Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Wednesday, 18 September 2024 – Wednesday, 25 September 2024

Virtual Hearing

Name of Registrant:	**Elzabeth Sarah Lennon**
NMC PIN:	97D0010E
Part(s) of the register:	Registered Nurse – Sub Part 1 Children's Nurse – Level 1 (30 June 2000)
Relevant Location:	Northampton
Type of case:	Misconduct
Panel members:	David Crompton (Chair, Lay member) Deepa Leelamany (Registrant member) Margaret Wolff (Lay member)
Legal Assessor:	Gillian Hawken
Hearings Coordinator:	Eyram Anka
Nursing and Midwifery Council:	Represented by Shaun McPhee, Case Presenter
Mrs Lennon:	Not present and unrepresented
Facts proved by way of admission:	Charges 1a, 1b, 1c, 1d, 2a, 2b, 2c, 3, 4, 5, 7
Facts proved:	Charges 6 and 8
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (12 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Lennon was not in attendance and that the Notice of Hearing letter had been sent to Mrs Lennon's registered email address by secure email on 4 September 2024.

Mr McPhee, 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).

Mr McPhee addressed the panel on the period of notice given to Mrs Lennon. He referred to an email from Mrs Lennon dated 17 September 2024 stating,

> *'Yes I accept a shorter notice period you provided and I'm not insisting on the usual 28 days that is given.'*

Mr McPhee submitted that Mrs Lennon clearly and unequivocally waives her right to notice and therefore invited the panel to find that notice was served effectively.

The panel accepted the advice of the legal assessor concerning the requirements of service.

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 Mrs Lennon's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence. It accepted that Mrs Lennon email dated 17 September 2024 indicated that she was content with the shorter notice period that that provided for in the Rules.

In the light of all of the information available, the panel was satisfied that Mrs Lennon 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 Mrs Lennon

The panel next considered whether it should proceed in the absence of Mrs Lennon. It had regard to Rule 21 and heard the submissions of Mr McPhee who invited the panel to continue in the absence of Mrs Lennon.

Mr McPhee referred the panel to an email from Mrs Lennon to the NMC case officer dated 4 September 2024 stating,

> *'As I have stated in previous paperwork that I have filled in previously. I will not be attending the hearing in person so it can go ahead regardless of my availability as I will not be there.'*

Mr McPhee submitted that Mrs Lennon is clearly aware of this hearing, has not made an application to adjourn and has voluntarily absented herself. It was his submission that the public interest in expedient and efficient disposal of these proceedings outweighs any prejudice to Mrs Lennon in those circumstances.

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

- No application for an adjournment has been made by Mrs Lennon

- Mrs Lennon informed the NMC that she received the Notice of Hearing and confirmed that she is content for the hearing to proceed in her absence
- There is no reason to suppose that adjourning would secure Mrs Lennon's attendance at some future date
- 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 2022
- 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 Mrs Lennon in proceeding in her absence. The evidence upon which the NMC relies will have been sent to her at her registered email address. She will not be able to challenge the evidence relied upon by the NMC 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. Furthermore, the limited disadvantage is the consequence of Mrs Lennon's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide oral evidence or make submissions during the hearing on her own behalf.

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

Details of charge

That you, a registered nurse:

1. On 16 March 2022:

    a) Failed to conduct regular hourly checks of Baby A's cannula site.
    b) On one or more occasion failed to investigate the reason for Baby A's Alaris pump to be alarming.
    c) Failed to escalate the repeated alarming of Baby A's Alaris pump.
    d) On one or more occasion inappropriately raised the pressure level of Baby A's Alaris pump.

2. On 16 March 2022:

    a) Failed to record accurately and/or at all the care provided to Baby A.
    b) Failed to document that Baby A's Alaris pump had been alarming.
    c) Failed to document the actions you took in response to the Alaris pump alarming.

3. On 16 March 2022 incorrectly recorded that you had observed Baby A's cannula site.

4. On 16 March 2022 incorrectly recorded pressure readings from Baby A's Alaris pump.

5. Your actions in charge 3 above were dishonest in that you knew you had not observed Baby A's cannula site.

6. Your actions in charge 4 above were dishonest in that you knew the pressure readings you had recorded were incorrect.

7. On 16 March 2022 incorrectly told Doctor A that 'Baby A's pump pressure readings had been normal during the day' or words to that effect.

8. Your conduct in charge 7 was dishonest in that you knew the pressure readings were not normal.

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

Background

Mrs Elizabeth Lennon was employed as a Band 5 Children's Nurse at Northampton Hospital NHS Trust ("the Trust") from 3 May 2000 until 24 August 2022, when Mrs Lennon was dismissed for gross misconduct. Mrs Lennon had worked at the Trust in High Dependency Units ("HDU") for 22 years. Mrs Lennon appealed this decision but the decision to dismiss was upheld.

It is alleged that while Mrs Lennon was working on the HDU at the Paddington ward of the Trust on 16 March 2022, she was responsible for the care of a seven-week-old baby ("Baby A"). Baby A had been admitted to the Hospital due to bronchiolitis on 15 March 2022. It is alleged that Baby A sustained a deep tissue injury to their left hand (formation of a Grade 3-4 pressure ulcer), due to a dislodged cannula through which Intravenous fluids (IV) were infused on 16 March 2022 causing extravasation.

It is further alleged that the infusion pump alarmed several times throughout the day on 16 March 2022, and Mrs Lennon increased the pressure twice on the pump, but did not document the increase. Mrs Lennon also recorded that she had undertaken hourly checks of the cannula site, when she had not.

In summary, the Trust investigated the following concerns around Mrs Lennon's practice in that Mrs Lennon:

- falsified entries into the fluid balance chart indicating Mrs Lennon had checked the cannula site hourly (it is alleged that Mrs Lennon did not check the cannula site until ten hours into their shift);
- failed to document Baby A's IV pump had been alarming and what measures Mrs Lennon took in response (it is alleged that Mrs Lennon had increased the

IV pump pressures, but the documented pressures did not match the download from the IV pump and show manual increases in the alarm so that alarm pressures would not alarm);

- acted negligently in their duty of care which resulted in permanent harm to the patient (deep tissue injury to Baby A's left hand); and
- lied about checking the cannula site and taking the bandage down or un-swaddling the baby to check the site.

Mrs Lennon was re-deployed on 6 April 2022 by the Trust into a non-clinical role whilst the investigation was completed.

The Trust's investigation was commissioned by the Matron for Paediatrics. The Case Manager for the investigation was Witness 1, who reviewed the evidence and decided that there was a case to answer and that it should proceed to a disciplinary hearing.

The disciplinary hearing took place on 24 August 2022, all the allegations were upheld, and a decision was made to dismiss Mrs Lennon on the grounds of gross misconduct.

Baby A's mother also made a complaint to the Trust on 18 April 2022. The Trust investigated concerns via a Serious Incident ("SI") review and the final report, dated 13 October 2022, made recommendations for the Trust to adopt.

Decision and reasons on facts

Mr McPhee submitted that Mrs Lennon makes a number of significant, clear and unequivocal admissions. He referred the panel to Mrs Lennon's Case Management Form dated 15 April 2024 in which she made full admissions to charges 1a, 1b, 1c, 1d, 2a, 2b, 2c, 3, 4, 5, 7. He submitted that Mrs Lennon's admissions are supported by documentary evidence namely, the local investigation interview and Mrs Lennon's response to the allegations during the local investigation and to the NMC.

On that basis, Mr McPhee invited the panel to find that Mrs Lennon made full admissions to charges 1a, 1b, 1c, 1d, 2a, 2b, 2c, 3, 4, 5, 7.

The panel had regard to the documentary evidence before it. The panel determined that Mrs Lennon made clear admissions during the local investigation and has reiterated this in her response bundle to the NMC and her Case Management Forms (CMF). Further, the panel considered that Mrs Lennon gave specific reasons as to why she disputes charges 6 and 8 in her CMF but maintained her admission of the other charges. Therefore, in the panel's view Mrs Lennon made thoughtful admissions which are consistent with the documentary evidence before it.

The panel therefore finds charges 1a, 1b, 1c, 1d, 2a, 2b, 2c, 3, 4, 5, 7 proved in their entirety, by way of Mrs Lennon's admissions.

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 McPhee on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mrs Lennon.

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

- Witness 1: Interim Director of Governance and Associate Director of Nursing, at the relevant time

- Witness 2: Tissue Viability Nurse, at the relevant time

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 both the NMC and Mrs Lennon.

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

Charges 6 and 8

> "Your actions in charge 4 above were dishonest in that you knew the pressure readings you had recorded were incorrect."
>
> "Your conduct in charge 7 was dishonest in that you knew the pressure readings were not normal."

These charges are found proved.

In reaching this decision, the panel decided to consider these charges together as they have the same factual basis and relate to the same incident. It took into account Baby A's fluid balance chart, the Data download from the Alaris pump, Mrs Lennon's response to the charges in the CMF and Witness 1's oral and documentary evidence.

The panel had regard to Mrs Lennon's CMF in which she explains that she did not knowingly record incorrect pressure readings. With regard to charge 6 she states,

> *'I did not no that the readings that i recorded were incorrect. this is what i thought they were and this is what have stated verbally and on the refective account i have completed in which you should have a copy off. Although i do accept that i should have recorded when the pressure readings were high and the pump was alarming i thought thought was due to movment and due to B A being unsettled.'* (sic)

Although Mrs Lennon accepts that she incorrectly recorded pressure readings from Baby A's Alaris pump, she does not accept that it was done dishonestly, she stated that it was a mistake due to her being unable to read the numbers properly. Witness 1 addressed her inability to see the pump in her witness statement, which states

> *'…Mrs Lennon had documented throughout the day that they had observed the cannula site and that they had read the pressures on the pump. They then accounted that they could not see the pump correctly as Baby A's mother had been sitting in view of the pump. I went to look at the pump myself on 22 August 2022 and I did not believe that Mrs Lennon would not be able to see the pump…'*

The panel carefully considered Mrs Lennon's account and noted that it is clear from Baby A's fluid balance chart that she recorded the pump pressures hourly from 10:00/11:00 to 14:00/15:00. It was of note to the panel that Mrs Lennon recorded that the readings were normal on the pressure pump on five consecutive occasions during this period and that these figures were completely different to the data obtained from the Alaris pump download.

The panel had regard to Witness 1's oral evidence, in which she told the panel that the data download from Baby A's Alaris pump shows that the pump pressure alarm had been manually increased significantly during that period, on one occasion from 70mmHg to 130mmHg and on another occasion to 300mmHg. Mrs Lennon acknowledges in the CMF that she had made this change herself (see below). The panel questioned whether Mrs Lennon was aware of the significant increase in pressure when she was recording those pressure readings. It determined that she must have been aware because she had to record the readings five separate times, as such she should have become aware of the mistake at some point during that period. Furthermore, the panel took the view that her explanation of the pump readings being obscured by Baby A's mother was inherently implausible because there were five consecutive readings over a five-hour period where the recorded pressures were wholly at odds with the pump pressure. The panel accepted the evidence of Witness 1 that Mrs Lennon would have only needed to look around Baby

A's mother to see the correct reading on the Alaris pump display on each of these occasions.

In relation to knowing whether the pressure readings were normal, the panel had regard to her response to charge 8 in the CMF stating,

> *'I informed the doctor that the pressure readings were normalall day because i thought that when the pump alarmed it was initially due to Baby A moving and being unsettled , i did increase the pressures on the pump manually but this was initallt ment as a temerory measure but unfortunaltly i forgot it put the pressures back down again (this is also explained in the relfective account i have done after the event. i didn't tell the doctor that they had been normal with the view to being dishonest.'*(sic)

The panel considered the evidence before it, including Mrs Lennon's own admissions that she manually increased the pressure on the pump twice and did not tell anyone that she did so. The panel considered this explanation in the context of her already having recorded, on multiple occasions, incorrect pressure readings on the Fluid Balance chart and took the view that she must have known that the pressure readings were abnormal. In view of Mrs Lennon's admission that she felt it appropriate to manually override the alarm by increasing the pressure, the panel determined that it is more likely than not that she knew the pressure readings were not normal and recorded them anyway.

The panel took into account that Witness 1's witness statement highlights and breaks down the discrepancies and inaccuracies between what Mrs Lennon recorded on Baby A's Fluid balance chart and the Alaris pump data. The panel was persuaded by the data before it and Witness 1's explanation of how the readings should have been recorded. It took the view that Mrs Lennon should have done the same assessment of the readings and recognised that the pressure readings were abnormal.

The panel also took into account the possibility that Mrs Lennon's [PRIVATE] may have influenced her inaccurate recording of the pump pressures. The panel noted in

Witness 1's evidence that Mrs Lennon had been asked if this affected her nursing practice and she commented that it did not. The panel also noted that Mrs Lennon recorded other data, such as the running fluid total, relatively accurately. In the circumstances, the panel took the view that this was unlikely to have been the cause of the inaccurate recording of the data by Mrs Lennon.

In the panel's view, when taking into account the repeated nature of recording the incorrect pressures together with her implausible reason for doing so, Mrs Lennon must have been aware that she was recording false data. Therefore, when applying the standards of ordinary decent people (per *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67), the panel determined that Mrs Lennon's conduct, in knowingly recording inaccurate readings and reporting to Doctor A that they had been normal, would be categorised as dishonest.

For these reasons, the panel concluded that Mrs Lennon was more than likely dishonest in her actions and therefore found in Charges 6 and 8 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 Mrs Lennon'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, Mrs Lennon'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 McPhee 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 McPhee submitted that on the basis of the charges found proved Mrs Lennon has breached the following sections of the Code: 1.2, 8.5, 10.2, 10.3, 13.1, 20.2.

Code 1.2

Mr McPhee submitted that Mrs Lennon failed to deliver the fundamentals of care effectively to Baby A. The panel heard in Witness 2's evidence that regular cannula checks are fundamental and any action in response to an alarming pump should have been properly documented. Further, he reminded the panel of Witness 1's evidence stating that management of a volumetric pump was one of the first things a nurse might learn in safe administration of fluids training.

Code 8.5

Mr McPhee told the panel that Mrs Lennon failed to work effectively with Doctor A to preserve the Baby A's safety. He stated the Mrs Lennon incorrectly and dishonestly told Doctor A that volumetric pump pressures had been normal throughout the day. He submitted that the abnormal pump pressures put in place by Mrs Lennon were the cause of Baby A's injuries. Mr McPhee said that Witness 2 stated in her evidence that Baby A's injuries could have been avoided if the pump pressures had been managed properly and checked regularly in accordance with Baby A's care plan.

Code 10.2

It was Mr McPhee's submission that Mrs Lennon did not keep accurate records of the problems that had arisen and did not record the steps she took to deal with them. He said that she inaccurately and dishonestly recorded that she had undertaken regular checks which, the panel heard during Witness 1's evidence, ought to have identified the problem and prevented Baby A's injuries.

Code 10.3

Mr McPhee referred to Mrs Lennon's own admissions to inaccurately recording the care provided to Baby A. She failed to record the alarming pump and failed to record that she raised the pressure in response to the alarm. Mr McPhee highlighted her further admissions to incorrectly and dishonestly recording that she had undertaken regular cannula checks. He reminded the panel of its findings that Mrs Lennon acted dishonestly in relation to charges 6 and 8 which he submitted were further examples of falsification.

Code 13.1

Mrs Lennon admits to incorrectly recording that she had observed Baby A's cannula site in charge 3. Mr McPhee said that the panel heard during Witness 2's evidence that observation was fundamental and could have prevented Baby A's injuries. He submitted that had Mrs Lennon undertaken the required checks as she dishonestly claimed to have done, she would have identified a worsening wound on Baby A's hand.

Code 20.2

Mr McPhee stated that there are three charges of dishonesty found proved. He submitted that the circumstances of not acting with honesty and integrity are extremely serious.

For these reasons, Mr McPhee submitted that Mrs Lennon's conduct in the charges admitted and proved amount to misconduct in that they fell far short of what is proper in the circumstances and what might reasonably be expected of a registered nurse.

Mrs Lennon indicated in the CMF that she does not admit that her fitness to practise is impaired by way of her misconduct.

Submissions on impairment

Mr McPhee 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 McPhee submitted that Mrs Lennon's failures breached the Code and the fundamental tenets of the nursing profession in several ways, from failing to provide the fundamentals of care effectively to falsifying records. Mr McPhee submitted that protection of the public requires that nurses in positions of trust, in caring for the most vulnerable of society, keep those tenets.

Mr McPhee told the panel that some of Mrs Lennon's misconduct is amenable to remediation. However, he submitted that her failings are serious and far ranging and there is nothing before the panel which indicates that Mrs Lennon has adequately addressed the failings. In the absence of robust evidence to the contrary, he submitted that Mrs Lennon's fitness to practise is currently impaired.

In relation to the charges of dishonesty, Mr McPhee referred the panel to the NMC Guidance namely, *'Serious concerns which are more difficult to put right'* (FTP-3a). He submitted that Mrs Lennon's misconduct falls into the category of serious concerns which are more difficult to put right because she failed to be open and honest when things went wrong with Baby A's care. Mrs Lennon dishonestly recorded inaccurate pressure readings, failed to document her actions in response to the pressure alarm and dishonestly told Doctor A that the readings on the pressure pump was normal.

Given the nature of these concerns, Mr McPhee asked the panel to consider whether Mrs Lennon has reflected, demonstrated insight into her failings and demonstrated a commitment to remediating the concerns identified. He submitted that there is nothing before the panel to suggest that any of those requirements are satisfied. Although Mrs Lennon admitted most of the charges, she denied two charges of dishonesty namely, charges 6 and 8. Mr McPhee submitted that this suggests that Mrs Lennon lacks insight into her misconduct, which is indicative of a real risk of repetition and thus present impairment.

Mr McPhee submitted that Mrs Lennon's misconduct put Baby A at an unwarranted risk of harm. He referred the panel to the evidence before it namely, photographs, statements and records of Baby A's injuries. He reminded the panel that Witness 2 said that Baby A's injuries were likely avoidable if proper care was given, and checks were undertaken in accordance with Baby A's care plan. He submitted that failing to undertake basic checks, dishonestly claiming and documenting that she had done so and also taking inappropriate actions led to a significant risk of harm to Baby A. He asked the panel to bear in mind the harm, emotional and otherwise, to Baby A's family as well.

Mr McPhee submitted that Mrs Lennon's fitness to practise is impaired because her misconduct, involving dishonesty and serious risk of harm to patients, breached the fundamental tenets of the nursing profession. He further submitted that there is no adequate evidence that Mrs Lennon has identified, reflected and learned from that experience or an indication of steps taken to ensure that conduct of the kind found proved is not repeated.

It was Mr McPhee's submission that Mrs Lennon's misconduct poses an ongoing risk to the public and public confidence in the nursing profession and the NMC as its regulator would be seriously undermined if a nurse found to have engaged in such serious and far-ranging misconduct, whilst caring for a vulnerable patient, were not found to be impaired. For these reasons, he invited the panel to find Mrs Lennon's fitness to practise currently impaired.

Mrs Lennon disputes that her fitness to practise is impaired in the CMF, stating,

‘Although i admit that i did wrong in this instance i have reflected and learnt from my mistakes. (Please see relfective account that you should have a copy off) i am truly sorry for what has happened and understand how it has effected Baby A and his family ,it has also had a massive impact on me and its something i feel will never get over, and i know that this would not ever happen in my futre practice.’ (sic)

The panel accepted the advice of the legal assessor which included reference to the NMC Guidance and 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), *Grant* [2011] EWHC 927 (Admin)*, GMC v Chaudhary* [2017] EWHC 2561 (Admin) and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Following the panel’s handing down of facts and prior to its deliberating on impairment, a document was provided by the NMC which had been overlooked (a reflective statement which was provided by Mrs Lennon’s former representatives on 27 July 2023). Having heard submissions from Mr McPhee, the panel deliberated and gave full consideration to this new document, but it did not change its determination on facts.

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 Mrs Lennon’s actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Lennon’s actions amounted to a breach of the Code. Specifically:

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

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively.’

*'8 **Work co-operatively***

To achieve this, you must:

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

*'10 **Keep clear and accurate records relevant to your practice***

To achieve this, you must:

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

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

*'13 **Recognise and work within the limits of your competence***

To achieve this, you must:

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

*'20 **Uphold the reputation of your profession at all times***

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel had regard to the serious failings in Mrs Lennon's nursing practice, including falsification of records, failure to observe Baby A's cannula site, failure to investigate the Alaris pump alarm and dishonestly reporting to the doctor that the pressure readings were normal. It determined that the areas of the Code that had been identified by the NMC were appropriate.

The panel considered that Mrs Lennon's conduct consisted of avoidable failures which resulted in actual harm to Baby A. The panel took into account that Baby A was particularly vulnerable and wholly reliant on Mrs Lennon. In the panel's view, Mrs Lennon's initial failures were compounded by her actions after the fact. The panel considered an example of this to be when Mrs Lennon failed to investigate why Baby A's Alaris pump was alarming but instead overrode a safety feature by increasing the pressure on the pump to stop the alarm, causing harm to Baby A. The panel took the view that fellow members of the profession would find Mrs Lennon's conduct deplorable.

The panel therefore found that Mrs Lennon's actions in relation to all the charges fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Lennon'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 February 2024, 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 and to maintain professional boundaries. 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 determined that all four limbs of *Grant* are engaged in this case. The panel found that Baby A was put at an unwarranted risk of harm, and it had sight of the physical harm caused to Baby A as a result of Mrs Lennon's misconduct. Mrs Lennon's misconduct, for example, by overriding the alarm settings on the Alaris pump and failing to conduct hourly cannula site observations on a young vulnerable infant, then falsifying readings brought the profession into disrepute and breached the fundamental professional tenets of acting with honesty and integrity. 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 determined that Mrs Lennon demonstrated developing insight into her misconduct. The panel considered that Mrs Lennon admitted to all but two of the charges in her CMF and demonstrated, in her reflective statements, an understanding of why her conduct was wrong and how her actions caused harm to Baby A as well as apologising to Baby A's family for her failures. She has expressed genuine remorse for her conduct. It noted that she addressed how she would handle a similar situation differently in the future.

The panel accepts from Mrs Lennon statement that although she made mistakes, she thought she was acting in Baby A's best interests. In her reflective statement, the panel took note of the following passage,

> *'On [Baby A],s fluid balance chart, I had ticked to say that [Baby A],s cannula site was checked hourly . but in fact I checked his arm periodically throughout the morning to check for signs of swelling and tissuing. However I didn't take the bandage and directly to observe the cannula site, which was wrong , I should have been more vigilant and looked at the cannula site and not just [Baby A] arm for signs of the cannula tissuing. I can't recall the exact times at which I observed and looked his arm, but When I did it was on occasions that he was unsettled and needed comforting, or his nappy changed, the reasoning for not doing it every hour was that when he was asleep and*

settled, he was swaddled as this would help him settle. He was also needing regular analgesia and chloral hydrate to try and keep him settled as at times not tolerating the Nasal CPAP, and he was hungry as he was on iv fluids, and initially nil by mouth at the beginning of the shift. When he was settled and asleep I wanted to leave so that the Nasal CPAP could work effectively. When [Baby A] became unsettled, he would cry and move around causing the Nasal CPAP to come off and it would take a while to settle him back down again, therefore during those unsettled times the CPAP would not be as effective. So I felt at the times he was settled it was important to leave him and let him rest.' (sic)

However, the panel took the view that Mrs Lennon's insight is limited because she has not meaningfully engaged with the dishonesty element of the charges in the same depth that she dealt with the other concerns identified. The panel determined that she does not sufficiently reflect on the seriousness of her misconduct in terms of the nature and gravity of her failures. Further, it noted that she has not demonstrated an understanding of how this impacted on her colleagues and the reputation of the nursing profession.

Dishonesty is difficult to remediate but the panel considered whether it was possible in this case. The panel was satisfied that the misconduct in this case is capable of being remedied. It took the view that Mrs Lennon demonstrated remorse into her actions regarding Baby A but did not specifically address her dishonesty.

The panel carefully considered the evidence before it. It acknowledged Mrs Lennon's reflective statements and determined that these contributed to its finding of developing insight. It also had regard to the positive testimonials she provided, the authors of which all stated that they knew of the allegations faced by Mrs Lennon. It determined that the evidence of courses undertaken, and certificates of training suggest that she has taken steps to strengthen her practice and address the relevant areas of concern.

When considering whether there remains a future risk, the panel considered that there were several failings that were avoidable. Given Mrs Lennon's limited insight

into the dishonesty charges, the panel determined that there is an ongoing risk of repetition. It 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 are 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 Mrs Lennon's actions breached fundamental tenets of the profession, pose an ongoing risk to patient safety and would be deemed concerning by the members of the public fully appraised of the particulars of this case. The panel conclude that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Lennon's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mrs Lennon's registration has been suspended.

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 McPhee informed the panel that in the Notice of Hearing, dated 4 September 2024, the NMC had advised Mrs Lennon that it would seek the imposition of a striking-off order if it found Mrs Lennon's fitness to practise currently impaired.

Mr McPhee referred to the panel's decisions and reasons for its finding of impairment. He took the panel to the NMC Guidance on *'Factors to consider before deciding on sanctions'* (San-1) and submitted that the guidance requires it to consider both aggravating and mitigating factors. Mr McPhee submitted the following aggravating factors:

- Vulnerability of patient
- Risk of harm and actual harm sustained
- Mrs Lennon's dishonesty when harm was identified

Mr McPhee stated that the guidance makes it clear that the panel is concerned with risk. He submitted that a patient suffering harm would make a registrant's failing worse, if the registrant deliberately chose to take an unreasonable risk with the safety of a patient in their care. He reminded the panel that it heard repeatedly in witness evidence that Baby A's injuries could have been avoided if Mrs Lennon had provided the appropriate care, in accordance with Baby A's care plan.

Mr McPhee outlined some mitigating factors that the panel may wish to consider such as, Mrs Lennon's reflective statements and her evidence of relevant training.

Mr McPhee invited the panel to consider the guidance on *'Considering sanctions for serious cases'* (San-2). The guidance states that some forms of dishonesty are likely to call into question whether a nurse should be allowed to remain on the register. Mr McPhee submitted that Mrs Lennon's conduct demonstrates a deliberate breach of her duty of candour because she dishonestly claimed to have provided care which she did not and dishonestly failed to maintain proper records of the actions she took. It was his submission that Baby A was an extremely vulnerable acutely unwell baby,

unable to express his discomfort, wholly reliant on Mrs Lennon to provide care for him and to do so appropriately. He further submitted that Mrs Lennon's conduct caused Baby A's injuries and likely also caused Baby A's family distress.

Mr McPhee submitted that Mrs Lennon's care of Baby A was inadequate and amounted to neglect because she failed to recognise and respond to his basic needs, in accordance with Baby A's care plan and risked harm to him as a result.

Mr McPhee took the panel through the sanctions and submitted that imposing no order or a caution order would be wholly inappropriate given the seriousness of this case. He submitted that a conditions of practice order would also be inappropriate in this case because the panel found that Mrs Lennon demonstrated limited insight into the dishonesty charges. It was his submission that there is a real risk of non-compliance with any conditions that the panel might impose. He emphasised that this is not merely a case of inadequate clinical practice, but one exacerbated by significant and repeated dishonesty, which placed a patient at risk of harm. He therefore submitted that a conditions of practice order would not be adequate to protect the public in this case.

Mr McPhee submitted that when considering a suspension order in this case, the panel may wish to consider whether it would sufficiently to protect the public and maintain public confidence. He asked the panel to bear in mind that Mrs Lennon provided inadequate care resulting in a serious risk of harm to an exceptionally vulnerable baby and was repeatedly dishonest before and after Baby A's injuries were discovered. He submitted that a suspension order would not be appropriate in this case.

Given that the panel found that Mrs Lennon's conduct breached the fundamental tenets and brought the profession into disrepute, it was Mr McPhee's submission that this raises questions about Mrs Lennon's professionalism. He stated that public confidence in the nursing profession would be undermined if a nurse in these circumstances was permitted to remain on the Register. Mr McPhee submitted that Mrs Lennon's misconduct is of a type that is exceptionally difficult to remediate.

He reminded the panel that it found that Mrs Lennon demonstrated limited insight into her dishonesty, which he submitted, is one of the most significant concerns in this case. He further submitted that there remains and ongoing risk to members of the public.

For these reasons, he invited the panel to impose a striking-off order. It was his submission that there is no less restrictive order which would appropriately and proportionately mitigate the risk.

The panel accepted the advice of the legal assessor which included reference to the NMC Guidance and a number of relevant judgments. These included: *Lusinga v NMC* [2017] EWHC 1888 (Admin), *Parkinson v NMC* [2010] EWHC 1898 (Admin), *Atkinson v GMC* [2009] EWHC 3636 (Admin), *Burrows v General Pharmaceutical Council* [2016] EWHC 1050 (Admin), *Kamberova v NMC* [2016] EWHC 2955 (Admin) and *GMC v Ahmed* [2022] EWHC 403 (Admin).

Decision and reasons on sanction

Having found Mrs Lennon'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:

- Vulnerable nature of Baby A
- Actual harm caused to Baby A

The panel also took into account the following mitigating features:

- Admissions to most of the charges

- Genuine remorse with developing insight
- Apologised to Baby A and Baby A's family
- A series of incidents in a single shift
- Evidence of steps taken to address the concerns such as relevant training.

The panel gave consideration to the health matters raised by Mrs Lennon in the documents she provided. However, the panel afforded this limited weight because there was no independent verification.

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, the public protection issues identified and the public interest considerations, an order that does not restrict Mrs Lennon'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 Mrs Lennon's 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 Mrs Lennon's 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;*
- *No evidence of general incompetence.*

As set out in its decision on impairment, the crux of the panel's concern in this case relates to the dishonesty charges found proved. The panel has noted Mrs Lennon's efforts to strengthen her practice in relation to the clinical failures in this case. In light of the ongoing concerns in relation to Mrs Lennon's insight around her dishonesty, the panel concluded that conditions of practice are not appropriate. There are no practicable or workable conditions that could be formulated to address the dishonesty.

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

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

The panel accepted Mr McPhee's submission that these concerns have raised fundamental questions about Mrs Lennon's professionalism. However, the panel viewed Mrs Lennon's failings as one incident on one shift, with different elements as opposed to a repetitive series of incidents. It did not accept that Mrs Lennon's clinical failings were an act of deliberate neglect but instead, a display of poor professional judgement and clinical decision making within the context of what she thought was in Baby A's best interests.

The panel considered that Mrs Lennon has demonstrated sufficient insight into her clinical failings but limited insight into her dishonesty. Having taken into account Mrs Lennon's genuine remorse and positive testimonials, together with her 22-year unblemished nursing career prior to this incident, the panel was satisfied that Mrs Lennon's misconduct was not fundamentally incompatible with remaining on the register.

The panel went on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. The panel determined that the dishonesty it found in this case appears to be out of character, based on the positive character references Mrs Lennon provided and her 22-year nursing career with no other concerns. As per *Atkinson*, the panel was satisfied that there is the prospect of Mrs Lennon returning to practice without the reputation of the nursing profession being disproportionately damaged.

Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Lennon's case to impose a striking-off order. Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Mrs Lennon. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

In making this decision, the panel carefully considered the submissions of Mr McPhee in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a suspension order would be the most appropriate and proportionate order in this case, for the reasons set out above.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct, protect the public and maintain the public interest.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mrs Lennon's attendance at the at any future review.
- A reflective statement addressing the importance of honesty and integrity in the nursing profession and particularly reflecting on the dishonesty found proved in this case.

This will be confirmed to Mrs Lennon in writing.

Interim order

As the suspension 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 Mrs Lennon's 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 Mr McPhee. He invited the panel to make an interim suspension order for a period of 18 months. He submitted that an interim suspension order is necessary on the grounds of public protection and is otherwise in the public interest, given the nature of the risks identified and the need to protect the reputation of the nursing profession and the NMC as regulator. It was his submission that imposing an interim suspension order would enable an appeal period to lapse and ensure that the order is of good effect.

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 12 months to allow for the time that may be taken before an appeal can be heard. Not to do so would be inconsistent with the sanction imposed. The panel took account of the impact that an interim order will have on Mrs Lennon, but was satisfied that this order, for this period, is proportionate.

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

That concludes this determination.