes inflamed it can result in sharp chest pain and tenderness, which may develop gradually or start suddenly'.* The panel noted in Patient A's notes that you had prescribed Naproxen as analgesia for the pain.

For the reasons set out above, the panel finds that there was no failure on your part to record that Patient A was experiencing chest pain.

In relation 1a(ii), the panel noted that you recorded in Patient A's history '*her chest feels tight, not expectorating any phlegm'.* The panel determined during your examination you considered shortness of breath / breathlessness and your assessment was recorded as *'not sob [short of breath] and speaking in full sentences'*, and *'no increased work of breathing'.* The panel determined that you did make a record in Patient A's notes that related to shortness of breath / breathlessness.

For the reasons set out above, the panel finds that there was no failure on your part to record that Patient A was experiencing shortness of breath / breathlessness.

Charge 1a(iii)

The panel did not consider this sub-charge following its finding that there was insufficient evidence that you were advised that Patient A was experiencing back pain.

Charges 1b and 1c

b) Failed to undertake/refer for an electrocardiogram ("ECG").

c) Failed to escalate/onward refer them to secondary care that day for assessment.

These charges are found NOT proved.

The panel considered charges 1b and 1c together given that they related to your diagnosis of costochondritis and whether there was a requirement for subsequent tests or referral to secondary care for assessment.

The panel considered the duty on you to undertake or refer for an ECG. Witness 4 said in oral evidence that these decisions were for the clinician to make and stated: *'...the clinicians are expected to operate in line with their codes of practice and national guidelines'.*

He stated that there are guidelines from the National Institute for Health and Care Excellence (NICE) that *'would talk about how to assess people with chest pain, but these guidelines are general and not prescriptive'.*

The panel took account of the expert Witness 3 report where reference was made to The Code: Standards of conduct, performance and ethics for nurses and midwives, in which it states:

> *'...it is notable that the Code of Conduct does not cover the specific circumstances in which nurses make decisions and judgements.'*

In your oral evidence you said if an ECG had been clinically indicated you would have undertaken one. However, given the diagnosis you did not consider an ECG necessary. A positive diagnosis of costochondritis had been made by you. You said that if a patient presented with cardiac chest pain, *'they would be going to secondary care'*. You had ruled out that this was cardiac related chest pain although you acknowledged that you should have written this in Patient A's notes.

Witness 4 in his evidence said that given Patient A's presentation and assessment (as recorded), he would have been reassured of the same diagnosis.

The expert witness report confirmed that from your notes your diagnosis appeared reasonable in the circumstances and that no further tests were required:

> *'A diagnosis was recorded as 'costochondral joint syndrome' which would appear a reasonable conclusion in light of the symptoms reported to the Registrant (as documented within the medical records) presenting complaint and clinical findings. Therefore, in light of this no further tests including an ECG were required.'*

The panel noted the expert's comment that no further tests were required and therefore there was an inference that there was no need to escalate or refer to secondary care for assessment or further tests.

> *'I understand the response from the surgery that they were also supportive of the Registrant's diagnosis. One of the key points that they submitted was that pain on palpation of the sternoclavicular joint would not be indicative of a cardiac problem.'*

The panel was therefore not satisfied, on the basis of the evidence before it, that you were under a duty to either undertake or refer Patient A for an ECG and escalate / onward refer them to secondary care that day for assessment.

The panel therefore finds these charges not proved.

Charge 2

2) That you, a registered nurse, on 13 December 2019 in respect of Patient A:

Failed to discuss clinical red flag warning signs.

This charge is found proved.

In reaching this decision, the panel took into account Patient A's notes, which commented as follows:

> *'advised analgesia and any concerns at all review, ooh-111*
> *Discussion about clinical red flag warning signs'*

The panel noted that no further information was recorded in the notes about what clinical red flag warning signs were either highlighted or discussed with Patient A and Witness 1. In your oral evidence, when asked you were unable to expand on what red flag warning signs were communicated at the time but said you always referenced what to look out for. When questioned, you acknowledged that you should have elaborated further and that you now make sure that the patient has understood what you have said and that you sometimes ask them to repeat the red flag warning signs back to you. In your second reflective piece you acknowledged the importance of setting out what red flag warning signs should be looked out for.

In Witness 1's witness statement, he stated the following:

> *'The notes stated that we were advised to review if we had any concerns or call 111 out of hours ('ooh'), however, this was never mentioned to us by [you]. [You] seemed so convinced with [your] diagnosis of costochondritis because the cause of Patient A's pain and I believed her. She did not give any red flag warnings.'*

The panel took into account Witness 1's oral evidence that he was '*100%'* certain that no mention of red flag warning signs were discussed and further that Patient A had not noted any red flag warning signs in her diary. The panel noted in Witness 1's evidence he said if red flag warning signs had been mentioned he would have been a lot more vigilant, *'on his guard'* and not as reassured as he was and would probably have followed up and taken Patient A to hospital. The panel was of the view that Witness 1 was consistent and clear in his evidence.

In respect of your duty in relation to the red flag warning signs , the panel relied on the expert witness report of Witness 3 dated 19 October 2022, which states:

> *'It is best practise to advise all patients irrespective of presenting complaint of potential red flags and the need to seek review should there be any changes or concerns.'*
>
> *...*
>
> *'Patient A's husband, however, reports in his statement dated the 3rd of July 2022. 'Miss Nixon did not tell us to call 111 or seek further medical advice. If Patient A became too ill [sic]. She did not say anything like that. She was categorically sure that Patient A would be fine.' if this evidence is accepted, this would represent conduct that fell far below the standard expected. Lack of sign posting and explanation of red flags can lead to serious risk of harm to patients. They will be unaware of symptoms that are potentially life threatening or need further review. This is always undertaken at the end of every consultation.'*

The panel focussed on the word *'discussed'* which meant that there had to be an element of conversation between you and Patient A. The panel was not satisfied that there had been a discussion. The panel was of the view that the entry in the patient notes could have simply been added as a matter of routine after the consultation had ended. You said in oral evidence '*you make sure your words are documented as quickly as possible after the patient has left. I did them at the end'.* You said in oral evidence that you were time pressured and time was limited.

However, the panel determined that there was no evidence to show that any discussion took place about red flag warning signs during the consultation.

The panel concluded that you had a duty to discuss red flag warning signs and that you failed to do so and therefore charge 2 is found proved.

Charge 3a and 3b

That you, a registered nurse, on 13 December 2019 in respect of Patient A:

3) Failed to advise Patient A that if they experience any worsening symptoms and/or have any concerns then they should:

   a) contact out of hours/111.

   b) seek further medical advice/review.

This charge is found proved.

The panel considered charges 3a and 3b together given that they related to your failure to advise Patient A that if they experience any worsening symptoms and/or have any concerns then they should seek further assistance.

In reaching this decision, the panel took into account Patient A's notes in which you recorded the following:

> *'advised analgesia and any concerns at all review, ooh-111'*

In respect of your duty to advise Patient A to contact out of hours / 111 and / or seek further medical advice / review, the panel considered the expert witness report of Witness 3 dated 19 October 2022, which states:

> *'Patient A's husband, however, reports in his statement dated the 3rd of July 2022. 'Miss Nixon did not tell us to call 111 or seek further medical advice. If became too well. She did not say anything like that. She was categorically sure that would be fine.' if this evidence is accepted, this would represent conduct that fell far below the standard expected. Lack of sign posting and explanation of red flags can lead to serious risk of harm to patients. They will be unaware of symptoms that are potentially life threatening or need further review. This is always undertaken at the end of every consultation.'*

The panel had regard to Witness 1's written statement, which included:

> *'Ms Nixon was very good at reassuring us. She made us feel very at ease and we felt confident with her diagnosis. I recall Ms Nixon saying, 'I can understand why you are worried, but I can categorically state that she will be absolutely fine'. I remember exactly how she said, 'categorically'. She went onto reassure us that Patient A would have a lot of discomfort for three or four dates, maybe up to a week, but that she would then get over it and she would be fine. Patient A and I believed every word that Ms Nixon said because she sounded so confident in what she was saying.'*

In his oral evidence Witness 1 said that you did not tell him to call 111. He said that there was a conversation with you when they were leaving your room when he apologised for taking up your time and said they were worried because of Patient A's heart condition. He said that you said that you could categorically state that Patient A would be fine and would be uncomfortable for four or five days. Witness 1 said that they were both reassured by you. He further added that you did not mention to them about calling anywhere else and, if you had done so, that would have put doubt in their minds. Witness 1 added that there was no mention of 111 or red flags. He said that they totally believed in what you told them. He added that if he had not believed what you said he would have gone to the hospital.

In oral evidence Witness 1 said:

> *'...And to us, that meant a lot because we were worried. And she reassured us, and we felt better because she'd said that. But she did not mention anything about phoning up somewhere else, because if she'd said that, that would have put doubt in our minds. Because we would have felt that she wasn't 100% certain and she was 100% certain.'*

The panel had regard to Patient A's diary entry of 13 December 2019:

‘1.15pm Had an appt with Julia Nixon nurse practitioner
She gave me a good examination sounded my chest and back
Looked in my ears and throat
Said the pain I was having in my chest and back was something called Costochondritis
Which is inflammation of cartilage that joins your ribs to your sternum.
...said it could last for days or even longer – great!!’

The panel was of the view that Witness 1 was consistent in his evidence and Patient A’s diary supports his assertion that you did not advise Patient A or Witness 1 if she experienced any worsening symptoms and/or had any concerns then they should contact out of hours/111.

The panel noted that reference was made in the contemporaneous notes that 111 was mentioned. However, the panel preferred Witness 1’s clear and consistent evidence that out of hours (ooh) and 111 were not mentioned. Witness 1 stated in evidence that if it had been mentioned he would have been on his guard and Patient A’s diary entry supports this and shows that she was reassured by the advice.

The panel concluded that you had a duty to advise Patient A if she experienced any worsening symptoms and / or had any concerns, that she should contact out of hours / 111 and seek further medical advice / review. The panel determined that you failed to do so and therefore charges 3a and 3b are found proved.

Charge 4

That you, a registered nurse, on 13 December 2019 in respect of Patient A:

4) Recorded in Patient A’s notes that you had discussed clinical red flag warning signs with them when you had not.

This charge is found proved.

The panel has had sight of your records of your consultation with Patient A, which state:

'Discussion about clinical red flag warning signs'

Having established that this is your record, and the panel has found in charge 2 that you failed to discuss clinical red flag warning signs, charge 4 is found proved.

Charge 5

That you, a registered nurse, on 13 December 2019 in respect of Patient A:

5) Recorded in Patient A's notes that you had advised them that if they had any concerns at all they should seek review and/or provided details for out of hours/111 when you had not.

This charge is found proved.

The panel has had sight of your records of your consultation with Patient A, which state:

'advised analgesia and any concerns at all review, ooh-111'

Having established that this is your record, and the panel has found in charge 3 that you failed to advise Patient A in relation to out of hours / 111 or around seeking further medical advice / review, charge 5 is found proved.

Charges 6

That you, a registered nurse, on 13 December 2019 in respect of Patient A:

6) Your actions at charge 4 above were dishonest in that you deliberately sought to represent you had discussed clinical red flag warning signs when you knew you had not.

Charge 7

7) Your actions at charge 5 above were dishonest in that you deliberately sought to represent you had advised them that if they had any concerns at all they should seek review and/or provided details for out of hours/111 when you knew you had not.

Charges 6 and 7 are found NOT proved.

The panel then considered both of the charges that allege that you were dishonest in your recording in Patient A's notes. It is the NMC's case that you deliberately sought to represent that you had had a discussion about clinical red flag warning signs and or given advice to Patient A, when you knew you had not. The panel decided to consider both of these charges 6 and 7 together.

In considering these charges the panel took into account the NMC's guidance document DMA-8, entitled 'Making decisions on dishonesty charges', and applied the test for dishonesty set out by the Supreme Court in the case of *Ivey* that it should first ascertain the actual state of your knowledge or belief as to the facts; and then determine whether your conduct was honest or dishonest by applying the objective standards of ordinary decent people. The panel was mindful that the NMC guidance around a panel's approach to determining dishonesty states, *'It is important that the panel considers whether there is an alternative explanation for the nurse's conduct, which points away from them having behaved dishonestly. It can be useful to ask whether their mind was engaged with what they were doing, or could they simply have made an innocent or careless mistake?'*

The panel made the following findings:

The panel has found that you recorded in Patient A's notes having had the discussion/having given the advice when you did not do so. In line with the first limb of *Ivey*, the panel first considered your knowledge and belief at the time that you made the brief entries in Patient A's notes that relate to charges 4 and 5. The panel was satisfied

that you knew, at that time, that you would be expected to discuss clinical red flag warning signs with Patient A and to provide what you have referred to during this hearing as *"safety netting"* advice. Your oral evidence to the panel was that this was something that you *"always do".* You maintained that you had discussed clinical red flag warning signs with Patient A but you could not recall what these were.

The panel determined that you were more likely than not to have made an innocent or careless mistake rather than deliberately misrepresenting that you had discussed clinical red flag warning signs or advised that they should seek review or provide details of out of hours / 111. The panel considered your evidence that you had been working under time pressure at the end of the appointment which could have contributed to this mistake. You said in oral evidence '*the notes are documented as quickly as possible after the patient has left. I did them at the end...so that's why I did them quick [sic]'.*

There had been suggestion in the hearing that you may have retrospectively altered Patient A's notes. The audit trail confirmed that this had not been the case. In any event, the panel determined that when you concluded the consultation and made your entry in the notes, you would have had no knowledge as to what would have transpired in the days ahead in relation to Patient A. As a consequence, the panel determined that you would had no motivation on your part to misrepresent what you told Patient A in the consultation.

In the panel's view, the NMC has provided no cogent evidence to support the fact that you deliberately sought to represent that you had discussed clinical red flag warning signs or advised in relation to ooh / 111 when you knew that you had not.

In line with the second limb of *Ivey*, the panel next applied the objective standard to your knowledge and/or belief at the time. The panel considered that as you believed that you had had this discussion and given the advice, your actions in recording that you had done so did not amount to dishonesty. The panel therefore determined that due to your knowledge and/or belief, an ordinary decent person would not consider that your actions as found proved in charges 4 and 5 were dishonest.

Accordingly, the panel determined that the NMC has failed to discharge its burden in relation to a finding of dishonesty and the panel found charges 6 and 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 your 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Khan invited the panel to take the view that the charges found proved amount to serious misconduct and that your fitness to practise is currently impaired. She referred the panel to NMC guidance, namely: FTP-2a 'Misconduct', DMA-1 'Impairment'; FTP-3a 'Serious concerns which are more difficult to put right'; and FTP-3c 'Serious concerns based on public confidence or professional standards'; as well as relevant case law *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311.

Ms Khan referred the panel to The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2015) (the Code) and identified the following specific, relevant standards where your actions amounted to misconduct: 1.2, 1.3. 2.2 to 2.6, 6.1, 10.1, 10.2 10.3, 13.1 13.2, 13.3, 14.1, 14.2, 19.1, 20.1, 20.2 and

20.3. She submitted that your misconduct in this case is serious and falls short of the standards expected of a registered nurse.

Ms Khan submitted that charges found proved relate to basic nursing skills and practice. She submitted that you failed to safeguard Patient A and recognise the situation that was associated with her physical health. Ms Khan submitted that your lack of advice resulted in Patient A and her family members placing importance and acceptance on your diagnosis and advice regarding her pain.

Ms Khan submitted that good record keeping is a basic fundamental standard required by a registered nurse and your failure to undertake such tasks adequately fell below the expected standards of a registered professional. She submitted that your actions posed a risk to the safety, health and well-being not only to Patient A, but also to other patients that might be in your care.

In conclusion, Ms Khan invited the panel to find that your actions in charges 2, 3, 4 and 5 amounted to misconduct.

Mr Richmond referred the panel to a number of references / testimonials provided on your behalf.

Mr Richmond submitted that in assessing misconduct in relation to the erroneous record keeping and the lack of red flag warnings and appropriate sign posting. He referred the panel to its decision that you were more likely than not to have made an innocent or careless mistake, rather than deliberately misrepresenting that you discussed the clinical red flag warning signs or to seek review or further medical advice and provide details about out of hours /111.

Mr Richmond referred the panel to the testimonial from Ms 2 (reportedly provided on 24 October 2024 and written on the same day), who is a nurse practitioner currently working alongside you at the Haywood Walk-In Centre (the Centre). He submitted that this demonstrates a commitment to your work and dedication to providing an excellent

service as at today's date. He submitted that you continue to enjoy the support of your colleagues, line manager and the wider team.

Mr Richmond submitted that you accept that it would be naïve to think that misconduct should not be found in these circumstances.

Mr Richmond submitted that it is a matter for the panel to determine whether the charges found proved amounted to misconduct.

Submissions on impairment

Ms Khan moved on to 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 Khan submitted that the three questions outlined in paragraph 76, where Mrs Justice Cox referred to Dame Janet Smith's "test", read 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) *….'*

She submitted that limbs a), b) and c) of the test in *Grant* are engaged in your case. Ms Khan submitted that breaches of the fundamental tenets of the profession place patients at risk if records do not accurately reflect what has occurred. She submitted that the record in Patient A's notes that you had discussed the clinical red flag warning signs with them when you had not, placed Patient A at risk of harm. In addition, your action of recording in Patient A notes that you had advised them that if they had any concerns at all that they should seek review or provided details for out of hours /111 when you had not, means that you deliberately sought to represent that you advised Patient A and Witness 1 that if they had any concerns at all, they should seek review or contact those services, when you knew you had not.

Turning to the first of your reflective statements, Ms Khan submitted that you recognise the anger of Witness 1 and understood why he was upset but highlighted that cardiac causes and the need for an ECG had been ruled out. In your reflective piece for NMC revalidation, you stated: *'it was a very unfortunate co-incidence that she passed away so soon after assessment'*. You said that at times, '*horrible things still happen that I can't foresee'* and maintained throughout that you had acted appropriately, stating that you had safety netted Patient A as well and you do not accept responsibility. In a further reflective account, whilst you recognised issues with your documentation, you attributed this in part to the high pressure and time limited service, thereby absolving yourself of any responsibility and apportioning blame elsewhere.

Ms Khan submitted that your reflections are self-serving as you attempt to justify your actions. She submitted that your remorse and acceptance of these matters are limited and the panel cannot be satisfied that there is no risk of your conduct being repeated were you to be permitted to practise unrestricted.

Ms Khan referred to the guidance referenced in DMA-1, whether the nurse, midwife or nursing associate can practise kindly, safely and professionally. She submitted that the panel may wish to consider how an informed member of the public would view these charges compared to what they expect the conduct of a registered nursing professional to be.

Ms Khan submitted that not all breaches of The Code result in a finding of impairment. However, when the breach involves a breach of a fundamental tenet of the profession, a finding of impairment is required to mark the profound unacceptability of the behaviour and to reaffirm proper standards of behaviour. She referred the panel to the questions posed in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) where the court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

She submitted that your conduct raises fundamental questions about your ability, attitude, and suitability to be in the role of a nurse. It therefore cannot be said that you have fully remediated as you continue to refuse to accept responsibility for your actions. She submitted that if the panel find that your conduct is remediable, the NMC submit that it has not been adequately remedied in this case. She submitted that there continues to be a risk of repetition due to your lack of insight and as a consequence, your actions have the potential to put patients at risk of future harm.

Ms Khan concluded that a finding of current impairment is necessary to maintain the public confidence in the profession and in the NMC as a regulator in upholding professional standards.

Ms Khan submitted that despite the passage of time and your ability to practise, there continues to be very limited insight into the impact your actions might have had on

patients or colleagues and the wider nursing profession. She raised the fact that there is also an ongoing investigation in relation to a referral from the Surgery, the allegations themselves are not dissimilar to the charges considered in this case. The allegations involve your failure to ensure patient safety, poor record keeping, failure to recognise the worsening conditions of patients and a failure to escalate the concerns during the period between July 2022 and 10 March 2023.

Ms Khan submitted that the panel may conclude that those allegations in their current form are not dissimilar to the allegations that you had initially been charged with in respect of these proceedings. She submitted that on 6 December 2023 and 16 May 2024, interim conditions of practice were confirmed and continued. She further submitted that the Case Examiners have recently confirmed that there is a case to answer in respect of those allegations. Ms Khan submitted that it is a matter for the panel to determine how much weight it places in respect of this information.

Ms Khan submitted that your failures relate to basic nursing care and that you have undermined the reputation of the nursing profession. She submitted that a finding of impairment is necessary to uphold the standards of the nursing profession. She invited the panel to make a finding of current impairment.

Mr Richmond referred the panel to the 'test' in *Grant.* He submitted that in reference to your reflective pieces the panel can draw from this that you have not stopped thinking about the consultation with Patient A on 13 December 2019, neither have you stopped thinking about Patient A's passing a few days later and Patient A's family in relation to your record keeping.

He submitted that you have never been shy to acknowledge that you wished your record keeping had been more in depth on this occasion. He submitted that you are entirely sensitive to the situation as a whole and of the sad passing of Patient A. He submitted that the panel will be aware that you have recounted how you have replayed things over in your own mind and to how the consultation could have gone differently.

Mr Richmond submitted that you have subsequently completed training to refresh your skills on chest pain assessment and management to ensures your skills are kept up to date and to benefit patient well-being. He submitted that the panel may be concerned that you had denied the charges that the panel has found proved and, as such, you are not showing significant or relevant insight. He submitted that through your submissions, evidence and reflections in this matter, you have demonstrated insight and there is no real risk of repetition in the future.

Mr Richmond submitted that throughout your career, you have prided yourself in your commitment to the public and colleagues. He submitted that this incident of 13 December 2019 should be placed in the context of your career as a whole. He submitted that misconduct has been remediated since you continue to work at the Centre and enjoy the support of your line manager and other colleagues. He referred the panel to the reference from your colleague Ms 2. He also highlighted a reference from the Centre manager and submitted that this demonstrates that you have been working well in your present role despite the imposition of interim conditions of practice.

Mr Richmond submitted that you registered with the NMC around September 2009. He submitted that with the exception of this incident and the other matter currently under investigation by the NMC, for which you are now working under interim conditions of practice, you have an otherwise unblemished career and record.

Mr Richmond referred to the separate matter currently being investigated by the NMC. He submitted that the panel should adopt a high degree of caution when considering the current interim conditions of practice order. He submitted there have been no findings made with respect to those allegations. He submitted that you continue to partake in regular continuous professional development in your current role whilst working at the Centre.

Mr Richmond submitted that you have shown remorse and insight through your submissions. In all of the circumstances, a member of the public would recognise that you are a committed and hard working individual who made an isolated error. He submitted therefore, that the likelihood of reputation is low.

Mr Richmond referred the panel to the case of *PSA v GMC and Uppal* [2015] EWHC 1304 (Admin). He submitted that in relation to dishonesty, this present case is not analogous to that case. He referred the panel to *Meadows v GMC* [2006] EWCA Civ 1390 which confirms that the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings, but to protect the public against the acts and omissions of those who are not fit to practise. He submitted that you accept that it would be naive to think that misconduct should not be found in these circumstances. He submitted that that the public interest would be satisfied if a finding of misconduct was imposed.

Mr Richmond submitted that this was an isolated lapse in an otherwise unblemished career and that the difference between this case and *Uppal* is that no facts have been proved in relation to dishonesty. Further, it was found that the risk of repetition was extremely low, not least because of insight in the steps taken to remediate. He submitted that, applying the present facts, the risk of repetition here is low. He submitted that you have continued to work since the incident under interim conditions of practice and you enjoy the ongoing support of your colleagues, in particular your line manager.

He referred to your highly supportive character references which cover both your past and present performance. He submitted that this tends to show that there is no real or substantial risk of repetition.

In conclusion, Mr Richmond submitted that there is no real risk of repetition and therefore your fitness the practise is not impaired by reason of your misconduct.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), General Medical Council v Meadow [2007] QB 462 (Admin) and Schodlok v General Medical Council [2015] EWCA Civ 769, *Cohen and Grant*.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance* 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.'* 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 your actions in the charges found proved individually and collectively, did fall significantly short of the standards expected of a registered nurse, and that these amounted to a breach of the Code. Specifically:

The panel determined these parts of the code have been breached:

> ***'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*
>
> *2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care*
>
> ***6 Always practise in line with the best available evidence***
> *To achieve this, you must:*
> *6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services*
>
> ***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:*

10.2 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 ...

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

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

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

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

Charges 2, 3a and 3b

The panel considered each of these charges separately. However, the reasoning and conclusions in respect of finding misconduct for each are the same and therefore addressed together in this determination.

The panel placed weight on Witness 3's expert report, which highlights how your actions fell far below the standards expected of a registered nurse, as stated below:

> *'It is best practise to advise all patients irrespective of presenting complaint of potential red flags and the need to seek review should there be any changes or concerns.'*
>
> *...*
>
> *'Patient A's husband, however, reports in his statement dated the 3rd of July 2022. '[YOU] did not tell us to call 111 or seek further medical advice. If Patient A became too ill [sic]. She did not say anything like that. She was categorically sure that Patient A would be fine.' if this evidence is accepted, this would represent conduct that fell far below the standard expected. Lack of sign posting and explanation of red flags can lead to serious risk of harm to patients. They will be unaware of symptoms that are potentially life threatening or need further review. This is always undertaken at the end of every consultation.'*

The panel determined that there was no discussion about red flag warning signs or what to do in the event of worsening symptoms and / or having any concerns by contacting ooh/111 or seeking further medical advice/review. The panel was of the view that these were not basic errors, rather they were failures in fundamental nursing practice.

The panel was of the view that Patient A and Witness 1 would have been unaware of symptoms that could potentially be life threatening or need further review. The panel therefore determined that any patient would expect when they have a consultation with a nurse practitioner that essential information such as this should be given and discussed. A failure to do this could result in serious risk of harm to patients.

The panel heard from Witness 1 that he and Patient A were totally reassured by what you had told them about Patient A's condition of costochondritis. On the basis of the information you had given that the pain would last for three or four days or up to a week, they remained at home and did not seek further medical attention. This was because of the reassurances you had given them about the pain and that you had failed to give them advice on red flag warning signs or what to do in the event of Patient A's

symptoms worsening and / or having any concerns by contacting ooh/111 or seeking further medical advice/review.

The panel determined you had a duty to discuss red flag warning signs as set out in charge 2 and to advise Patient A as set out in charges 3a and 3b. The panel determined that your failures in this regard fell far below the standard expected of a registered nurse.

Charges 4 and 5

The panel considered each of these charges separately. However, the reasoning and conclusions in respect of finding misconduct in each are the same and therefore addressed together in this determination.

The panel determined that the making of accurate entries / notes in clinical records is an essential and fundamental aspect of nursing practice. The panel took into account that in both your oral and written evidence you stated that your documentation could have been in more depth. The panel also had regard to Witness 3's expert report (as quoted above).

The panel has determined that your record keeping inaccurately reflected what you said in the consultation to Patient A in that the advice was not given and there was no discussion of red flag warning signs. The panel therefore determined that this was a clear departure from the standards and fell far short of what is expected of a registered nurse and amounts to misconduct.

In these circumstances, the panel determined that your actions in charges 2, 3a, 3b, 4 and 5 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 established, your 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 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) ...'

The panel finds that limbs a), b) and c) are engaged. The panel determined that Patient A was put at risk of harm as a result of your misconduct. Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered your reflective pieces. The panel was of the view that you appear to exonerate yourself and do not take full responsibility for your actions. The panel noted in your undated written response to the NMC that you stated *'the Ombudsman concluded there was no wrongdoing on my party[sic] and as such no case to answer.'* You conceded in response to a panel question that this was not factually correct. The panel was of the view that your focus was on yourself and not what you could have done differently in relation to all of the charges and was not patient-centred. The panel determined that you have not demonstrated insight or a full understanding of your failures and how this impacted negatively on Patient A and her family, colleagues and the reputation of the nursing profession.

The panel had regard to your various references provided all of which were supportive of you and some made reference to having knowledge of the regulatory concerns. The panel noted the reference from your current line manager who is supervising you working under interim conditions of practice relating to the further allegations, and another from a colleague who states that you are abiding by those interim conditions of practice.

The panel was satisfied that the misconduct in this case is capable of being remediated. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. Mr Richmond told the panel that you had undertaken training in chest pain assessment and management. However, there was no certificate provided to the panel or any details of what the training had entailed.

The panel had been informed by Ms Khan that your practice has been restricted since June 2023 due to further allegations. These interim conditions of practice require indirect supervision and monthly meetings with your manager to discuss aspects of your practice, including record keeping. This may mitigate some of the risks of repetition. However, despite these interim conditions of practice you have not provided this panel with any evidence of a personal development plan, recent reflections, training in relation to the charges found proved, such as: accurate record keeping; patient consultation skills; effective communication skills including listening and working in partnership with patients; and evidence based practice in relation to safety netting and providing advice. Therefore, there is limited evidence that you have strengthened your practice or that the risk of repetition has been reduced. The panel finds that there is a risk of repetition and therefore finds that your fitness to practise is impaired on the ground of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is also required because of the seriousness of the charges found proved. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

The panel placed very limited weight on the new regulatory concerns brought to its attention during the submissions on impairment by the NMC. The panel was of the view that there is an important difference between a registrant having previous regulatory findings against them of a similar nature, compared with your situation where further allegations (again of a similar nature) are currently being investigated by the NMC. The panel determined that those concerns are due to be heard by another fitness to practise committee at a substantive hearing in due course.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Ms Khan referred the panel to the NMC's guidance San-1 'Factors to consider before deciding on sanctions' where it sets out matters of proportionality, aggravating features and mitigating features; San-2 'Considering sanctions for serious cases' and San-3 **'**Available sanction orders'.

Ms Khan informed the panel that the NMC's sanction bid is a 6-month suspension order. She submitted a six month suspension order is the only order which will meet the aim of maintaining public confidence in the profession and to declare and uphold proper professional standards and are proportionate to the charges found proved.

She submitted that the following aggravating features are present in your case: limited insight; conduct which put Patient A at risk of suffering harm; a failure to escalate and an attitudinal problem.

Ms Khan submitted that Patient A was vulnerable and due to this she was at a significant risk of harm. She submitted that your decision making and quality of record keeping were important factors in this case. She submitted that your failure to demonstrate any meaningful level of insight, remorse and remediation into your failings indicate an attitudinal problem.

Ms Khan submitted that either taking no further action or imposing a caution order are not suitable in your case, given the serious misconduct found proved. She submitted that a conditions of practice order would not be an appropriate sanction as it is difficult to remediate attitudinal concerns and further, would not address the public protection

and public interest considerations in your case. She submitted that you were fully aware of what your limitations were, what your actions were and how they breached the basic tenets of nursing practice. She submitted that for these reasons there are no practicable or workable conditions that could be formulated to address the misconduct identified in your case.

Mr Richmond invited the panel to impose a conditions of practice order. He submitted that any conditions imposed should include some specific focus on training to address the specific issues found by the panel. He submitted that this would allow you an opportunity to remediate the misconduct by addressing the gaps in your insights, strengthen your practise and demonstrate that, over time, you no longer present a risk to the public or patients.

Mr Richmond submitted that a conditions of practice order would allow you an opportunity to continue your otherwise good clinical practice and underline and reinforce the need to ensure that you carry out safety-netting of patients, give red flag warnings during consultations, signpost patients appropriately, as well as ensuring that your record keeping is up to the required standard. He submitted that part of your training under supervision could include a preparation and submission of reflective accounts to be submitted to the NMC. This will help to remedy the gaps as identified in the panel's decision. He highlighted that you have engaged with these proceedings and have shown your ability to work under conditions of practice with no reported issues from your current workplace line manager.

Mr Richmond submitted that a more severe sanction is not necessary. He submitted that a suspension order is not proportionate to the charges as it would not take account of the insight you have shown and your engagement with the process, as well as your long career without any other proven issues of this nature, albeit he acknowledged the second referral to the NMC. He also submitted that striking off order would be wholly disproportionate in these circumstances for all the reasons he has referred to earlier in his submissions. He submitted that a striking off of a dedicated nurse would be unduly harsh in terms of the public interest.

The panel heard and accepted the advice of the legal assessor who referred to the case of *Raschid and Fatnani v GMC* [2007] 1 WLR 1460.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The limited insight shown into your failings and the impact these had
- Your conduct put a vulnerable patient at risk of suffering harm
- Your attitude to taking responsibility for your actions
- You did not prioritise Patient A's safety

The panel also took into account the following mitigating features:

- A number of supportive testimonials provided by your line manager and work colleagues

In making this decision, the panel carefully considered the submissions of Ms Khan in relation to imposing a sanction of a 6-month suspension order which the NMC was seeking. However, despite these charges being of a serious nature and attitudinal issues identified, the panel did not agree that workable and practicable conditions of practice could not be formulated to address the charges found proved.

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 not

address the risks identified nor would it be proportionate or 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 your 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 the matters it has found proved and the related misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *...*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel noted

that whilst it found you to have attitudinal issues, it was of the view that this does not appear to be a case where there is evidence of deep-seated attitudinal problems and has the potential to be addressed with a time for reflection. The panel concluded that, based on the evidence it has had regard to, with appropriate safeguards, you should be able to work under conditions and continue to practise, albeit with restrictions.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order. The panel concluded that there are specific workable and measurable conditions which could be formulated in this case that would address the risks identified by restricting your practice and therefore protect the public.

The panel was of the view that to impose a suspension order would be disproportionate and would not be a reasonable response in the circumstances of your case.

Having regard to the matters found proved, the panel has concluded that a conditions of practice order will also mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must limit your nursing practice to one substantive employer which can be an agency. Any clinical placement via agency must last a minimum of three months.

2. You must ensure that you are supervised by another registered nurse any time you are working. Your supervision must consist of working at all times on the same shift as, but not always directly observed by, another registered nurse.

   Ten percent of your patient consultations must either be directly observed by your line manager or recorded (with patient consent). All observed consultations and recordings should be reviewed by your line manager in conjunction with the relevant patient notes.

   The review of your patient consultations should focus on the issues outlined in Condition 4 below.

3. You must not be the sole nurse or the nurse in charge on any shift.

4. You must meet with your line manager every month for a reflective discussion focussing on your performance and progress in the following areas:

   - The accuracy of your record keeping
   - The effectiveness of your patient consultations
   - The effectiveness of communication skills including listening skills and working in partnership with patients
   - How you practically provide safety netting advice, clinical red flag warning signs, signposting and what your rationale for the advice given was
   - How you demonstrate that you prioritise patient safety.

5. You must work with your line manager to create a personal development plan (PDP). Your PDP must address the areas outlined in Condition 4 and any relevant training you have undertaken to strengthen your practice in these areas.
   You must:

• Send your NMC case officer a copy of your updated PDP every 4 months and the next review hearing or meeting.

6. To provide at the review hearing or meeting a comprehensive reflective piece focussing on your insight into your failings and the impact these had on Patient A and her family, colleagues and the reputation of the profession. In addition, you should evidence how you have strengthened your practice in these areas.

7. You must send to the NMC every 4 months and the next review hearing or meeting a report from your line manager, commenting on your performance and progress in the areas highlighted in Condition 4. This should also include details of your line manager's observations and review of recordings of your consultations as referenced in Condition 2 above should be provided.

8. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

9. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

10. You must immediately give a copy of these conditions to:

a) Any organisation or person you work for.
b) Any agency you apply to or are registered with for work.
c) Any employers you apply to for work (at the time of application).
d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

11. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

12. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at any future review hearing

Interim order

As the conditions of practice 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 your own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Khan she submitted that an 18-month interim conditions of practice order is appropriate and proportionate in this case for the same reasons already addressed by the panel regarding the substantive order.

Mr Richmond raised no objection to the application.

Decision and reasons on interim order

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

The panel concluded that an interim suspension order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim conditions of practice order for a period of 18 months, with the same conditions that are set out in the substantive order, on the basis that the appeal process, if commenced by you, might last for that period of time.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive interim conditions of practice order 28 days after you are sent the decision of this hearing in writing.

This will be confirmed to you in writing.

That concludes this determination.