Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Monday, 2 September 2024 – Wednesday 18 September 2024

Virtual Hearing

Name of Registrant:	**Samantha Jamieson**
NMC PIN	90I1170E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (13 September 1993)
Relevant Location:	Portsmouth
Type of case:	Misconduct
Panel members:	Louise Fox (Chair, Lay member) Shorai Dzirambe (Registrant member) Paul Hepworth (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	John Kennedy
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Miss Jamieson:	Not present and unrepresented
Facts proved:	Charges 1, 2a, 2b, 3, 5, 6a, 6b, 7a, 10, 11a, 11b, 14a, 15, 17a, 17b, 22a, 22c, 23b, 23c, 26a, 26b, 26c and 26d

Facts proved by admission:	Charges 4, 6c, 7b, 8a, 8b, 9a, 9b, 9c, 12, 13, 14b, 16, 18, and 19.
Facts not proved:	Charges 17c, 20, 21, 22b, 23a, 24a, 24b, and 25
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Note on Name of Registrant

At the outset of the hearing the panel noted that in the exhibits and witness statements Miss Jamieson is sometimes identified as Samantha Jamieson-Davies, SJD, or Mrs Jamieson-Davies. However, the panel was satisfied that on her entry in the Register her name is listed as Miss Jamieson and therefore the panel decided to use the title and name as it appears on the Register.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Jamieson was not in attendance and that the Notice of Hearing letter had been sent to Miss Jamieson's registered email address by secure email 25 July 2024.

Mr Edwards, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Jamieson's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Miss Jamieson

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

Mr Edwards referred the panel to the documentation from Miss Jamieson which included an email dated 26 August 2024 stating:

> *'I have received the bundle from the NMC. I confirm the notice of hearing and also confirm that I have agreed to waive the notice period. As discussed, I will not be attending but agree for the panel to proceed in my absence*.'

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Miss Jamieson;
- Miss Jamieson has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;

- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Eight witnesses have attended to give live evidence,
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2017 to 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Jamieson in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Miss Jamieson has also made some written submissions which the panel can take into account. Furthermore, the limited disadvantage is the consequence of Miss Jamieson's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented.

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

Decision and reasons on first application to amend the charge

The panel heard an application made by Mr Edwards, on behalf of the NMC, to amend the wording of charge 26d.

The proposed amendment was to correct a typographical error. It was submitted by Mr Edwards that the proposed amendment would replace the reference to charge 27 to be charge 26. He submitted that there is no charge 27 and that it is therefore clearly a typographical error and that it should be amended to be accurate.

> '26)d) Your actions at Charges 6, 17 and 27 **26** (a) – (c), created an intimidating and / or hostile and / or degrading and / or humiliating environment for one or more nurses and/or staff'

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Jamieson and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, a Registered Nurse:

1) On 9 November 2017 failed to arrange for a senior nurse to cover the overnight shift on the Stroke Ward.

2) On 17 July 2018:
   a) failed to escalate requests for patients scans
   b) subsequently incorrectly indicated to the doctor that you had done so

3) Your actions at Charge 2(b) were dishonest in that you knew that you had not escalated the requests.

4) On 26 February 2019 failed to undertake a test for infection on Patient F

5) On 27 May 2019 failed to attend a fire alarm and said “let them burn”

6) In June 2019 used threatening behaviour towards Colleague A by:
   a) Grabbing them by the collar
   b) Pushing them against the wall
   c) Saying “I’m giving you flexible working, if you leave I’m going to kill you”

7) On 2 August 2019 failed
   a) to recognise and respond appropriately to Patient G’s deterioration
   b) to respond appropriately to concerns raised by Patient G’s family

8) On 25 August 2019 failed to administer Patient A’s medication in accordance with their care plan and / or dietary requirements in that you:
   a) Failed to crush Patient A’s tablets
   b) Failed to reposition Patient A into an upright position

9) On15 September 2019 failed to record
   a) whether insulin had been administered to Patient B
   b) any update in Patient B’s notes or handover
   c) whether insulin had been administered to Patient C

10) On 15 September 2019 attempted to use the incorrect syringe to administer a dose of Insulin.

11) On 15 September 2019:
   a) Failed to administer a patient’s insulin at the correct time
   b) When reminded by Colleague B replied “I don’t give a fuck”

12) On 18 September 2019 failed to sign medication records indicating the correct day for the administration of insulin to Patient I.

13) On 19 September 2019 failed to undertake neurological observations on Patient H following their unwitnessed fall.

14) On 20 September 2019 failed to record
    a) whether insulin had been administered to Patient I
    b) whether 3 medications had been administered

15) On 20 September 2019 failed to administer a Fentanyl patch to Patient J.

16) On or about 23 September 2019 left a used unsheathed needle on the medications trolley.

17) Between January 2018 and 29 September 2019 failed to support:
    a) Colleague A in January 2018 in their return to practice
    b) Colleague B on 20 September 2019 to prepare for attendance at a meeting to consider actions into patient safety incidents, (a “SWARM” meeting)
    c) Colleague C in completing medication training

18) On 28 September 2019 failed to conduct observations on Patient D’s blood sugar levels.

19) On 10 October 2019 instructed 3 nurses to administer an unsafe lift on Patient K following an unwitnessed fall.

20) On 12 October 2019 failed to act in accordance with Patient L’s care plan and administered an enema to Patient L.

21) On or about 14 October 2019 failed to undertake an audit on Deprivation of Liberty Standards for a patient.

22) Used offensive language towards Colleague B:
    a) On 22 November 2019 you said to them “that’s because you’re a cunt”
    b) Around December 2019 you said “try not to be a cunt it’s Christmas.”
    c) On another occasion in December 2019 you said “that’s because you’re a twat”

23) On 5 December 2019 you told Colleague D:
    a) to leave the ward,
    b) to pick up her bag
    c) to take it with her.

24) Your actions at Charge 23 were:
    a) racially motivated
    b) discriminatory

25) Dishonestly made retrospective entries to records to conceal errors you had made.

26) a) Attended work when off duty and brought cakebars with a picture of Roald Dahl’s Grand High Witch on the packaging for Colleague B
    b) Described colleague B as “Witch Hunt coordinator”
    c) Said to Colleague B “you wouldn’t require fixed working if you weren’t such a passive wife”
    d) Your actions at Charges 6, 17 and 26 (a) – (c), created an intimidating and / or hostile and / or degrading and / or humiliating environment for one or more nurses and/or staff

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

Decision and reasons on second application to amend charge

After the charges had been read and the panel considered the admissions by Miss Jamieson in the Case Management form (CMF), Mr Edwards made a second application to amend the charges.

Mr Edwards made this application in relation to charges 11a, 22a, 12, and 21. The amendment on charge 11a is to address the questions raised by the panel about what the drug referenced is. In making enquiries Mr Edwards discovered that there had been a clerical error in recording the drug in the charge in line with the evidence which the panel will hear in oral evidence. The charge currently states it is the drug warfarin; however, it should read insulin. Mr Edwards submitted that while this changes the specific drug it does not substantially change the mischief of the charge which is about the failure to administer medication at the correct time.

The amendment on charge 22a is to also address questions raised by the panel about the correct date being referenced. Mr Edwards submitted that while the charge currently reads it was on '*9 December 2019…'* in making enquiries he discovered that while the date the incident was first reported was on 9 December 2019 it was alleged it was actually said on 22 November 2019. He submitted that to change the date to read 22 November 2019 would be in line with the evidence presented to the panel and to correct a clerical error that occurred.

Mr Edwards made a final application to amend charges 12 and 21 to change the current wording which abbreviated the month listed and that to properly be consistent these should be written out in full.

The proposed amendments are:

11) On 15 September 2019:
    a) Failed to administer a patient's ~~warfarin~~ **insulin** at the correct time

12) On 18 Sept**ember** 2019 failed to sign medication records indicating the correct day for the administration of insulin to Patient I.

21) On or about 14 Oct**ober** 2019 failed to undertake an audit on Deprivation of Liberty Standards for a patient.

22) Used offensive language towards Colleague B:
    a) On ~~9 December~~ **22 November** 2019 you said to them “that’s because you’re a cunt”

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel considered the amendment to charge 11a, it noted that while this amendment does change the particular drug mentioned the chief mischief of the charge, namely administering medication at the incorrect time, remains the same. The panel considered that in the evidence heard it appears that on 15 September 2019 there are two alleged incidents involving medication, one involving warfarin and one involving insulin. The panel considered that it appears to have been a clerical error in drafting the charge as in the oral evidence witnesses are clear it was insulin that was administered at the incorrect time. The panel decided therefore that the proposed amendment would be in line with the overall interest of justice and there would be no prejudice to Miss Jamieson or injustice to either party. The panel therefore allowed the amendment to charge 11a.

The panel considered the amendments to charges 12 and 21, noted that they are both similar and to correct the style of wording to ensure consistency throughout all the charges. The panel considered that there is no substantive change in these that could cause any prejudice or injustice to either party. The panel therefore decided to allow the amendments to charges 12 and 21.

The panel considered the amendment to charge 22a, and noted the submissions by Mr Edwards which were provided in response to inquiries the panel had previously made. The panel accepted that it appears to have been a clerical error in the dates with the differences being explained as when the alleged statement was said by Miss Jamieson and the date on which it was first reported. The panel considered that there would be no injustice to Miss Jamieson as the chief mischief of the charge remains the same, and that the proposed amendment is to ensure that the charge is consistent with the evidence heard and would correct a clerical error. The panel therefore decided to allow the amendment to charge 22a.

Decision and reasons on third application to amend the charge

After all witnesses had completed giving oral evidence, Mr Edwards made an application to amend charge 14a. He made this application as in the evidence both given orally and in the documents that the drug referred to in this charge should be insulin and not warfarin as written. He submitted that similar to the previously accepted amendment to charge 11a this amendment is to address a clerical error in the charge and does not substantially change the chief mischief of the charge.

The application to amend the charge is:

14) On 20 September 2019 failed to record
    a) whether ~~warfarin~~ **insulin** had been administered to Patient I

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel considered the amendment to charge 14a. It noted that while this amendment does change the particular drug mentioned the chief mischief of the charge, namely administering medication at the incorrect time, remains the same.

The panel considered that it appears to have been a clerical error in drafting the charge as in the oral evidence witnesses are clear it was insulin that was administered at the incorrect time. In addition, there is evidence before the panel that Miss Jamieson was aware that the alleged medication error of Patient I related to insulin and not warfarin. The panel decided therefore the proposed amendment would be in line with the overall interest of justice and there would be no prejudice to Miss Jamieson or injustice to either party. The panel therefore allowed the amendment to charge 14a.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Edwards under Rule 31 to allow the hearsay testimony into evidence. The hearsay evidence is appendices 3, 4, 5, 7, 8, 22, 29, 31, 37, 38, and 39 of the *Investigation Report 17 August 2020.* While the report itself and the other appendices not listed above have been accepted into evidence as Exhibit HH/1 the enumerated appendices were not adopted in this exhibit as they contained hearsay evidence from people who are not called to give evidence at this hearing. Mr Edwards informed the panel that in light of the large number of witnesses that would have to be called to testify to these appendices it would be infeasible and disproportionate for the panel to hear from them all in order to conclude the hearing in an expeditious manner. He therefore made an application that the appendices should be accepted as hearsay evidence as they are highly relevant and were produced as part of the Portsmouth Hospital NHS Trust's (the Trust) internal investigation.

In the preparation of this hearing, the NMC had indicated to Miss Jamieson in the CMF, dated 7 March 2024, that it was the NMC's intention for these appendices to be included in the evidence bundle before the panel. Despite knowledge of the nature of the evidence included in these appendices, Miss Jamieson made the decision not to attend this hearing. The panel had regard to the email from Miss Jamieson dated 26 August 2024 which stated:

'Also I wish to confirm that I do not agree to the contents within appendices; 3,4,5,7,8,22,29,31,37,38 & 39 within the exhibits bundle being accepted as hearsay, furthermore I object to the applications.'

The panel noted that the appendices had been prepared as part of the local investigation carried out by the Trust, and that the report they are part of is before the panel.

The panel considered that as Miss Jamieson had been provided with a copy of the appendices and, as the panel had already determined that Miss Jamieson had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine witnesses in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered the test for admitting hearsay evidence as set out in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). The panel concluded that for appendices 3, 4, 7, 8, 22, 29, 31, 37, 38, and 39 the evidence is not sole and decisive for any of the charges. However, in considering appendix 5 the panel noted that it can be seen to be sole and decisive to charge 17c. The panel bore in mind though that the information contained within appendix 5 is recorded and referenced in the body of the report which is already in evidence before the panel. Therefore, the issue of appendix 5 being sole and decisive would be more appropriate as regards what weight the panel gives it when considering that charge.

The panel noted that while Miss Jamieson has objected to the appendices in both content and in the panel accepting them as hearsay, there is no detail provided beyond a statement of objection. Therefore, the panel is unable to fully consider the nature and extent of the objection to admitting the appendices. The panel noted that the appendices were prepared as part of a local disciplinary investigation carried out by the Trust and there is no suggestion that they would have been fabricated or in any way fanciful. The panel noted that the allegations are very serious and this is likely to remain the case with or without the hearsay bundle.

The panel noted that there had been no attempt by the NMC to secure the attendance of the witnesses referenced in the appendices; however, the panel accepted that given the large amount of witnesses already called to attend this hearing, and the significant number of additional witnesses that would be required to attend to speak to all the appendices it would be a disproportionate action to take and would have unduly lengthened the time to conclude the hearing. The panel was satisfied that it would not have been in the overall interest of justice to have all the additional witnesses before the hearing and that there is no prejudice to either party by this action, which is in accord with standard practice. The panel noted that Miss Jamieson did have sight of the appendices before the hearing and that an application to admit them as hearsay evidence would be made.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of appendices 3, 4, 5, 7, 8, 22, 29, 31, 37, 38, and 39 of the *Investigation Report 17 August 2020*, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

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

During the course of the hearing, Mr Edwards made a request that this case be held in private on the basis that [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

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

The panel decided that those parts of the hearing that make reference [PRIVATE], should be held in private but that the rest of the hearing shall be held in public.

Background

The charges arose whilst Miss Jamieson was employed as a registered nurse by the Trust in 2017 to 2020.

The allegations from the Trust relate to concerns about Miss Jamieson's clinical competence, her conduct, and her attitude towards multiple patients and colleagues and cover a prolonged period.

Decision and reasons on facts

Once the charges were read out, the panel had regard to the completed CMF which was submitted to the NMC on 7 March 2024 by an officer of the Royal College of Nursing (RCN) who was at that time acting as Miss Jamieson's representative. The CMF stated that Miss Jamieson made full admissions to charges 4, 6c, 7b, 8a, 8b, 9a, 9b, 9c, 12, 13, 14b, 16, 18, and 19. The panel noted that during proceedings an application was made and accepted to charge 12, which Miss Jamieson had admitted to in the CMF. However, as noted above the panel considered this amendment to be a typographical change to correct a spelling error; therefore, it considered there is no unfairness in continuing to accept Miss Jamieson's admission to this charge.

The panel noted that charge 11a was admitted in the CMF but as the panel have questions around this charge and the drug referred to in it, it has decided not to accept Miss Jamieson's admission on this charge.

The panel noted that Miss Jamieson had admitted to charge 14a in the CMF and while this was accepted at the start of the hearing in light of the third application to amend the charges which the panel accepted, on Day 7 of the hearing, it would therefore be unfair to continue to accept this admission. The panel noted that while the chief mischief of the charge remains the same post amendment the particulars of the charge have been

changed since Miss Jamieson made the admission in the CMF. Therefore, the panel have decided to find charge 14a to be disputed and will consider it as part of findings on facts.

The panel therefore finds charges 4, 6c, 7b, 8a, 8b, 9a, 9b, 9c, 12, 13, 14b, 16, 18, and 19 proved in their entirety, by way of Miss Jamieson's admissions, in the CMF.

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

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

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

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

- Witness 1: Band 5 Registered Nurse at the Trust who worked on the ward
- Witness 2: Staff Nurse at the Trust working on the ward
- Witness 3: Specialist Nurse at the Trust working on the Stroke Ward
- Witness 4: Locum Stroke Consultant doctor at the Trust
- Witness 5: Agency Registered Nurse

- Witness 6: Senior Matron for Older Persons Medicine at the Trust
- Witness 7: Deputy Divisional Nurse Director for Network Services and Senior Matron for Cancer Care Group at the Trust, now retired
- Witness 8: Senior Sister for Older Persons Medicine at the Trust

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

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

Charge 1

> On 9 November 2017 failed to arrange for a senior nurse to cover the overnight shift on the Stroke Ward.

This charge is found PROVED

In reaching this decision, the panel took into account the evidence of Witness 3 and Witness 7. The panel noted that Witness 3 stated that on the overnight shift there was no cover arranged for the '*1788 bleep'*, which is a critical role needed to be filled by a senior nurse who is on call to cover any emergencies in the hospital. The nurse who was on the rota for this shift had informed the Trust at 13:15 they would be unable to attend work that day. The witness stated that Miss Jamieson was informed by the ward clerk of the call

and, as the ward manager Miss Jamieson would have been expected to take action to arrange for cover of the night shift.

In their evidence Witness 7 also confirmed that Miss Jamieson did receive the call about the nurse who was on rota being unavailable for the night shift. As the member of management team who received the call Miss Jamieson's role was to escalate this and to seek to ensure there was an appropriately skilled nurse able to provide overnight cover. Instead, Witness 7 notes, that there was no indication during the local investigation that Miss Jamieson did anything and that when her shift ended at 17:15 Miss Jamieson told Witness 3 that there was no senior cover before leaving.

In her written submission Miss Jamieson stated:

> *'I would not have failed to ensure nursing cover overnight, the off duty was sent to the matrons for approval.'*

The panel noted; however, that Miss Jamieson did not comment on the specific night in question and preferred the evidence of Witnesses 3 and 7 as their accounts are supported by the local investigation report which was carried out at the time.

Charge 2 in its entirety

> On 17 July 2018:
> a) failed to escalate requests for patients scans
> b) subsequently incorrectly indicated to the doctor that you had done so

This charge is found PROVED

The panel considered sub-charges a and b together in this charge as they are inextricably linked and the evidence for both comes from the same witness.

The panel noted that Witness 4 stated that on 17 July 2018 they informed Miss Jamieson that two patients were requiring a discharge dependent scan that day in order for them to be discharged as soon as possible from hospital. Miss Jamieson had been asked by the witness at the morning multidisciplinary team (MDT) meeting to escalate this request for the scans to be completed that day.

Witness 4 told the panel that by chance they met the manager responsible for the scans and when they enquired if the request had been escalated was told that nothing had been escalated that day.

Witness 4 went back to Miss Jamieson to confirm if the request for scans had been escalated and the witness said that she was adamant that they had been done. They explained that it was the same on previous occasions and that there was a pattern of the scans not getting done when Miss Jamieson was on duty. Witness 4 explained to the panel that this meant that the patients' discharges were delayed.

Miss Jamieson denied this charge stating:

> *'I have never knowingly not escalated an incident when a situation had required it, as this would be dishonest and I am not a dishonest person and will / would have taken responsibility for my actions.'*

However, Miss Jamieson did not give any information about this specific allegation on this date and the panel preferred the oral evidence from Witness 4 supported by contemporaneous documentation including the email of complaint on the same day and subsequent statements for the local investigation.

Charge 3

> Your actions at Charge 2(b) were dishonest in that you knew that you had not escalated the requests.

This charge is found PROVED

In reaching a decision on this charge the panel had regard to the case of *Ivey v Genting Casinos Ltd t/a Crockford* [2017] UKSC 67 which has set out the test for determining dishonesty.

The panel noted that at the local investigation meeting Miss Jamieson stated that she would have escalated any request from the consultant doctor. However, the panel was satisfied that Miss Jamieson failed to escalate the request as described by Witness 4. The panel was also satisfied that Miss Jamieson's claim when challenged by Witness 4 that she had escalated the scans was, as she well knew, untrue. The panel decided that Miss Jamieson's subjective knowledge or belief as to the facts was that she knew that she had not escalated the requests. The panel was satisfied that lying about escalating the request when she had not done so would be seen as dishonest by the objective standards of ordinary decent people. Accordingly, the panel found this charge proved.

Charge 5

> On 27 May 2019 failed to attend a fire alarm and said "let them burn"

This charge is found PROVED

In reaching its decision the panel had regard to the statement of Witness 7 which stated:

> *'On 27 May 2019 [Miss Jamieson] was the bleep holder when the fire alarm went off, and she was alerted of this over the bleep. [Miss Jamieson] didn't go onto Ward F4 to help. She was working with HCSW … at the time, who heard her comment "Let them burn". The bleep holder is the point of contact to deal with any staffing issues and escalations.'*

This was corroborated by the oral evidence of Witness 8 who was present when the incident occurred. They stated that they told Miss Jamieson that she had to respond to the bleep and if she did not then Witness 8 would go themselves. At that point they stated that Miss Jamieson did go and investigate and returned to say there had been a fire in a microwave. Witness 8 stated to the panel that the incident was very distressing as Miss Jamieson's actions placed patient safety at risk and was not in accordance with the fire plan that was in force on the ward.

Miss Jamieson stated she recalled the incident and did respond to the bleep. She did not comment on whether she had said *"let them burn".*

The panel therefore found this charge proved.

Charge 6a and 6b

> In June 2019 used threatening behaviour towards Colleague A by:
> a) Grabbing them by the collar
> b) Pushing them against the wall

This charge is found PROVED

The panel considered these charges together as they relate to the same incident with Witness 1.

The panel heard in oral evidence from Witness 1 that Miss Jamieson became threating towards them. Witness 1 stated that as Miss Jamieson was their line manager she needed to sign off the ongoing working arrangements. Following Witness 1's request they told the panel Miss Jamieson informed them that it had been agreed by grabbing their collar, pushing them up against the wall and said:

> *'"I'm giving you flexible working, if you leave I'm going to kill you".'*

Miss Jamieson in her written submissions denied grabbing Witness 1 by the collar or pushing them against the wall but did admit to using the phrase *'if you leave I'm going to kill you*' which she said was a *'joke*'. Witness 1, however, did not think Miss Jamieson was joking and felt physically threatened by her.

The panel noted that the local investigation and contemporaneous records of the incident corroborate the account given by Witness 1 and preferred their account over that of Miss Jamieson.

Therefore, on the balance of probabilities the panel found this charge proved.

Charge 7a

> On 2 August 2019 failed to recognise and respond appropriately to Patient G's deterioration

This charge is found PROVED

In reaching this decision the panel had regard to the DATIX (incident form) entry of 2 August 2019 which stated:

> *'Deteriorating patient not recognised and care for patient and relative lacked compassion. Student had to go around [Miss Jamieson] and bleep Registrar.'*

The panel heard in oral evidence from Witness 8 that this was a serious event where Miss Jamieson was the Ward Manager and was supervising a student nurse, and was responsible for the care of Patient G on that shift. During the shift Patient G had signs of deterioration and Miss Jamieson did not take any action to escalate the care needed and tried to *"avoid the situation".*

Witness 8 in their evidence state they were working in the office when Miss Jamieson came in and said *"[Patient G] was kicking off"* and she was going to give the patient suppositories to *"shut [them] up"*. Witness 8 explained to the panel that they urged Miss Jamieson to conduct a clinical assessment of Patient G, but she declined to do so. The student nurse; however, was so concerned about the patient, who had renal problems, that they contacted the Registrar who transferred Patient G back to the renal ward due to the significant deterioration in their health.

Miss Jamieson did not make any submissions to address the substance of this charge.

The panel considered that on the balance of probabilities this charge is found proved.

Charge 10

> On 15 September 2019 attempted to use the incorrect syringe to administer a dose of Insulin.

This charge is found PROVED

In reaching this decision, the panel noted from the evidence of Witness 2 that it is standard practice across the NHS that the type of syringes used to administer insulin are distinctive and have an orange cap on them to ensure they can be identified easily. The panel noted that this has been common practice for many years across hospitals and care homes and it is highly likely that Miss Jamieson, as a Band 7 registered nurse, would have known this.

The panel heard evidence from Witness 2 which stated that:

> *'Insulin is always kept in the fridge as this is the hospital's policy. I pointed to where it was kept and [Miss Jamieson] picked the wrong syringe. I explained to her that [Miss Jamieson] couldn't use that syringe for insulin…'*

The panel noted that in the reflective accounts submitted to the NMC and at the local investigation Miss Jamieson said she had asked where the syringes were kept as she was new to the ward and denied she does not know the difference between an ordinary syringe and one required for insulin. However, the panel preferred the account of Witness 2, which is supported by contemporaneous notes.

Therefore, the panel found this charge to be proved on the balance of probabilities.

Charge 11a

On 15 September 2019: Failed to administer a patient's insulin at the correct time.

This charge is found PROVED

In reaching this decision the panel noted that Miss Jamieson had admitted to the charge in the CMF. However, at the start of the hearing the panel heard and accepted an application to amend the charge so that the drug listed is changed from '*warfarin'* to *'insulin*'. As noted above the panel felt this does not change the chief mischief but that since it has changed the particular of the charge it would be unfair to rely on Miss Jamieson's admission.

The panel noted that in the contemporaneous notes of Witness 8 written on 15 September 2019 state:

'[Miss Jamieson] didn't give insulin to patient until after 7pm'

The panel accepted the evidence of Witness 8 who confirmed that the insulin should have been administered around 17:00 before the patient had eaten. Witness 8 further outlined the possible consequences of the delay on the patient's health and that there was no clinical justification this.

The panel accepted it is not in dispute that Miss Jamieson was responsible for administering insulin to the patient on this date.

Therefore, the panel found this charge proved.

Charge 11b

> On 15 September 2019: When reminded by Colleague B replied “I don’t give a fuck”

This charge is found PROVED

In reaching this decision the panel considered the local investigation report carried out by Witness 7 which stated:

> *‘On 27.05.19 [Witness 8] discusses that [Miss Jamieson] was prompted to give Insulin to a patient when she was conducting her drug round (it should have been administered prior to the evening meal). She reports that [Miss Jamieson] said, ‘I don’t give a f**k.’’*

The panel also heard from Witness 8 in oral evidence which confirmed this account to be accurate.

Miss Jamieson denied this charge on the CMF but gave no explanation to explain why.

The panel noted that the language used in this charge is similar to other examples of language used by Miss Jamieson and that it is therefore more than likely that Miss Jamieson would have used such language.

The panel therefore considered that on the balance of probabilities this charge is found proved.

Charge 14a

On 20 September 2019 failed to record whether insulin had been administered to Patient I

This charge is found PROVED

The panel noted that Witness 7 stated in their evidence that:

'On 20 September 2019 [Miss Jamieson] failed to sign for insulin administration on Patient I's MAR chart'

The panel also had sight of a '*Medicines Error Reflection Form*' in which Miss Jamieson acknowledged that she did not sign for the patient's insulin.

Therefore, the panel found this charge to be proved.

Charge 15

On 20 September 2019 failed to administer a Fentanyl patch to Patient J.

This charge is found PROVED

The panel considered the evidence of Witness 7 which states:

'[Miss Jamieson] also omitted to administer a Fentanyl patch to Patient J. a Fentanyl patch is a very strong painkiller…'

The panel noted the oral evidence of Witness 8 that a fentanyl patch is a controlled drug which requires two registered nurses to sign for before administering the drug. On the shift

in question there were only three registered nurses working and Miss Jamieson did not ask Witness 8 or the other registered nurse to witness and counter sign for the drug. On a stock check carried out that day by Witness 8 the controlled drug log was not signed and the stock count of fentanyl was the same as the paper record. Therefore, it would not be possible, as alleged by Miss Jamieson in the local investigation, that she administered fentanyl to the patient but had merely failed to record it.

On the balance of probabilities therefore the panel found this charge to be proved.

Charge 17a

> Between January 2018 and 29 September 2019 failed to support: Colleague A in January 2018 in their return to practice

This charge is found PROVED

In reaching this decision the panel considered the evidence of Witness 1, who for the avoidance of doubt is Colleague A, who stated during their oral evidence that they had been offered two weeks of shadowing and training opportunities by Miss Jamieson but that these did not materialise. Witness 1 explained that they had not practised as a nurse for 12 years and this was their first nursing role in the UK. In addition, with their level of training they were not supposed to do the drugs rounds without supervision but Miss Jamieson told them *"to crack on"* as they had a PIN. Witness 1 went on to explain that they had been left on an acute bay with no support despite being told this would not happen due to the level of risk to patient safety. They explained that as ward manager Miss Jamieson was responsible for these decisions and the lack of support.

Miss Jamieson was the Ward Manager and Witness 1's line manager, and the panel concluded it was therefore her responsibility to ensure Witness 1 was supported in their return to practice, but she failed to do so.

The panel therefore found this charge to be proved.

Charge 17b

> Between January 2018 and 29 September 2019 failed to support: Colleague B on 20 September 2019 to prepare for attendance at a meeting to consider actions into patient safety incidents, (a “SWARM” meeting)

This charge is PROVED

The panel considered the evidence from Witness 8, who for the avoidance of doubt is also Colleague B, who stated:

> *‘[Miss Jamieson] also volunteered for me to attend a SWARM meeting regarding pressure damage in her place. The meeting was scheduled on Monday and I was informed by [Miss Jamieson] on the Friday afternoon so it was not much notice to complete the report which was pages long when I was next scheduled to work on Sunday. A SWARM meeting is where the multidisciplinary team focus on unpicking a particular event that has happened in the clinical area you oversee, such as a fall with harm, a medication error, hospital acquired pressure damage. It would take at least an hour of uninterrupted focus to analyse evidence including patient records to investigate how and why it may have happened. As the Senior Sister I would have expected Sam to attend the meeting or guide myself or … through the process as we were unfamiliar with it. I had not attended a SWARM meeting before and it was the first moderate harm event that had occurred on E4.’*

In their oral evidence Witness 8 stated that Miss Jamieson failed to provide them with the information they had requested or any assistance to prepare for the meeting.

The panel concluded that Miss Jamieson as the Ward Manager would have been responsible for providing Witness 8 with support to prepare for the SWARM meeting,

which she had delegated to them, and accepted Witness 8's evidence that she had not provided this.

Therefore, the panel found this charge proved.

Charge 17c

> Between January 2018 and 29 September 2019 failed to support: Colleague C in completing medication training

This charge is found NOT PROVED

The panel noted that as stated above the sole and decisive evidence for this charge comes from appendix 5, which was a local statement from Colleague C regarding a lack of support from Miss Jamison. This was admitted as hearsay evidence.

The panel noted that the charge relies on specific dates *'Between January 2018 and 29 September 2019*' in order to be found proved. The panel noted that in appendix 5 there is some confusion over the dates of the incident referred to, which on a plain text reading indicate it occurred in 2020. While the panel was mindful that these could have been typographical errors, as the witness is not before the panel to address this point in questioning it would be unfair to conclude that it is explained by typographical errors.

Therefore, the panel concluded that this charge is not proved.

Charge 20

> On 12 October 2019 failed to act in accordance with Patient L's care plan and administered an enema to Patient L.

This charge is found NOT PROVED

The panel noted a DATIX report stating:

> *'Patient given an enema in error during final stages of life. Care plan had changed and not to be given…'*

The panel considered that it is not in doubt that Miss Jamieson was involved in administering an enema to Patient L on the 12 October 2019. The panel noted the doctor wrote in Patient L's clinical notes on 10 October 2019 that they felt the patient would not benefit from '*further treatment should [they] get e.g. further infection.'* The panel noted there was no reference to the enema being discontinued in this note. In addition the MAR chart reflects that the enema was only discontinued on 17 October 2019, five days after Miss Jamieson administered it.

Therefore, the panel concluded that it is not clear that the enema was not in accordance with a care plan on 12 October 2019, and this charge is found not proved.

Charge 21

> On or about 14 October 2019 failed to undertake an audit on Deprivation of Liberty Standards for a patient.

This charge is found NOT PROVED

The panel considered based on the evidence before it that it appears the Deprivation of Liberty Standards (or Safeguards) (DOLS) had been properly filled in but that it has not been sent onto the Council as required.

The panel noted from Witness 8 that there is usually a weekly audit carried out on DOLS to ensure they are fully completed and sent on to the appropriate person. However, the

panel noted from Witness 8 that the band 6 nurses and Miss Jamieson took turns to carry out the audit. The panel noted there is no copy of the roster which would identify that it was Miss Jamieson's responsibility to complete the audit on or around 14 October 2019. Witness 8 in their oral evidence stated they could not say who was responsible for the audit that week.

Therefore, on the balance of probabilities the panel concluded that there is not sufficient evidence before it to find this charge proved.

Charge 22a

> Used offensive language towards Colleague B: On 22 November 2019 you said to them "that's because you're a cunt"

This charge is found PROVED

The panel heard from Witness 8 in their oral evidence that Miss Jamieson used this phrase towards them when they were explaining to her how to complete a Human Resources process for returning to work after a period of sickness. Witness 8 stated that Miss Jamieson said the phrase under her breath but loud enough for them to hear.

Although Miss Jamieson denied this allegation in the CMF, in local interviews she acknowledged she had used language that had offended Witness 8 and said she had apologised.

The panel also noted the findings of the local investigation report which stated:

> *'Upon interviewing [Miss Jamieson] on the 21st February 2020 [sic] she confirmed that she did use derogatory language towards [Colleague B] on the 22nd November 2019 [sic] with the reference of "oh don't be a c***"…'*

The panel therefore found this charge proved.

Charge 22b

> Used offensive language towards Colleague B: Around December 2019 you said "try not to be a cunt it's Christmas."

This charge is found NOT PROVED

The panel noted that in the evidence of Witness 8 it is stated that the phrase *"try not to be a cunt it's Christmas"* was said as part of a song in a video shown by Miss Jamieson to Colleague B but was not something that Miss Jamieson said herself, nor was it directed at Witness 8.

In concluding statements Mr Edwards confirmed that this is correct given the evidence heard.

Therefore, as Miss Jamieson did not say that phrase this charge is found not proved.

Charge 22c

> Used offensive language towards Colleague B: On another occasion in December 2019 you said "that's because you're a twat"

This charge is found PROVED

The panel noted that in the contemporaneous handwritten notes of Witness 8 they record that Miss Jamieson said to them in December 2019 *"that's because you're a twat"*, and that this was corroborated in their oral evidence.

Miss Jamieson denied this charge in the CMF but provided no reason. The panel

accepted the oral evidence of Witness 8 which was supported by their witness statement and contemporaneous journal entries, and found it more likely than not that Miss Jamieson said this phrase to Colleague B.

Therefore, the panel found this charge to be proved.

Charge 23a

On 5 December 2019 you told Colleague D: to leave the ward

This charge is found NOT PROVED

The panel heard from Witness 5, who for the avoidance of doubt is also Colleague D, who stated that when they turned up as an agency nurse for the shift Miss Jamieson informed them that they were not booked on her ward and that the ward was fully covered. Witness 5 explained in their oral evidence that Miss Jamieson did speak with them in a very rude tone, they explained that they would not have written the statement if they had been spoken to in a normal or polite way but said that the tone was very abrupt and very rude. They went on to say *"in my entire nursing career I've never known anyone deal with anyone as [Miss Jamieson] spoke to me. I felt like I was a nobody."*

Witness 5 in oral evidence however, confirmed that they were not told to leave the ward but was asked to check with the High Care Unit to see if they were booked for a shift there.

The panel considered that this is not consistent with the charge that Miss Jamieson told Colleague D to leave. Therefore, this charge is not found proved.

Charge 23b and c

On 5 December 2019 you told Colleague D:

b) to pick up her bag

c) to take it with her.

These charges are found PROVED

The panel considered these sub-charges together as they relate to the same incident and are inextricably linked.

The panel considered Witness 5's oral and written evidence where they stated that after being told by Miss Jamieson that they had not been booked on a shift on that ward, that they should go and check the High Care unit, they said that they were walking there and were then told by Miss Jamieson to pick up their bag and take it with them.

Miss Jamieson in her response in one of her local disciplinary interviews stated that she did tell Witness 5 to *'go down the corridor, that door, go down that end, press the buzzer etc.'*

Taking all the information into account the panel therefore found these charges proved.

Charge 24a

Your actions at Charge 23 were: racially motivated

This charge is found NOT PROVED

The panel noted that in response to questions Witness 6 stated that Miss Jamieson could be rude and abrupt to all her colleagues and they did not think Miss Jamieson's actions were racially motivated.

The panel understood why Witness 5, who had never met Miss Jamieson before, might have concluded the reason she was rude to them was because of their race. However, the

panel took into account that as had been found in other charges Miss Jamieson has demonstrated a pattern of behaviour of being rude, intimidating, harassing, or otherwise bullying towards other staff. These incidents were not dependent on the race of any of the colleagues and that Miss Jamieson appears to have acted in the same aggressive manner regardless.

Therefore, the panel was not satisfied that there was racial motivation for the way Miss Jamieson acted towards Colleague D and this charge is found not proved.

Charge 24b

Your actions at Charge 23 were: discriminatory

This charge is found NOT PROVED

The panel bore in mind that this charge arose out of the suggestion Miss Jamieson had treated Colleague D unfavourably because of their status as an agency nurse.

The panel noted its conclusions above at 24a and considered that in a similar manner there is no indication that Miss Jamieson's treatment of colleagues changed if they were full time, part time, or agency workers.

The panel therefore concluded that this charge is not proved.

Charge 25

Dishonestly made retrospective entries to records to conceal errors you had made.

This charge is found NOT PROVED

The panel heard evidence from Witness 8 that they had suspected Miss Jamieson had returned to patient records and made retrospective entries having failed to write notes contemporaneously. They said other staff had also brought this to their attention. However, Witness 8 stated that it has not been possible to identify any specific records which may have had retrospective entries made by Miss Jamieson.

The panel considered that there is not sufficient evidence before it to consider that the entries had been made retrospectively, and, in the light of this conclusion, the test for dishonesty under *Ivey v Genting Casinos* does not arise for the panel's consideration.

Therefore, this charge is found not proved.

Charge 26a

> Attended work when off duty and brought cakebars with a picture of Roald Dahl's Grand High Witch on the packaging for Colleague B

This charge is found PROVED

The panel noted that in oral evidence Witness 8 stated that Miss Jamieson attended the ward while off duty with her family and handed them cakes bought with a picture by Quentine Blake of Roald Dahl's Grand High Witch character.

The panel considered that this is consistent with the local investigation report where Miss Jamieson appears to acknowledge having brought in cakes with a Roald Dahl witch on them.

Therefore, this charge is found proved.

Charge 26b

Described colleague B as “Witch Hunt coordinator”

This charge is found PROVED

The panel noted the statements of Witness 8 that other colleagues had said Miss Jamieson described them as the witch hunt coordinator. Witness 8 stated that they believed this was in response to an email they had sent to all staff reminding them to report medication errors and complete reflections. When a colleague asked Miss Jamieson who to send the reflections to, she referred them to Witness 8 calling them “*the witch hunt coordinator”*. The panel considered that this forms part of the context for charge 26a above, and was the reason behind Miss Jamieson bringing in cakes specifically with the Grand High Witch character on them.

Therefore, on the balance of probabilities the panel found this charge proved.

Charge 26c

Said to Colleague B “you wouldn’t require fixed working if you weren’t such a passive wife”

This charge is found PROVED

The panel noted that from the evidence of Witness 1 and Witness 8 there is a pattern of behaviour demonstrated by Miss Jamieson when staff asked for reasonable flexible working arrangements, and that Miss Jamieson would become aggressive when these requests were made.

The panel heard in oral evidence [PRIVATE] that Witness 8 was experiencing which led them to approach Miss Jamieson, who was their line manager, to request flexible working arrangements. Witness 8 told the panel when Miss Jamieson agreed the arrangements

she said: *"you wouldn't require fixed working if you weren't such a passive wife"*. Witness 8 described how upsetting this was to hear [PRIVATE].

In the CMF Miss Jamieson denied this charge but made no further comment.

The panel considered that on the balance of probabilities given the pattern of behaviour this charge is found proved.

Charge 26d

> Your actions at Charges 6, 17 and 26 (a) – (c), created an intimidating and / or hostile and / or degrading and / or humiliating environment for one or more nurses and/or staff

This charge is found PROVED

In considering this charge the panel considered each charge enumerated to determine if any of the parts of the charge can be made out.

Regarding charge 6 the panel considered that all parts of the charge are made out. The panel noted that Miss Jamieson was Witness 1's line manager at the time and that any example of being grabbed, pushed against a wall, or having a line manger threating to kill a person is inherently intimidating, hostile, degrading, and humiliating.

Regarding charge 17, the panel considered that the main part to find proved is charge 17b for this purpose. The panel considered the meaning of the word *hostile* which as per the online Cambridge University Dictionary is:

> *'unfriendly and not liking something:…*
> *difficult or not suitable for living or growing:'*

The panel therefore considered that by not providing support to Colleague B in the preparation of attending the SWARM meeting this created a workplace environment which was not supportive. Therefore, in line with the definition above the panel considered that this would be consistent with a hostile environment and found it made out on that part of the charge.

Regarding charge 26a-c the panel found it made out on all parts of the charge. The panel considered that the actions taken by Miss Jamieson while a line manager created an environment which is wholly intimidating, hostile, degrading, and humiliating.

Therefore, the panel concluded that this charge is found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Miss Jamieson's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

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

Mr Edwards identified the specific, relevant standards where Miss Jamieson's actions amounted to misconduct. He submitted that the facts found proved breach the Code in multiple places throughout and amount to serious misconduct.

Submissions on impairment

Mr Edwards 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Edwards submitted that in light of the above misconduct Miss Jamieson's fitness to practice is currently impaired. He submitted that the facts proved occurred over a prolonged period impacting multiple patients and colleagues, and there is no evidence that Miss Jamieson has taken steps to strengthen her practice. Mr Edwards further submitted that while there have been some positive testimonials submitted by Miss Jamieson her insight remains limited. Therefore, there is a high risk of continued repetition. He submitted

that a finding of impairment is necessary for both the public protection and otherwise in the public interest.

Mr Edwards also directed the panel to the completed CMF document where Miss Jamieson admitted that her fitness to practise is impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Schodlok v General Medical Council* [2015] EWCA Civ 769, *Rimmer v General Dental Council* [2011] EWHC 3438 (Admin), and *R (on the application of Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

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

> *'1.1 treat people with kindness, respect and compassion*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> *2.1 work in partnership with people to make sure you deliver care effectively*

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3.1 pay special attention to promoting wellbeing, preventing ill health…

6.2 maintain the knowledge and skills you need for safe and effective practice

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

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

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel noted the substantial areas of the Code that have been breached and that they are not limited to one area of nursing practice. The panel determined that many of the facts found proved put patients at unwarranted risk of harm including a range of significant medication errors, failing to escalate deterioration or scans and failing to follow care plans to ensure patient safety. The panel also noted there were serious failings regarding Miss Jamieson's attitude towards colleagues, poor leadership and a finding of dishonesty, which had a significant detrimental impact on many of the witnesses. The panel was of the view that the charges found proved do amount to serious misconduct.

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

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

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

The panel considered that all four limbs of *Grant* are made out. Regarding limb a the panel concluded that the medication errors and the lack of action during a fire alarm placed patients at a real risk of harm. The panel heard during oral evidence how colleagues and members of the public were appalled by Miss Jamieson's actions and found limb b to be made out on those grounds. In relation to limb c the panel considered that Miss Jamieson breached the fundamental tenets of nursing in multiple ways by acting unkindly towards colleagues and patients and in placing patients at unnecessary risk. The panel considered that as it had found Miss Jamieson acted dishonestly limb d is also made out.

The panel finds that patients were put at unwarranted risk of physical and emotional harm as a result of Miss Jamieson's misconduct. Miss Jamieson's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered there is limited insight by Miss Jamieson on the impact of the facts found proved and limited remorse demonstrated. In the CMF and her reflections Miss Jamieson has shown some insight into the clinical failings but either denied the facts relating to the behavioural and poor leadership issues, or minimised them as a joke. The panel also noted that there is little information acknowledging the impact on patients, colleagues, and the nursing profession. The panel also noted that Miss Jamieson did admit in the CMF that she is impaired.

The panel was satisfied that the misconduct relating to clinical practice in this case is capable of being addressed. However, the panel considered the attitudinal issues, including dishonesty, are more difficult to remediate. Therefore, the panel carefully considered the evidence before it in determining whether or not Miss Jamieson has taken steps to strengthen her practice. The panel noted that there have been a number of positive testimonials submitted by Miss Jamieson regarding her practice prior to these incidents but there was no evidence before the panel that she has taken steps to strengthen her practice since. The panel took into account that Miss Jamieson has provided some reflective pieces on the incidents and made partial admissions. However, the panel noted that this is very limited.

The panel is of the view that there is a risk of repetition as the facts found proved covered a long period of time and that a number of the charges proved indicated deep seated attitudinal concerns, which are difficult to remediate. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because a reasonable and well-informed member of the public would be shocked if a registered nurse who has acted in the way found proved did was able to practice without being found impaired.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Jamieson's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Jamieson's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Jamieson off the register. The effect of this order is that the NMC register will show that Miss Jamieson has been struck-off the register.

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

Submissions on sanction

Mr Edwards informed the panel that in the Notice of Hearing, dated 25 July 2024, the NMC had advised Miss Jamieson that it would seek the imposition of a striking-off order if it found Miss Jamieson's fitness to practise currently impaired. He submitted that given the facts found proved a striking-off order is the only appropriate sanction as the failings identified are a significant departure from the fundamental behaviours expected of a registered nurse.

The panel noted that Miss Jamieson has made no submission on sanction.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Abuse of a position of trust
- Lack of insight into failings
- A pattern of misconduct over a period of time and impacted many patients
- Conduct which put vulnerable patients at risk of suffering harm
- Conduct which put colleagues at risk of harm and had a long-lasting negative impact on junior colleagues
- Miss Jamieson was a senior leader on the ward
- Evidence of deep-seated attitudinal concerns, including dishonesty

The panel also took into account the following mitigating features:

- Lack support from senior leadership across the Trust
- Partial admissions at an early stage

The panel noted that Miss Jamieson made reference to experiencing homophobic, and anti-Semitic abuse, [PRIVATE]. However, the panel had no further information about this

before it [PRIVATE], therefore the panel was unable to attach any significant weight to these matters.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Jamieson's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Jamieson's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Jamieson's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. While the panel considered that the clinical misconduct may be something that can be addressed through retraining, the attitudinal concerns which included dishonesty are not something that can easily be remediated. Furthermore, the panel concluded that the placing of conditions on Miss Jamieson's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel considered that Miss Jamieson's behaviour spanned a significant period of time involving a number of patients and colleagues, there was evidence of deep-seated personality or attitudinal problems and Miss Jamieson showed little insight and there was a significant risk of her repeating the behaviour.

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

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

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

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

Miss Jamieson's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss

Jamieson's actions were very serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Miss Jamieson in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Jamieson's own interests until the striking-off 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 Mr Edwards. He submitted that an interim order is necessary to provide protection during any appeal period.

Decision and reasons on interim order

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

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

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

That concludes this determination.