Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Wednesday, 31 July 2024 – Monday, 12 August 2024
&
Wednesday, 25 – Thursday, 26 September 2024 (virtually via Teams)

Nursing and Midwifery Council
10 George Street, Edinburgh, EH2 2PF

Name of Registrant:	**Jacqueline Ballantyne Russell Mcaulay**
NMC PIN	01H0102S
Part(s) of the register:	Registered Adult Nurse (2004)
Relevant Location:	Lanarkshire
Type of case:	Misconduct & lack of competence
Panel members:	Des McMorrow (Chair, Registrant member) Donna Green (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	Attracta Wilson
Hearings Coordinator:	Leigham Malcolm
Nursing and Midwifery Council:	Represented by Ms Brittany Buckell, NMC Case Presenter
Mrs McAulay:	Present and represented by Mr Tim Haddow
Facts proved by admission:	Charges 1, 2, 3, 4, 5a, 5b, 7 & 9b
Facts proved:	Charges 6, 10
Facts not proved:	Charges 8, 9a, 9c

Fitness to practise:	Currently impaired by reason of your misconduct, in respect of charges 1-4
Sanction:	**Caution order (2 years)**

Background to your case

On 8 January 2020 the Nursing and Midwifery Council (NMC) received a referral from NHS Lanarkshire in relation to your nursing practice. The referral alleged that you produced reflective statements for your NMC revalidation in 2019, which were plagiarised from reflective accounts submitted by your colleague, a Senior Charge Nurse, in 2016. It is also alleged that you prepopulated the reflective discussion form including the Senior Charge Nurse's details and the short summary of discussion section before having undertaken any conversation.

The NMC were also made aware of alleged clinical errors which were reported to have taken place between July and August 2019. The clinical errors were identified by NHS Lanarkshire during the course of its investigation into the issues with your revalidation.

Decision and reasons on application to admit documentary evidence

Prior to the hearing the panel was provided with several bundles. The bundles included, amongst other things, a 'Management Case' document prepared by the NMC which set out the background to your case and details of the NMC's investigation. Also included were the notes of your disciplinary hearing dated 3 December 2019 and your disciplinary hearing outcome letter from NHS Lanarkshire.

Ms Buckell, on behalf of the NMC, informed the panel that the NMC had previously agreed to the numerous redactions to the 'Management Case' document for them to be provided to the panel in good time, ahead of the hearing. However, she submitted that despite them having been redacted it would be fair and relevant to admit some of the information, namely that relating to the Trust's investigation and methodology, as well as the notes of your disciplinary meeting and the disciplinary outcome letter.

Ms Buckell submitted that disciplinary meeting notes set out the impact of the allegations on patients and the outcome letter speaks to the Trust's internal investigation and the action subsequently taken.

Ms Buckell invited the panel to admit this previously redacted information into evidence on the basis that it would be fair and relevant to do so.

Mr Haddow, on your behalf, objected to the application. He submitted that, generally, the material referred to by Ms Buckell amounts to the opinion of third parties and therefore it would be unfair, irrelevant and prejudicial to admit it.

The panel accepted the advice of the legal assessor.

The panel did not accept Mr Haddow's submission that generally the material amounted to the opinions of third parties. Whilst the disciplinary outcome letter included some third-party views, it amounted to a summary of your position and the documentary evidence available to the Trust at the time, rather than opinion.

The panel had regard to the case of *Enemuwe v Nursing and Midwifery Council* (*NMC*) [2015] EWHC 2081 and considered that prior findings by a local disciplinary body, should not normally be admitted in proceedings before the NMC. The panel bore in mind that the local investigation was conducted for a different purpose, whereas these are regulatory proceedings.

The panel took account of the fact that much of the material contained within the disciplinary outcome letter was already available to it elsewhere in the bundles. The only new information was the final section setting out the outcome. For this reason, the panel decided to admit the disciplinary outcome letter except for page 48, which contained information the panel had not previously seen.

It considered the information relating to the Trust’s investigation and methodology, as well as the notes of your disciplinary meeting to be relevant and it decided that it would not cause any prejudice to you to admit it. It would however be unfair to the NMC for it not to be included in support of the NMC’s case.

The panel accepted, however, that it would be prejudicial to admit page 48 of the disciplinary outcome letter because it is a finding by a Trust and should not influence the panel during these independent regulatory proceedings.

Details of charge

That you being a Registered Band 6 nurse

1. In or about early August 2019, plagiarised reflective accounts forms taken from your Line Manager, Colleague 1’s 2016 reflective accounts which you then submitted to her for the purposes of revalidation

2. Your actions at Charge 1 were dishonest in that you

(a) Knew the reflective accounts forms were not your own

(b) Purported to represent they were.

3. In or about the 31 July 2019, you falsely populated a Reflective Discussion Form with details of discussions with your Line Manager, Colleague 1.

4. Your actions at Charge 3 were dishonest in that you

(a) Knew that there had been no discussion with Colleague 1 at that time

(b) Purported to represent that there had been.

5. On the 6 July 2019,

(a) failed to administer a controlled drug to a patient and

(b) erroneously signed the chart that you had administered it.

6. On the 9 July 2019, having recognised medication was out of stock, failed to send the drug requisition book to pharmacy.

7. On 15 July 2019 handed controlled drugs to a student nurse and asked her to lock them away.

8. On 21 August 2019, failed to administer medication to a patient between 16.00 and 18.00 hours alternatively administered medication but failed to record it contemporaneously.

9. On 15 July 2019

(a) failed to document important information namely that a patient had been deliberately trying to fall all day and had been found on the floor.

(b) permitted a Clinical Support worker to complete a nursing centred care plan and record care documentation for this patient.

(c) failed to complete the risk assessment tools for the patient

10.Failed to respond to a deteriorating patient's NEWS score of 0 to 2 due to an emergent tachycardia.

And in the light of Charges 1 to 4 your fitness to practise is impaired by virtue of your misconduct.

And in the light of charges 5 to 10, your fitness to practise is impaired by virtue of your lack of competence.

Decision and reasons on application to amend the charges

The panel next heard an application made by Ms Buckell to amend the charges in two regards. The first proposed amendment was to Charge 10. Ms Buckell proposed inserting '21 August 2019' at the start of Charge 10, so that it reads as follows:

> *'10. **On 21 August 2019** failed to respond to a deteriorating patient's NEWS score of 0 to 2 due to an emergent tachycardia.'*

Ms Buckell submitted that this proposed amendment would provide clarity and more accurately reflect the evidence.

The second proposed amendment was to insert '*or misconduct'* into the closing sentence of the charges, to read as follows:

> *'And in the light of charges 5 to 10, your fitness to practise is impaired by virtue of your lack of competence **or misconduct**'*

Mr Haddow did not oppose the first amendment, to Charge 10, however, he objected to the second amendment, to the final sentence of the charges.

In relation to the second proposed amendment, Mr Haddow submitted that your case had been ongoing for four years and the NMC had had all that time to decide on a final version

of the charges. He stated that until now, the NMC had proceeded on the basis that charges 5 to 10 amounted to a lack of competence. He told the panel that you have a right to know in detail what charges you face and must be provided sufficient time to prepare your defence. He submitted that at this late stage it was unreasonable to seek to make such a significant amendment.

Further, Mr Haddow referred the panel to the case of *Johnson and Maggs v NMC* [2013] EWHC 2140 (Admin) and argued that charges 5 to 10 do not constitute misconduct. Ms Buckell reminded the panel that whether charges 5 to 10 constituted misconduct was a matter to be addressed at a later stage in proceedings.

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

In respect of the amendment to Charge 10, the panel determined that such an amendment, as applied for, was in the interest of justice. It was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the insertion of the date '*on 21 August 2019'* as applied for, to ensure clarity and accuracy.

In respect of the second amendment, however, the panel was not satisfied at this late stage, that it would be fair to you to allow the amendment. The panel considered the statutory responsibility on the NMC to properly investigate concerns in the public interest. However, it bore in mind that the NMC has had four years to prepare its case, decide on the appropriate charges in the context of the complaints and to raise the issue of an amendment at the earliest opportunity. It took into account that the proposed amendment was only raised on Monday 29 July 2024, and only before the panel today, Wednesday 31 July 2024, and considered it significant that it was not raised at a recent case conference. The panel considered your right to a fair hearing and that includes an entitlement to know the charges you face and sufficient time to prepare your defence. The panel determined that the proposed amendment would alter the substance of charges 5 to10 and would

have a negative and unfair impact upon your right to a fair hearing in that you would be deprived of an opportunity to properly defend the serious charges against you.

For these reasons, the panel decided not to allow Ms Buckell's application to amend the final sentence of the charges.

Decision and reasons on application to admit hearsay evidence

Ms Buckell made the panel aware of her intention to apply to admit hearsay evidence. She referred the panel to the cases of *Mansaray* v *Nursing and Midwifery Council* [2023] EWHC 730 (Admin) and *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin) and submitted that it was appropriate to make the application sooner rather than later.

The panel accepted the advice of the legal assessor who referred the panel to *Thorneycroft* v *NMC* [2014] EWHC 1565 and *Squier* v *General Medical Council* [2016] EWHC 2793 (Admin). She reminded the panel to consider the factors to be taken into account when considering a hearsay application and to address its mind to whether it would be able to make an informed decision on a hearsay application at this stage.

Mr Haddow informed the panel that he was neutral as to the timing of the application to admit hearsay evidence. The panel noted the evidence which is to be subject to the hearsay application and considered that it would be able to make an informed decision on the hearsay applications at this stage of the proceedings.

The panel therefore decided to hear Ms Buckell's application to admit the hearsay evidence.

Rule 19

[PRIVATE].

[PRIVATE].

Application to admit hearsay evidence

The panel heard an application made by Ms Buckell under Rule 31 to allow the written statement of Witness 1 into evidence. Witness 1 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, they were unable to attend today due to [PRIVATE].

Ms Buckell submitted that Witness 1’s written evidence was sole and decisive in relation to charge 8. Further, she submitted that there was nothing to suggest that her evidence was unreliable as it was consistent with the notes of her local interview. Ms Buckell accepted that if admitted into evidence, Witness 1’s statement was not able to be challenged. She highlighted, though, that there were no objections from Mr Haddow.

Ms Buckell made a further application to admit exhibits KM4, KM5, KM6 and internal interview notes by Person 1 and Person 2. She submitted that these exhibits include multiple interview notes and whilst they are not sole and decisive, they do provide relevant background to your case. She submitted that it would not be proportionate to call the authors of the notes to give evidence at this hearing, instead, she invited the panel to admit the notes as hearsay evidence.

Mr Haddow confirmed that he did not object to any of the proposed documents being admitted into evidence. He told the panel that he intended to refer to much of the material during proceedings and therefore invited the panel to admit it into evidence.

The panel heard and accepted the legal assessor’s advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is ‘fair and relevant’, a panel may accept evidence in a range of forms and circumstances, whether it is admissible in civil proceedings.

As a first step the panel considered the evidence the subject of this hearsay application and was satisfied that the evidence is relevant to the charges. The panel then proceeded to consider fairness and took into account that Mr Haddow did not object to the admission of any of the evidence as hearsay and informed the panel that he would be relying on some of it in this conduct of your case.

The panel bore in mind the following factors set out in the case of *Thorneycroft*:

- Whether the documents were the sole and decisive evidence in support of the charges;
- The nature and extent of the challenge to the contents of the documents;
- Whether there was any suggestion that the witness had reason to fabricate their allegations;
- The seriousness of the charge, taking into account the impact which adverse findings might have on your career;
- Whether there was a good reason for the non-attendance of the witness;
- Whether the NMC had taken reasonable steps to secure the attendance of the witness;
- Whether you had prior notice that the witness statement was to be read.

The panel considered fairness in the context of Witness 1 evidence being admitted as hearsay. The panel was satisfied that there is good reason for Witness 1's absence and further that Witness 1's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by her. It noted that Witness 1's statement is sole and decisive evidence in support of charge 8 and the panel considered the explanation for Witness 1's absence to be clear and reasonable. The panel took into account that the NMC and Mr Haddow were in agreement that admission of the evidence as hearsay would be fair to both parties.

The panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 1 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

In relation to the application to admit exhibits KM4, KM5, KM6 and internal interview notes by Person 1 and Person 2, the panel bore in mind that they were not sole or decisive pieces of evidence in relation to any of the charges, and both parties agree that the documents should be admitted as hearsay. It also agreed with Ms Buckell that although the documents provide relevant context to your case, it would not be proportionate to call the authors of the notes to give evidence at this hearing. In these circumstances, the panel decided that it would be fair to accept into evidence the exhibits KM4, KM5, KM6 and internal interview notes by Person 1 and Person 2 into evidence as hearsay.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Buckell, at Mr Haddow's request, to admit a person-centred care plan into evidence. She submitted that the care plan related to charge 10, detailing the patient's NEWS score in respect of the emergent tachycardia, and therefore it would be fair and relevant. On this basis, she invited the panel to allow the application.

Mr Haddow confirmed that he wished for the document to be entered into evidence.

The panel heard and accepted the legal assessor's advice. It accepted the submissions of Ms Buckell and considered it to be fair and relevant to enter the care plan into evidence.

Decision and reasons on application to amend the charges

The panel heard a further application made by Ms Buckell to amend the charges.

In relation to Charge 5a Ms Buckell invited the panel to amend the charge to insert the words *'at the time issued'*, as follows:

5. On the 6 July 2019,

(a) failed to administer a controlled drug to a patient ***at the time issued*** *and*

In relation to Charge 5b, Ms Buckell applied to amend the sub charge entirely, from *'erroneously signed the chart that you had administered it', to the words* ***'follow the correct recording procedure once it had been administered'*****.**

In relation to Charge 9b, Ms Buckell invited to amend the charge, changing the word *'nursing'* to *'person' as follows:*

(b) permitted a Clinical Support worker to complete a **person-centred** *care plan and record care documentation for this patient.*

In relation to Charge 10, Ms Buckell invited to add a second sub charge as follows:

10 ***(a)*** *On 21 August 2019 failed to respond to a deteriorating patient's NEWS score of 0 to 2 due to an emergent tachycardia.*

(b) or, in the alternative, failed to record a decision not to conduct the four hourly observations.

Ms Buckell submitted that these proposed amendments would provide clarity and more accurately reflect the evidence.

Mr Haddow did not oppose the proposed amendments to charges 5a, 5b and 9b. He did however object to the addition of the alternative limb to charge 10, stating that it was simply too late in the hearing to add further charges. He told the panel that, as previously

set out, you have a right to know in detail the exact charges you face and must be provided sufficient time to prepare your defence. He submitted that at this late stage, it was unreasonable for the NMC to seek to make such a significant amendment and that it was important that the panel exercised its functions fairly.

The panel accepted the advice of the legal assessor.

The panel bore in mind that the proposed amendments to charges 5a, 5b, and 9b were not opposed by Mr Haddow. The panel accepted that the amendments would clarify the charges and better reflect the evidence presented. Further, the panel was unable to identify any potential unfairness to you. It was satisfied that there would be no prejudice to you and no injustice would be caused to either party by these proposed amendments being allowed. It therefore decided that such amendments were in the interests of justice and allowed the amendments to charges 5a, 5b and 9b to ensure clarity and accuracy.

In relation to the proposed addition of charge 10b, the panel again, bore in mind that the NMC have had four years to decide on the appropriate charges in the context of the complaints and the evidence gathered during its investigation. No new evidence had arisen during the hearing giving rise to any mischief which could be addressed by the proposed addition of charge 10b; *or, in the alternative, failed to record a decision not to conduct the four hourly observations.* In the absence of any mischief to address, the panel identified no benefit, from a public interest perspective, to adding the additional charge.

Again, the panel considered that any unfairness to the NMC in not allowing the amendment was outweighed by the overriding duty to promote fairness and prevent injustice. It determined that the proposed addition of charge 10b would have an unfair impact upon your right to a fair hearing as you would be deprived of a sufficient opportunity to prepare to defend the proposed alternative charge.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Haddow that there is no case to answer in respect of charges 8 and 10. The application was made under Rule 24(7).

In relation to charge 8*,* Mr Haddow submitted that the evidence before the panel consisted of records of drugs administered to a patient and did not evidence that any medication due to be administered had been missed or that there were any record keeping failures.

Mr Haddow referred the panel to the relevant patient records and noted that many of the administration sections corresponding to the prescribed drugs had been left blank or marked to indicate that they were unavailable. Where there were any blank administration sections Mr Haddow highlighted that they corresponded to drug administration times outside of charge 8, and times that you had not been on shift. Therefore, they were not relevant to the charge.

He also referred the panel to the witness statement of Witness 1 which set out:

> *'The NMC have provided me with Patient A's medication chart… and asked me to identify the boxes that I drew to indicate where medication had been omitted. On review now, I am unable to identify them and it appears that this information is not contained within [the medication chart].'*

On the basis that the patient's medication chart did not evidence that any medication due to be administered had been missed or that there were any record keeping failures, Mr Haddow invited the panel to find that you have no case to answer in respect of charge 8.

Mr Haddow also invited the panel to find that you have no case to answer in respect of charge 10 for two reasons. The first reason was that the evidence before the panel suggested that the only significant change in the patient's condition was that of a higher pulse rate. He submitted that a higher pulse rate alone did not amount to a deteriorating condition.

Second, that although you should have recorded why you decided not to undertake four hourly observations, there is insufficient evidence that you failed to respond appropriately to the patient's increased pulse rate. Mr Haddow highlighted that in the circumstances you had discretion as a nurse not to undertake four hourly observations and decided not to do so. He submitted that there was insufficient evidence that a response was required, or that you failed to respond appropriately to the clinical situation. In these circumstances, he submitted that this charge should not be allowed to remain before the panel.

Ms Buckell objected to Mr Haddow's application for 'no case to answer' in respect of both charges 8 and 10 and referred the panel to the NMC's guidance (DMA-6) which sets out the following:

> *'There may be situations where, at the close of our case, the nurse, midwife or nursing associate feels that we just haven't put forward enough evidence to mean they still have a case to answer.*
>
> *There will be no case for a nurse, midwife or nursing associate to answer where, at the close of our case, there is:*
>
> 1. *no evidence*
> 2. *some evidence, but evidence which, when taken at its highest, could not properly result in a fact being found proved against the nurse, midwife or nursing associate, or the nurse, midwife or nursing associate's fitness to practise being found to be impaired.*
>
> *The question of whether there is a case to answer turns entirely on our evidence. Evidence which might form part of the nurse, midwife or nursing associate's case will not be taken into account.*
>
> *Where the strength or weakness of our evidence depends on the weight it should be given, a submission that there is no case to answer is likely to fail. That issue is best considered after all the evidence has been heard.'*

Ms Buckell referred the panel to the evidence which she considered to support charges 8 and 10. She submitted that the strength or weakness of that evidence should be assessed by the panel after all the evidence had been heard.

The panel accepted the advice of the legal assessor who referred to the test set out in the case of *R v* Galbraith [1981] 1 WLR 103.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented by the NMC, such that it could find the facts proved and whether you had a case to answer.

In relation to charge 8 the panel had regard to the written statement of Witness 1, the patient's medication chart, as well as the notes of the investigations on 18 September 2019 and then 1 October 2019. Witness 1's written statement set out the following:

> *'I noticed that some of the teatime medications due to Patient A between 16:00 and 18:00 hours appeared to have been omitted because at the start of my shift, nor were there any notes in patient A's nursing notes to explain why. When I noticed this, I drew boxes around the spaces where there were missing signatures indicating omitted doses in the medication chart.'*

The panel considered that evidence was provided in relation to charge 8 and that further that evidence was not inherently weak or tenuous within the meaning of *R v Galbraith* [1981] 1 WLR 1039. On the evidence before it, the panel determined that there is a case to answer in respect of charge 8.

In relation to charge 10, the panel did not accept the submissions of Mr Haddow. The panel considered that a rising NEWS score would be capable of indicating that a patient's condition would be deteriorating.

The panel took account of the notes of your disciplinary hearing on 3 December 2019, which, in response to the question '*What is normal practice in ward if patient has NEWS 2?'* you said:

> *'Look at [observations]. Patient was palliative and in pain. Done in morning and do again within four hours. Make sure checks in four hours. Didn't do in this instance.'*

The panel also took account of the written statement of Witness 1 and the Trust's Clinical Observations Guidance (acute care) which sets out that a NEWS score of 1-4 should be subject to four hourly observations.

The panel considered that evidence was provided in relation to charge 10 and that further that evidence was not inherently weak or tenuous within the meaning of *R v Galbraith*. What weight the panel gives to any evidence in relation to charges 8 and 10 remains to be determined at the conclusion of all the evidence.

Charges as amended

That you being a Registered Band 6 nurse

1. In or about early August 2019, plagiarised reflective accounts forms taken from your Line Manager, Colleague 1's 2016 reflective accounts which you then submitted to her for the purposes of revalidation

2. Your actions at Charge 1 were dishonest in that you

(a) Knew the reflective accounts forms were not your own

(b) Purported to represent they were.

3. In or about the 31 July 2019, you falsely populated a Reflective Discussion Form with details of discussions with your Line Manager, Colleague 1.

4. Your actions at Charge 3 were dishonest in that you

(a) Knew that there had been no discussion with Colleague 1 at that time

(b) Purported to represent that there had been.

5. On the 6 July 2019,

(a) failed to administer a controlled drug to a patient at the time issued and

(b) follow the correct recording procedure once it had been administered

6. On the 9 July 2019, having recognised medication was out of stock, failed to send the drug requisition book to pharmacy.

7. On 15 July 2019 handed controlled drugs to a student nurse and asked her to lock them away.

8. On 21 August 2019, failed to administer medication to a patient between 16.00 and 18.00 hours alternatively administered medication but failed to record it contemporaneously.

9. On 15 July 2019

(a) failed to document important information namely that a patient had been deliberately trying to fall all day and had been found on the floor.

(b) permitted a Clinical Support worker to complete a person-centred care

plan and record care documentation for this patient.

(c) failed to complete the risk assessment tools for the patient

10 On 21 August 2019 failed to respond to a deteriorating patient's NEWS score of 0 to 2 due to an emergent tachycardia.

And in the light of Charges 1 to 4 your fitness to practise is impaired by virtue of your misconduct.

And in the light of charges 5 to 10, your fitness to practise is impaired by virtue of your lack of competence.

Decision and reasons on facts

At the outset of the hearing Mr Haddow informed the panel that you admitted to charges 1, 2, 3 & 4. At the completion of the NMC's case and the application in relation to 'no case to answer' he informed the panel that you also admitted to charges 5a, 5b, 7 and 9b.

In relation to charge, 7 Mr Haddow explained to the panel that the student nurse in question was two weeks away from qualifying and you considered her competent and capable of handling the medication.

In relation to charge 9b, Mr Haddow explained that, again, the support worker in question was a second-year student nurse, and you considered him competent and capable of completing the documentation under your supervision.

The panel therefore finds charges 1, 2, 3, 4, 5a, 5b 7 and 9b proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel considered all the oral and documentary evidence in this case together with the submissions made by Ms Buckell, on behalf of the NMC, and by Mr Haddow, on your behalf.

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

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

- Witness 2: Band 5 staff nurse at NHS Lanarkshire
- Witness 3: Deputy Chief Nurse at NHS Lanarkshire
- Witness 4: Registered Nurse at NHS Lanarkshire

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The panel made the following findings:

Charge 1

1. In or about early August 2019, plagiarised reflective accounts forms taken from your Line Manager, Colleague 1's 2016 reflective accounts which you then submitted to her for the purposes of revalidation. **Proved by admission**

Charge 2

2. Your actions at Charge 1 were dishonest in that you

(a) Knew the reflective accounts forms were not your own **Proved by admission**

(b) Purported to represent they were. **Proved by admission**

Charge 3

3. In or about the 31 July 2019, you falsely populated a Reflective Discussion Form with details of discussions with your Line Manager, Colleague 1. **Proved by admission**

Charge 4

4. Your actions at Charge 3 were dishonest in that you

(a) Knew that there had been no discussion with Colleague 1 at that time **Proved by admission**

(b) Purported to represent that there had been. **Proved by admission**

Charge 5

5. On the 6 July 2019,

(a) failed to administer a controlled drug to a patient at the time issued and **Proved by admission**

(b) follow the correct recording procedure once it had been administered

Proved by admission

Charge 6

6. On the 9 July 2019, having recognised medication was out of stock, failed to send the drug requisition book to pharmacy.

The panel took account of the documentary and oral evidence of Witness 2, Witness 3, the patient's drug chart, the notes of the formal conduct investigation on 1 October 2019, the notes of the disciplinary hearing on 3 December 2019, the Datix completed the day after the incident, and your oral evidence.

In oral evidence you explained that after learning that the drug was out of stock you annotated '*4'* on the drug chart, completed the drug requisition [indent book] to request the medication, and then handed the indent book to a colleague for the purposes of adding medication required by them from the pharmacy.

Consistent with your explanation, the patient's drug chart indicates that the drug was out of stock at the time and the copy of the indent book provided records your entry of the medication. The panel noted, however, that in the notes of the disciplinary hearing on 3 December 2019 you admit that you did not send the indent book to the pharmacy.

The evidence before the panel showed that the indent book contained entries after yours. This was consistent with your explanation of handing the book to a colleague for the purpose of additional entries, and the panel accepted that you might have expected your colleague to send the indent book to pharmacy.

Witness 3 told the panel that the nurse in charge was responsible for sending the indent book to the pharmacy. However, Witness 2 told the panel that whichever nurse used the indent book last, it was their responsibility to send it to the pharmacy. However, despite checking whether the drug had arrived later in the day, you did not check whether the indent book had been sent.

Although it may have been customary for whichever nurse who last used the indent book to send it to the pharmacy, the panel considered that as the nurse in charge of the patient in question, and the nurse in charge of the ward, you had a duty to ensure that the indent book was sent to the pharmacy. Your failure to ensure that this was done and that the drug was ordered resulted in the patient not receiving their prescribed medication until the following day.

You recognised that the drug was out of stock and unavailable for a patient in your care, and failed to send or ensure that the drug requisition book was sent to the pharmacy. On the basis of the evidence before it, the panel found charge 6 proved.

Charge proved

Charge 7

> *7. On 15 July 2019 handed controlled drugs to a student nurse and asked her to lock them away.* **Proved by admission**

Charge 8

> *8. On 21 August 2019, failed to administer medication to a patient between 16.00 and 18.00 hours alternatively administered medication but failed to record it contemporaneously.*

The panel considered that as a registered nurse you were under a duty to ensure that your patients received prescribed medication when required.

The panel took account of the written statement of Witness 1, the patient's medication chart, the notes of the investigation meetings on 18 September 2019 and then 1 October 2019 as well as your oral evidence.

The panel was not assisted by the general terms in which charge 8 was drafted, and its lack of specificity as to the medication that was not given.

Within the patient's drug chart, the panel identified numerous prescribed drugs which appeared to have been administered by you as they corresponded with your signature, on 21 August 2019 at 16:00 to 18:00 hours. The panel was also able to identify numerous drugs which were not due to be administered, which had been discontinued, or which were unavailable. It was not apparent to the panel if any drugs had been missed, and if so, which ones.

At the time of the Trust's local investigation Witness 1 was clear about which drugs had been administered and which had not. Witness 1 was clear that several of the medications had been missed at teatime. In her witness statement, admitted as hearsay evidence, however, she was unable from the exhibits to identify the drugs which you are alleged to have missed and not administered, as follows:

> *'On review now, I am unable to identify them and it appears that this information is not contained within [the exhibits].'*

There was no evidence to support Witness 1's assertion in her local interview that she had administered the medications which had been missed.

The panel considered that you were consistent in your oral evidence, which was supported by the patient's medication chart. On the basis that the patient's medication chart did not evidence that any medication due to be administered had been missed or that there were any record keeping failures, the panel found charge 8 not proved.

Not proved.

Charge 9

> *9. On 15 July 2019*
> *(a) failed to document important information namely that a patient had been deliberately trying to fall all day and had been found on the floor.*

The panel had regard to the investigation notes of 17 September 2019 (Witness 4), 24 September 2019 (Person 4), 22 October 2019 (Person 3) and the disciplinary hearing notes involving Person 2 dated 3 December 2019, along with the written and oral evidence of Witness 4.

During a formal conduct investigation on 17 September 2019 Witness 4 set out the following:

> *'At the handover I was told by [Nurse Mcaulay] that there was a young girl who was step down from MHDU with an overdose, she was playing up a bit. He behaviour was out of character. At the handover I was told the patient had an unwitnessed fall in the bathroom, and kept falling on the floor deliberately. There was no datex [sic] done. There was nothing in the patients notes documented. The protocol was not followed.'*

During a formal conduct investigation on 24 September 2019 Person 4 set out the following:

'I didn't go into the room, I think this patient came up when the other sick patient was sent to MHDU – it was the same room. I think the patient came in the back of six, and I finished about half past 7. I read the handover sheet and remember that she was suicidal.'

Within the investigation meeting Person 4 was unable to comment or provide any clarity as to whether the patient was found on the floor, and if so, how they got there. During a formal conduct investigation on 22 October 2019 Person 3 set out the following:

'I was chatting to the patient and reassuring her. Her mum was there with her. I was helping the patient back and forward to the toilet, sometimes when the patient was walking she would say that she could not move. She was on the floor at one point, I did not see her do this someone shouted for help.'

During a formal conduct investigation Person 2 set out that she though the patient was lying on the bed, and she did not do any observations because she did not think that the patient had fallen.

The panel had no direct evidence of the patient falling. Neither Person 2, Person 3, Person 4 nor Witness 4 were present at the relevant time. Further, the panel found Witness 4's recall to be inconsistent with other evidence, to include documentary evidence.

The panel could not be satisfied of the identity of the patient that Witness 4 was referring to when recalling the handover. On balance, the panel was not satisfied that a patient referred to in the charge had been deliberately trying to fall all day or that they had been found on the floor. It therefore found charge 9a not proved.

Charge not proved.

(b) permitted a Clinical Support worker to complete a person-centred care plan and record care documentation for this patient. **Proved by admission**

(c) failed to complete the risk assessment tools for the patient

In her oral evidence Witness 1 set out that there was no standard risk assessment, but she would have expected one to have been conducted if the patient was a known risk. There was no evidence before the panel to suggest that this was the case.

Witness 1 also stated that alternatively, she would have expected a risk assessment to be conducted after a fall. Having found that it more likely than not that either there was no fall, or you were unaware of a fall if it had taken place, the panel determined that there was no duty on you to complete a risk assessment for this patient.

Charge not proved.

Charge 10

10. On 21 August 2019 failed to respond to a deteriorating patient's NEWS score of 0 to 2 due to an emergent tachycardia.

In considering the wording of the charge, the panel interpreted '*failure to respond'* as meaning failure to respond appropriately to a deteriorating NEWS score of 2.

The panel had regard to the patient's care plan and NEWS chart, your disciplinary hearing letter from the Trust, the notes of the disciplinary hearing on 3 December 2019, the written statement of Witness 3 and the Trust's Clinical Observations Guidance (acute care).

The Trust's Clinical Observations Guidance (acute care) clearly sets out that a NEWS score of 1-4 should be minimum 4 hourly and clearly documented on the NEWS chart

unless a decision has been made at a Band 5 or above to increase or decrease this frequency. The NEWS frequency must be documented on the NEWS chart and the case notes, and both signed.

The notes of the disciplinary hearing on 3 December 2019 set out that in response to the question '*What is normal practice in ward if patient has NEWS 2?*' you said:

> *'Look at [observations]. Patient was palliative and in pain. Done in morning and do again within four hours. Make sure checks in four hours. Didn't do in this instance.'*

The Trust's disciplinary hearing letter sets out that you acknowledged that you did not check the patient's NEWS when giving medication and the checks were not carried out at the correct times.

In your oral evidence you stated that you believed the patient's elevated pulse rate to be pain related, and that you responded by administering pain medication and formed the clinical judgement that four hourly observations were not required. However, this was neither followed up or recorded in the patient's records.

The Trust's Clinical Observations Guidance (acute care) sets out the following:

> *'The frequency of observations*
> *This should be determined by the nurse responder (band 5 or above) caring for the patient or medical staff / HECT managing the patient's care and should be clearly documented on the NEWS chart. Frequency of subsequent observations will depend on the NEWS score as per the NEWS flow chart. Clinical judgement can also be used to* ***increase*** *the frequency of observations when staff express "Cause for Concern"…'*

In view of all the guidance around NEWS scores there is a duty on a nurse to respond accordingly, or to document their reasoning for deciding to act outside of the guidance.

The purpose of the NEWS scoring system is to monitor deterioration and to take appropriate action in response to maximise patient safety. The panel bore in mind that you were working as a Band 6 nurse and would have had discretion to depart from the guidance although you would have been required to document your decision and reasoning. There was no evidence before the panel to indicate that you had documented or recorded your reason for deciding otherwise in response to the patient's NEWS score of 2.

The panel noted your position that you did respond by administering pain relief and checking the patient. However, the panel also noted that the guidance states: '*that frequency of observations should be clearly documented on the news chart and case notes* ***without exception.***' However, in circumstances where you failed to carry out four hourly observations or record your reasons for not doing so, the panel considered that on the balance of probabilities, you failed to respond appropriately to a deteriorating patient's NEWS score of 0-2, due to an emergent tachycardia.

Based on the evidence before it the panel found charge 10 proved.

Charge proved.

Fitness to practise

The panel then moved on to consider whether the facts found proved amount to misconduct and/or lack of competence and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

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

The panel heard oral evidence from the following witnesses called by Mr Haddow, on your behalf, who provided character references and spoke to your clinical nursing practice:

- Witness 5: Band 5 nurse, providing a character reference
- Witness 6: Band 7 nurse, providing a character reference

The panel also heard evidence from you under oath.

Submissions on misconduct, lack of competence and impairment

Ms Buckell invited the panel to take the view that the charges 1, 2, 3 and 4 found proved amount to misconduct. She referred the panel to The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) and identified the following standards which the NMC considered you to have breached, and which, she submitted, amount to misconduct: 10, 10.3 & 20.

Ms Buckell referred the panel to the case of *GMC v Theodoropoulos* [2017] EWHC 1984 (Admin) and submitted that your actions at charges 1 – 4 were serious because they undermined a system of regulation designed to protect the public.

Ms Buckell informed the panel that the NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Ms Buckell submitted that charges 5, 6, 7, 9b, and 10 related to basic nursing skills and in view of the facts found proved she invited the panel to find that they amounted to a lack of competence.

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

Ms Buckell submitted that all four limbs of the test set out in the case of *Grant* were engaged. She submitted that your actions put patients at risk of harm, breached fundamental tenets of the nursing profession and brought the profession into disrepute. Further, you admitted to acting dishonestly, and your dishonesty was directly related to your nursing practice. She stated that you have not fully reflected upon the impact of your dishonesty on the reputation of the profession. She submitted that, whilst some concerns were easy to put right, the nature of some of the concerns were more difficult to address.

Mr Haddow submitted that you have been consistent throughout these regulatory proceedings and that you are a credible and reliable witness to the circumstances of the charges. Whilst objectively, the information submitted as part of your revalidation was not true or accurate, and was therefore dishonest, it is clear from the evidence that you did not

set out to deceive anybody or shortcut the revalidation process. He submitted that on the scale of dishonesty your plagiarism is at the lower end.

Mr Haddow told the panel that within ten days of presenting the papers to your colleague, you rectified the situation and revalidated using original documents. He highlighted that you revalidated in 2020 without any issue and that there has been no repetition of the revalidation issues since the incident occurred in 2019. He stated that there was no evidence before the panel to suggest that you will act dishonestly again in the future.

In relation to lack of competence, Mr Haddow highlighted that the incidents occurred over a period of five or six weeks. He submitted that a period of five or six weeks was not enough time from which to draw any conclusions about your competence as a nurse and reminded the panel that no issues had been raised in the five years since those incidents occurred. He set out that the five years of practice without any issue suggested that you did not lack competence as a nurse. Further, he submitted that a few incidents over the course of five – six weeks may be more reflective of the environment and wider circumstances at the time, and not the quality of your practice.

Mr Haddow referred the panel to numerous positive character references which described you as hard working, diligent, and focused on patient care. He submitted that the incidents are not a symptom of an attitudinal issue or lack of competence. He set out that you have learned from your mistakes and have '*grown'* through the incidents; you now better understand yourself and your reactions to challenging circumstances, and you have support mechanisms in place to ensure that the mistakes are not repeated. He submitted that the panel could be satisfied that the incidents would not be repeated and that you are capable of kind, safe and effective nursing practice.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council (No 2*) [2000]

1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *Mallon v General Medical Council* [2007] CSIH 17.

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.'*

When determining whether charges 1-4 found proved amount to misconduct, the panel had regard to the terms of the Code. The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and amounted to a breach of the Code, including the following sections:

> ***10 Keep clear and accurate records relevant to your practice***
>
> > *To achieve this, you must:*
> >
> > ***10.3*** *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
>
> ***Promote professionalism and trust***
>
> *You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other health and care professionals and the public.*
>
> ***20 Uphold the reputation of your profession at all times***

To achieve this, you must:

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

***20.2** 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*

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

In relation to charge 1 the panel acknowledged Mr Haddow's submission that there was a '*culture of collaboration'* at the time of the incident and that it was not uncommon for staff to share documents for the purposes of learning. The panel accepted that there had previously been a culture of collaboration when the revalidation process had first been introduced in 2016. However, it did not consider this to be justification for your actions in 2019. The panel considered that as a registered nurse you should have known and understood the purpose and importance of the revalidation process, and that it is never acceptable to plagiarise the reflective accounts of others as part of that process. In all the circumstances, the panel considered your actions fell seriously short of the standards expected on a registered nurse. Therefore, the panel determined that your actions at charge 1 did amount to misconduct.

In relation to charge 2a, the panel bore in mind that you were aware that the reflective accounts were not your own. It again bore in mind the importance of the revalidation process for public protection purposes and for the purpose of maintaining trust and confidence in the nursing profession. It determined that by your actions you knowingly sought to undermine the integrity of the revalidation process. It considered there to be no justification for so doing and decided that your actions at charge 2a were seriously below the standards expected of a registered nurse and amounted to misconduct.

For reasons given at charges 1 and 2a, the panel also considered that your actions at charge 2b also fell short of what is proper and expected of a registered nurse and amounted to misconduct.

In relation to charge 3 you populated a Reflective Discussion Form with details of a discussion you had with your line manager, which you were aware had not yet taken place. The panel considered that your actions in this regard were knowingly dishonest and done to undermine the revalidation process. Notwithstanding your evidence as to [PRIVATE], it considered there to be no justification for your actions and determined that your conduct fell seriously short of the behaviour expected of registered nurses and amounted to misconduct.

The panel considered your conduct at charge 4a and 4b to amount to serious breaches of the code in that your actions were dishonest. Dishonesty is very serious and can never be justified. You failed, not only to show appreciation of the importance of genuine reflective nursing practice, but also sought to undermine the revalidation process, and in doing so acted dishonestly. The panel determined that your actions fell far below the standards expected of a registered nurse and did amount to misconduct.

Decision and reasons on lack of competence

The panel next looked at its findings relative to charges 5, 6, 7, 9b, and 10 and considered whether they amounted to a lack of competence. The panel noted that lack of competence requires an unacceptably low standard of professional performance based upon a fair sample of work, demonstrating that you lack the skill or judgement to practise safely.

In relation to charge 5, the patient required pain relief, which you failed to provide in the form of the controlled drug prescribed. The panel considered your actions to illustrate an inadequate standard of nursing care and poor judgment, which had the potential to cause the patient to suffer unwarranted pain.-The panel noted evidence of poor practice regarding the management and administration of controlled drugs within the ward which

as an experienced band 6 nurse you contributed to by your actions. The panel bore in mind that you are charged with lack of competence as opposed to misconduct with regard to this failing. However, the panel determined that your standard of performance relative to this charge was unacceptably low and amounted to a lack of competence on your part.

In relation to charge 6, the panel considered you to have demonstrated a lack of awareness of the importance of the drug requisition system. Because of your failure to send the requisition book to the pharmacy, or ensure that it was sent, a patient in your care went without medication for 24 hours. The panel considered that the medication prescribed was an important step in recovery from sepsis and having requisitioned the drug through the drug requisition book, you failed to take any steps to ensure that the book was sent to the pharmacy and the medication received. The panel bore in mind that you are charged with lack of competence as opposed to misconduct with regard to this failing. However, the panel determined that your standard of performance relative to this charge was unacceptably low and amounted to a lack of competence on your part.

In relation to charge 7, the panel bore in mind that at the time you had been dealing with a patient complaint and ensured that the controlled drugs were secured in the meantime. No negative consequences arose as a result of your actions and taking into account the pressures you were working under at the time; the panel is satisfied that you did your best to ensure that the controlled drugs were securely locked away in the controlled drugs cupboard. Although you did not follow the Trust policy, in the circumstances, the panel did not consider that your standard of professional performance was unacceptably low to amount to a lack of professional competence.

In relation to charge 9b, in the circumstances, the panel did not consider that your professional performance was unacceptably low. Clinical Support Workers (CSW) and student nurses may complete patient records in some circumstances and the panel considered that you exercised your judgement as to the appropriateness of the CSW completing the person-centred care plan and record care documentation on the occasion in question. It considered that you had taken into account the level of experience the CSW

in question had and accepted that they had acted under your supervision. It considered your actions at charge 9b did not amount to a lack of professional competence on your part.

In relation to charge 10, the panel considered you to have failed to provide sufficient and timely nursing care to a patient. Whilst the CSW took the patient's observations on your behalf, you failed to accurately interpret those observations and to take appropriate steps in response. It considered your actions to demonstrate very poor clinical judgement and to amount to an inadequate performance of a nursing function. The panel further determined that your standard of professional performance was unacceptably low to amount to a lack of professional competence.

The panel determined that charges 5, 6 and 10 individually and cumulatively amounted to lack of competence. It considered that a finding of lack of competence is ordinarily based upon a fair sample of nursing practice. It took into account that your failures span a period of time between 6 July 2019 and 21 August 2019 and determined that that this represents a fair sample of your nursing practice. The panel having decided that your actions relative to charges 5, 6 and 10 were all sufficient in themselves to amount to a lack of professional competence, also considered a fair sample of your nursing practice demonstrates a lack of professional competence on your part.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct and lack of competence, your 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.’

The panel considered the factors set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and determined that the misconduct is such that it can be addressed. In determining whether you had addressed your misconduct and lack of competence the panel had regard to the bundle of documents provided by Mr Haddow to illustrate your remediation.

Nurses occupy a position of privilege and trust in society and are expected at all times to be competent and 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 competent, honest, open and act with integrity. They must make sure that their conduct and competence at all times justifies both their patients’ and the public’s trust in the profession.

In considering impairment on the grounds of misconduct the panel took account of 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.'*

Impairment on the grounds of misconduct

The panel first considered impairment in relation to misconduct and decided that patients were put at risk of harm because of your misconduct. The revalidation process is designed to improve public protection by making sure that you remain fit to practise throughout your career. Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel has found that you have acted dishonestly in the past, and addressed its mind as to whether you are liable to act dishonestly in the future.

The panel bore in mind that although dishonesty can be difficult to remediate, in this case it determined that your misconduct was capable of being remediated. The panel carefully considered the evidence before it in determining whether there is a risk of repetition.

The panel proceeded to consider your insight. It had regard to the reflective statements provided by you and a number of training certificates and testimonials from:

- Witness 6 (Band 7 – an informal mentor)
- Witness 5 (Band 6 – a former colleague)
- Person 5 – involved in and incident saving a young girl's life
- Person 6 – Nurse
- Person 7 - Nurse

The panel bore in mind that you have revalidated twice successfully since the incident in 2019 and that the testimonials spoke to your good conduct and integrity. The panel was satisfied that there are no deep-seated attitudinal concerns in your case. Taking all of these factors into consideration, the panel determined that there is no risk of repetition of the misconduct, and therefore that a finding of current impairment is not required on the grounds of public protection.

The panel proceeded to consider whether a finding of current impairment is required to satisfy the public interest in your case, bearing in mind the need to uphold proper professional standards and public confidence in the nursing profession. The panel considered that public confidence in the nursing profession would be undermined if a finding of impairment was not made in the circumstances of your case.

Impairment on the grounds of lack of competence

The panel proceeded to consider whether your fitness to practise is currently impaired by reason of your lack of competence. The panel is satisfied that your lack of competence is remediable. It had regard to the positive oral evidence and testimonies speaking to your

good nursing practice. It also noted that you have been working as a registered nurse without any further incidents since 2019.

The panel considered you to have demonstrated insight into the circumstances which led to your lack of competence. The panel noted that your insight was more focused upon the impact of your behaviour on yourself than on the impact on nursing standards, the reputation of the profession, and the risk to patient safety. Nevertheless, when balanced against evidence of your good nursing practice since 2019, and the positive testimonials given both orally and in writing, that included senior colleagues, the panel determined that the risk of repetition is low and your fitness to practise is not currently impaired on public protection grounds.

The panel considered whether your fitness to practise is currently impaired on public interest grounds, in relation to your lack of competence. The panel applied its mind as to whether a well-informed member of the public would expect a finding of current impairment in the circumstances of this case.

The panel determined that a well-informed member of the public, considering all of the circumstances of this case, and your good nursing practice since 2019, would not expect a finding of current impairment on public interest grounds alone, in relation to your lack of competence.

Conclusion in respect of current impairment

Having regard to all the above, the panel determined that your fitness to practise is currently impaired only by reason of your misconduct, in respect of charges 1-4, on public interest grounds alone.

Sanction

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

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

Ms Buckell informed the panel that in the Notice of Hearing the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired. During the hearing, the NMC revised its proposal and submitted that a six-month suspension order, without a review, is more appropriate in light of the panel's findings.

Ms Buckell suggested that the following factors amounted to aggravating features in your case:

- That your conduct was dishonest and included plagiarising your colleague's revalidation documents.
- The misconduct occurred in the context of your nursing practice.

Ms Buckell further suggested that the following factors amounted to mitigating features in your case:

- Your cooperation and engagement with these regulatory proceedings.
- Your admissions to many of the allegations.
- [PRIVATE].

Ms Buckell referred the panel to case law including *General Medical Council v Theodoropoulos* [2017] EWHC 1984 (Admin) and *Bolton v The Law Society* [1994] WLR 512. She also referred the panel to the SG, specifically (SAN-2) and (FtP-3a) and highlighted the factors to consider when deciding on an appropriate sanction.

Ms Buckell submitted that although you have demonstrated insight and not repeated the misconduct, your dishonesty included a degree of premeditation and created a risk to patients receiving care. In these circumstances, she submitted that a suspension order for a period of six months, without a review, was appropriate to address the seriousness of your case and satisfy the public interest.

Mr Haddow submitted that this dishonesty fell at the lower end on the spectrum of seriousness. He told the panel that you did not intend to deceive or fool anybody; you did what you believed to be acceptable at that time.

Mr Haddow told the panel that you have already been formally reprimanded by your employer during the disciplinary process and highlighted that you were demoted from a charge nurse to a staff nurse. He also highlighted to that these regulatory proceedings have being ongoing since January 2020.

Mr Haddow told the panel that you have been working without further issues since 2019 and it is in the public interest for good nurses to remain on the register. He submitted that a suspension order, as suggested by the NMC, would be disproportionate in the circumstances of your case, and contrary to the public interest. He submitted that your case is a rare and unusual one where no order is necessary. Given that you have been reprimanded by your employer, he submitted that the panel's earlier finding of current impairment is sufficient to satisfy the public interest in your case, and he invited the panel to make no order.

Decision and reasons on sanction

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

The panel identified the following aggravating features:

- Your misconduct included a degree of premeditation, in that you attempted to submit accounts of conversations which had not taken place to the NMC, alongside plagiarised documents.
- Your misconduct gave rise to a risk of harm to patients because it undermined the revalidation process, designed to protect the public.

The panel also identified the following mitigating features:

- Your admissions to the dishonesty allegation.
- [PRIVATE].

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

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 found that the underlying motivation behind your dishonesty was to maintain your NMC registration, and not for direct financial gain. The panel noted that you demonstrated insight into your conduct and that you made early admissions. You have also apologised for your misconduct, showing evidence of regret, and you have engaged with the NMC and fully participated in proceedings. You have continued to work unrestricted, and you have successfully revalidated on two occasions since this incident. Further, the panel has been told that there have been no adverse findings in relation to your nursing practice since these incidents. Although your dishonesty included a degree of premeditation, the panel reached the view that it did fall at the lower end on the spectrum of dishonesty.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. However, having found your fitness to practice currently impaired on public interest grounds alone, there are no public protection concerns to address. Therefore, a conditions of practice order would not be practicable in your case and would serve no useful purpose.

The panel also considered whether a suspension order would be appropriate in your case. It considered the submissions of Ms Buckell in relation to the sanction that the NMC was seeking in this case. However, the panel determined that to impose a suspension order would be wholly disproportionate and unduly punitive in the circumstances of your case.

Whilst serious, the panel acknowledged that your dishonesty is not of the most serious kind. The panel had regard to the guidance in FTP3a: *Serious concerns which are more difficult to put right.*

The panel did not accept the NMC’s submission that your dishonesty was akin to falsifying qualifications, giving a false picture of employment history which hides clinical incidents in the past, not telling employers that their right to practise has been restricted or suspended, practising or trying to practise in breach of restrictions or suspension imposed by us. The

panel determined that the public interest in your case did not require a suspension order but could be adequately met with a caution order.

The panel has decided that a caution order would adequately mark the public interest. For the next two years, your employer - or any prospective employer - will be on notice that your fitness to practise has been found to be impaired and that your practice is subject to this sanction. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of two years would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered nurse.

At the end of this period the note on your entry in the register will be removed. However, the NMC will keep a record of the panel's finding that your fitness to practise had been found impaired. If the NMC receives a further allegation that your fitness to practise is impaired, the record of this panel's finding, and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to you in writing.

That concludes this determination.