Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

Monday, 10 February 2025-Friday, 21 February 2025

Virtual Hearing

Name of Registrant:	**Stephanie Benyon**
NMC PIN	09F1451E
Part(s) of the register:	Registered Nurse – Sub part 1 Mental Health Nursing (Level 1) – 22 April 2010
Relevant Location:	Worcestershire
Type of case:	Misconduct
Panel members:	Shaun Donnellan (Chair, Lay member) Alison Bielby (Registrant member) Paula Charlesworth (Lay member)
Legal Assessor:	Peter Jennings (10 February 2025) Robin Leach (11 February – 21 February 2025)
Hearings Coordinator:	Sabrina Khan (10 – 13 February 2025 and 17 – 21 February 2025) Charis Benefo (14 February 2025)
Nursing and Midwifery Council:	Represented by Nawazish Choudhury, Case Presenter
Mrs Benyon:	Present and represented by Jerome Burch, instructed by the Royal College of Nursing (RCN)
No case to answer:	**Charge 6a**
Facts proved:	**3a, 3b, 3c(i) (ii) (iii), 3d, 4 and 6b**
Facts not proved:	**1a, 1b, 1c, 2, 5, 7, 8, 9 and 10**
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (9 months)**

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

Details of charges (as amended)

That you a registered nurse:

Whilst working as a nurse at HMP Hewell:

1. On 1 March 2021 whilst conducting a reception screening assessment for Patient A you did not conduct an adequate assessment in that you:

    a. Did not conduct an in-depth conversation with Patient A in light of the information contained within his PER or did not record such a conversation in Patient A's records.

    b. Did not give consideration as to whether an ACCT should have been opened for Patient A or did not record any such consideration in Patient A's records

    c. Did not complete an adequate formulation/assessment of Patient A's risks or did not document an adequate formulation/assessment of risks in Patient A's records

2. Following your appointment as Patient A's care co-ordinator on 8 March 2021, failed to ensure that Patient A was discussed at the MPCCC meeting on 10 March 2021

3. On 16 March 2021 did not conduct an adequate assessment of Patient A in that you:

    a. Did not discuss with Patient A the content and context of voices that he was hearing or did not record such a discussion in Patient A's records

b. Did not discuss with Patient A whether he had thoughts of harming himself/suicidal thoughts or did not record such a discussion in Patient A's records

c. As part of your assessment you did not read Patient A's:

    i. Summary care record

    ii. Liaison and diversion records

    iii. Systm One notes including a nursing assessment of Patient A entered in his notes on 7 March 2021

d. Did not put in place a risk management plan

4. Between 8 and 23 March 2021 did not complete a care plan for Patient A

5. Between 1 and 23 March 2021 did not make an urgent referral to a psychiatrist or ensure that such a referral was considered in response to Patient A reporting to staff on multiple occasions that his depot injection 'was not holding him' or words to that effect

6. On 23 March 2021 during a welfare check on Patient A :

    a. did not engage with Patient A in a compassionate manner

    b. did not adequately explore Patient A's wellbeing with him or did not record this within Patient A's records

Whilst working as a nurse at the Kings Norton Hospital:

7. Did not update Patient B's risk assessment following ligature incidents on 14 and 15 July 2023

8. On or around 16 July 2023 permitted Patient B's risk items to be returned without first seeking input from the multi-disciplinary team

9. Following a ligature incident on 9 August 2023 did not ensure that Patient B's care plan and/or risk assessment were updated upon your return from leave

10. Between June 2023 and 8 August 2023 did not ensure that Patient C's risk assessment was kept up to date

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

Decision and reasons on application to amend the charge

On Monday, 10 February 2025, the panel heard an application made by Mr Choudhury, on behalf of the NMC, to amend the wording of charges 2 and 6.

The proposed amendment was to tidy up the wording for the charge. It was submitted by Mr Choudhury that the proposed amendment would provide clarity and more accurately reflect the evidence.

'That you a registered nurse:

Whilst working as a nurse at HMP Hewell:

1. On 1 March 2021 whilst conducting a reception screening assessment for Patient A you did not conduct an adequate assessment in that you:

a. Did not conduct an in-depth conversation with Patient A in light of the information contained within his PER or did not record such a conversation in Patient A's records

b. Did not give consideration as to whether an ACCT should have been opened for Patient A or did not record any such consideration in Patient A's records

c. Did not complete an adequate formulation/assessment of Patient A's risks or did not document an adequate formulation/assessment of risks in Patient A's records

2. Following your appointment as Patient A's care co-ordinator on 8 March 2021, ~~did not~~ **failed to** ensure that Patient A was discussed at the MPCCC meeting on 10 March 2021

3. On 16 March 2021 did not conduct an adequate assessment of Patient A in that you:

a. Did not discuss with Patient A the content and context of voices that he was hearing or did not record such a discussion in Patient A's records

b. Did not discuss with Patient A whether he had thoughts of harming himself/suicidal thoughts or did not record such a discussion in Patient A's records

c. As part of your assessment you did not read Patient A's:

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d. Did not put in place a risk management plan

4. Between 8 and 23 March 2021 did not complete a care plan for Patient A

5. Between 1 and 23 March 2021 did not make an urgent referral to a psychiatrist or ensure that such a referral was considered in response to Patient A reporting to staff on multiple occasions that his depot injection ‘was not holding him’ or words to that effect

6. On 23 March 2021 during a welfare check on Patient A ~~you did not~~:

a. **Did not** engage with Patient A in a compassionate manner

b. Did not adequately explore Patient A’s well being with him or did not record this within Patient A’s records

Whilst working as a nurse at the Kings Norton Hospital:

7. Did not update Patient B’s risk assessment following ligature incidents on 14 and 15 July 2023

8. On or around 16 July 2023 permitted Patient B’s risk items to be returned without first seeking input from the multi-disciplinary team

9. Following a ligature incident on 9 August 2023 did not ensure that Patient B’s care plan and/or risk assessment were updated upon your return from leave

10. Between June 2023 and 8 August 2023 did not ensure that Patient C’s risk assessment was kept up to date

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

Mr Burch on your behalf did not object to the proposed amendments.

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', as amended (the Rules).

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

Decision and reasons on application of no case to answer

On Wednesday, 12 February 2025, the panel considered an application from Mr Burch that there is no case to answer in respect of charge 6 (a). This application was made under Rule 24(7).

In relation to this application, Mr Burch submitted that it was being made at the close of the NMC's case because this is the appropriate opportunity to do so, and the NMC have not discharged the burden of proof at this stage in relation to charge 6 (a). Mr Burch relied on the case of *R v Galbraith [1981] 1WLR 1039 (Galbraith)* and outlined the relevant sections of the judgement for the panel as follows:

Mr Burch indicated that his submissions regarding assessing whether there is sufficient evidence for this case to move forward in the circumstances will be made under limb 2 of the Galbraith test. He submitted that this is not a case where there is no evidence, but the difficulty arises as there is some evidence, but it is of a tenuous character because of for example, some inherent weakness, vagueness or because it is inconsistent with other evidence. He further submitted that it is where the judge concludes that the prosecution evidence taken at its highest is that no properly directed tribunal could reasonably convict and that is the reason to stop a case. He submitted that in relation to charge 6 (a) the evidence is so inherently vague, inconsistent, and weak that a properly directed panel would not find the facts of the allegations proved.

Mr Burch referred the panel to the witness statement from Witness 1 which states in paragraph 42:

> *'Essentially, there should have been a more inquisitive and compassionate approach to engaging with Patient A.'*

He submitted that apart from this statement, there is no evidence that your engagement with patient A during a welfare check on 23 March 2021 was not undertaken in a compassionate manner. He further submitted that when Witness 1 was questioned about the engagement, she stated that she confirmed that she was not present and therefore, could not say how you engaged with Patient A. Mr Burch submitted that Witness 1 said that she never said that you were not compassionate in terms of the engagement itself, but there was a lack of compassion in the clinical record, as she could only say what had been documented, due to the fact that she was not present. He further submitted that Witness 1 said that *'the documentation was judgemental and not compassionate'*.

In these circumstances, it was submitted that the evidence presented with regards to this charge is inherently weak, and tenuous and therefore, this charge should not be allowed to remain before the panel.

Mr Choudhury accepted that Witness 1 was not present at the time when you conducted a welfare check on Patient A on 23 March 2021. However, he submitted that charge 6 (a) is not drafted as a poor record keeping but indicates that where you have made an entry on 23 March 2021 of Patient's A welfare check, a reading of that entry suggests a lack of compassion.

Mr Choudhury referred the panel to paragraph 41 and 42 of the witness statement of Witness 1 which stated that:

> *'On 23 March 2021 Ms Benyon had an impromptu visit with Patient A whilst he was in segregation. Ms Benyon recorded her notes of this meeting in the SystmOne records, which appear at page 21 (Exhibit LW/03). Ms Benyon*

recorded, 'attempted to blame his mental health' following dicussing [sic] the reason Patient A was placed in segregation. Ms Benyon also recorded, 'officers informed me that he had not had his depot however I believe this to be playing staff off against each other as he has had his depot and not just due to forgetting he had had it'. This entry was concerning for me and again, showed that Ms Benyon attributed and judged Patient A's difficulties as being 'behavioural', which was wrong.

Ms Benyon should have had a conversation with Patient A about his depot medication during this visit, and asked more probing questions…'

He submitted that the aforementioned paragraphs indicate that it was Witness 1's reading of your entry that suggested a lack of compassion.

Mr Choudhury further submitted that in her oral evidence Witness 1 made it clear that she did not say lack of compassion with regards to the engagement itself but only with regards to the documentation, as the way you made the entry about Patient A's welfare check was judgmental and lacked compassion. He also added that Witness 2 also suggested that the documentation indicate that you were not compassionate in your engagement with Patient A.

Mr Choudhury submitted that the test in *Galbraith* is not as simple that the NMC have not discharged its burden because that is a matter for fact-finding at the next stage, but the crux of it is whether a panel on one view of the evidence could find the facts proved. He submitted that there is neither the issue of the evidence being inherently weak or tenuous.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an 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, such that it could find the facts proved and whether you had a case to answer.

The panel considered the application carefully in respect of charge 6 (a). The panel had regard to all the evidence adduced by the NMC, both written and oral. The panel was mindful of the test in considering such applications, as set out in the judgment of Lord Lane LCJ in *R v Galbraith [1981] 1WLR 1039*.

The panel was mindful that it was not deciding whether any of the disputed charge were proved, only whether, applying the Galbraith test to the NMC evidence, it could find the charge proved. In regulatory proceedings, the panel should ask itself the question '*is there any evidence upon which a properly directed panel could find the alleged facts proved?*'. If the answer is '*yes it could'*, (not that it would), then the panel should proceed to hear the defence case.

Charge 6- On 23 March 2021 during a welfare check on Patient A :

a. did not engage with Patient A in a compassionate manner

There is no case to answer for this charge

The panel took account of the oral evidence provided by Witness 1 who stated that she was not present when you conducted the welfare check on Patient A. It agreed with Mr Burch's submission and noted that the charge was based on Witness 1's interpretation of your record entered in relation to the welfare check, which she found to be judgemental. The panel was of the view that it cannot be satisfied that you did not engage with Patient A in a compassionate manner based on a record entered.

The NMC have not provided sufficient evidence for this charge. Applying the second limb of Galbraith, the panel concluded that a properly directed panel could not find that the charge could be found proved or that there was a case to answer.

Background

You first registered as a mental health nurse in 2010. You worked at HMP Hewell ("the Prison") from approximately 2015. The mental health service was run through

the Trust, and you were employed by the Trust. You resigned from your role at the Prison after the incident took place, as you state that you were unable to carry out the care that you felt you should have been able to give to your patients, due to your high workload.

Incident 1

In March 2021, a 23 year old male patient, Patient A, was admitted to the Prison. Patient A had a diagnosis of paranoid schizophrenia which was treated with a long-term antipsychotic depot injection (Paliperidone), which was administered every four weeks. Patient A also had a history of alcohol addiction and illicit substance misuse. Patient A was noted to have a history of suicidal ideation and attempts to hang himself, as well as other harmful behaviour, such as walking into windows and walls and banging his head. Patient A would hear voices which told him to kill himself. Patient A was also known to struggle with his sleep. Patient A had a history of aggressive behaviour and criminal damage. Patient A had his last depot injection on 9 March 2021.

On 25 February 2021, Patient A had thrown two cans of lager at the windscreen of a police vehicle. As Patient A was being arrested for this, a shop owner approached the police and said that Patient A had stolen the cans of lagers from his store. Once arrested and seen in his cell, Patient A said he was going mad and believed that people were following him everywhere and that people from the future were coming for him. Patient A assaulted a police officer in custody and it was thought that his problems were social in nature. Patient A was assessed by two doctors, who said that Patient A was not suffering from mental disorder of a nature or degree to warrant hospital admission. It was determined that Patient A did not require formal admission as the issues related to his accommodation and the assault on the police. Patient A was remanded to the Prison.

On 23 March 2021, Patient A took his own life in prison whilst he was in his segregation cell. Patient A's death was investigated by the Prison and Probation Ombudsman ("PPO") and the death was reported to HM Coroner. The investigation and inquest were the reason for the delay in the Trust referring you to the NMC. The

PPO investigation identified that the care provided was not to an acceptable standard, and that the findings of their report should be shared with you. By the time the findings were published, you no longer worked at the Trust. The PPO investigation also included a clinical review as part of its remit.

The review found that your assessments of Patient A were limited and did not fully capture his risks, which directly impacted on the level of mental health support and assessment that Patient A received. The review found that the assessments were also limited to the extent that you did not review any of Patient A's historical information or records that were sent to the Prison, which showed that Patient A had recently attempted to take his own life. The review also found that Patient A did not have a care plan or risk assessment in place, and you should have created one when you became Patient A's care coordinator.

Incident 2

During the NMC's screening process into the substantive referral, your subsequent employer, Active Care Group, raised concerns about your practice. It was reported that you joined Kings Norton Hospital ("the Hospital") as a ward manager and later stepped down to a senior staff nurse role. Concerns were raised about your risk assessment skills and documentation in relation to two patients, Patient B and Patient C.

Patient B was admitted on 12 July 2023 and had numerous incidents of headbanging and tying ligatures, none of which were recorded on the risk assessment until 15 July 2023, when the Matron added them in to the assessment following an incident. The Matron stated that you were asked repeatedly to ensure that the assessments were up to date. Patient B also had all of her potential risk items removed upon admission however during a 1:1 with Patient B, you independently decided to say to Patient B that she could have her risk items back. This was without a discussion with the Multi-Disciplinary Team ("MDT"). The following day, the professionals at the morning meeting retracted your decision.

Patient C's risk assessments and care plans were out of date. The MDT agreed to refer Patient C to the psychiatric intensive care unit ("PICU") at another hospital.

However, the PICU referral was rejected the same day and was ultimately delayed for two weeks due to out of date documentation. The Matron stated that you were responsible for ensuring Patient C's care documentation was kept up to date.

The charges arose whilst you were employed as a registered mental health nurse by the Hospital.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Burch, who informed the panel that you made full admissions to charges 3a, 3b, 3c i, ii, iii, 3d, 4 and 6b.

The panel therefore finds charges number(s) proved in their entirety, by way of your 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 Choudhury and Mr Burch.

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

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

- Witness 1: Clinical reviewer;
- Witness 2: Acting senior cluster manager in Inclusion.
- Witness 3: Matron

- Witness 4: Ward Manager

The panel also heard evidence from you under affirmation.

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 Mr Choudhury, you and Mr Burch. This included a bundle provided by you which included your response and reflections, and a number of testimonials. The panel was also greatly assisted by the provision of detailed written final submissions on facts by both counsel.

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

Charge 1a)

That you a registered nurse:

Whilst working as a nurse at HMP Hewell:

1. On 1 March 2021 whilst conducting a reception screening assessment for Patient A you did not conduct an adequate assessment in that you:

    a. Did not conduct an in-depth conversation with Patient A in light of the information contained within his PER or did not record such a conversation in Patient A's records.

This charge is found NOT proved.

Patient A was assessed by you on 1 March 2021 when he was brought into Prison and you conducted a Reception Screening Assessment, ('the Assessment'). The process was conducted and recorded contemporaneously on Systm One using the template.

The panel initially considered what constituted the Assessment, you gave oral evidence that you viewed it as a '*snapshot of someone coming into the prison*' and its purpose was signposting and arranging medical support services.

The NMC case is that it is wider and deeper than that and both Witness 1 and 2 in their evidence spoke of the purpose of the Assessment being an important and significant event as it was the first occasion a patient would be seen by a healthcare professional when they arrived from custody or court.

The panel were persuaded that the Assessment was substantially more than a snapshot or a triage function to other services (although inevitably there would be some of the latter involved).

It was agreed that the setting for the Assessment was pressured and Witness 1 states that:

> '*It is fair to say in a reception environment it is very pressured, pressure of time you will never have a really extensive assessment in reception, lots of assessments, it's very busy*.'

Witness 1 stated that she would have expected a much more detailed assessment with more of a narrative detailing a '*defensive decision*' about self-harm. This was echoed by Witness 2 who said the assessment was too brief and '*does not capture all of Patient A's mental health risks*'.

There were two Prisoner Escort Records (PER) provided in the evidence bundle, an electronic and a paper version. It was not clear within the evidence which of the PER accompanied Patient A. The purpose of a PER is to accompany a person from one place of custody into another place. On the balance of probabilities the panel determined that you did have sight of the electronic PER and so you will have had sight of the facts that Patient A was considered a risk, that he was on a suicide and self-harm warning which included 30 minute observations whilst in custody and had mental health concerns.

The panel had sight of the electronic PER which provided information on physical health, mental health, including suicide and self-harm risk, alcohol and addictions. The panel noted that these were included in the Systm One assessment undertaken by you along with an immediate referral to a GP, request for the patient to be placed in 'first night observation cells' and for a mental health assessment to be undertaken the following day. The patient was appropriately referred for further assessments. The panel noted that you recorded contemporaneously the following comments on Systm One as part of your assessment:

> *'Presented as appropriate throughout assessment, engaged well in conversation understanding and answering all questions, speech was coherent and well presented. Maintained good eye contact throughout and his body posture appeared comfortable and relaxed. He was fully orientated to time, place and person. Firmly denies having any thoughts, plans or intentions of self-harm/suicide at this present time. requesting for zopiclone and quetiapine to help him sleep.'*

You said whilst you were cognisant of the comments in the PER and mindful of any risks you saw your role as dealing with how Patient A presented to you at the time he was received in prison and further explained that sometimes a person who presents in one way in police custody may present in another when he is remanded to prison.

It is clear from the record that you did have an in-depth conversation with Patient A. Whilst your documentation of the conversation on Systm One was succinct the panel was satisfied that it was a record of the conversation.

The panel determined that you had conducted an adequate assessment within the scope of an initial screening.

Therefore, on the balance of probabilities the panel found this charge to be not proved.

Charge 1b)

1. On 1 March 2021 whilst conducting a reception screening assessment for Patient A you did not conduct an adequate assessment in that you:

    b. Did not give consideration as to whether an ACCT should have been opened for Patient A or did not record any such consideration in Patient A's records.

This charge is found NOT proved.

Assessment, Care in Custody, and Teamwork (ACCT) is a framework that acts as a risk management tool and provides thorough and comprehensive support and acts as a second layer of safeguarding for vulnerable prisoners.

Witness 1 stated in her evidence that you did not document your thought process regarding the ACCT. She stated that given the recorded self-harm risks to Patient A, you should have either opened an ACCT or recorded the justification of why you did not.

Witness 2 supported your approach in that he stated that an ACCT could have been considered that this happens implicitly in prison assessments, and agreed with you that at the time it did not seem warranted. His view was that, '*the screening assessment provides reassurance that Patient A did not express any thought of self-harm or suicide at that time. Consequently, an ACCT referral did not seem warranted at this point*.' He explicitly stated that it was '*not a requirement'* to document that an ACCT was considered if it was ultimately deemed unnecessary.

In evidence, you explained that an ACCT would always be in the front of your mind to be considered whilst conducting prison assessments, but it was not required that it should always be entered in the notes if an ACCT was not something you believed was necessary.

The panel noted that that no other healthcare professional who assessed Patient A recorded an ACCT consideration either, suggesting that this was not standard practice at that time. It also noted that you followed the advice provided by National Institute for Health and Care Excellence (NICE) which is contained within the Mental

health of adults in contact with the criminal justice system, Guideline 66 (The Guidelines), which state that an ACCT plan should only be opened if there are serious concerns raised in response to questions about self-harm including thoughts, intentions or plans or observations. The panel was of the view that since Patient A *denied* self-harm thoughts at the time of screening, there was no requirement to open an ACCT.

The panel noted that you appropriately referred Patient A for further mental health assessments.

The panel accepted your evidence that you did consider opening an ACCT but did not feel it was necessary for you to record such a consideration. This accords with the evidence of Witness 2.

Therefore, on the balance of probabilities the panel found this charge to be not proved.

Charge 1c)

1. On 1 March 2021 whilst conducting a reception screening assessment for Patient A you did not conduct an adequate assessment in that you:

    c. Did not complete an adequate formulation/assessment of Patient A's risks or did not document an adequate formulation/assessment of risks in Patient A's records.

This charge is found NOT proved.

The panel took account of the fact that you did record details of self-harm and mental health concerns. It accepted Mr Burch's submission in that while some details from the PER were not explicitly copied over, the PER itself was available for reference, and not every detail needed to be duplicated.

The panel noted that Witness 2's evidence supported your approach and acknowledged that the reception screening was not intended to be a full mental health assessment. He stated that it was good practice that you had addressed

suicide risk and self-harm, and that he did not find the absence of further documentation to be a serious failing.

The panel considered the NICE Guidelines which did not require a full risk assessment at reception screening and that your referrals for further assessment were appropriate. The panel was of the view that it was reasonable for you to rely on Patient A's presentation at the time while ensuring that Patient A was seen by a GP and referred for a further mental health assessment.

The panel determined that your formulation/assessment of Patient A's risks was adequate and your documentation of the formulation/assessment of Patient A's risks was documented adequately.

Therefore, on the balance of probabilities the panel found this charge to be not proved.

The panel determined that your Assessment of Patient A was overall an adequate assessment.

Charge 2

2. Following your appointment as Patient A's care co-ordinator on 8 March 2021, failed to ensure that Patient A was discussed at the MPCCC meeting on 10 March 2021.

This charge is found NOT proved.

The panel had no evidence of any MPCCC meeting minutes on 10 March 2021 and therefore it was unable to ascertain who attended or who was discussed at this meeting. There was evidence from Witness 2 that the MPCCC meeting on 10 March 2021 did not include Patient A.

The panel determined that you did not ensure that Patient A was discussed at the MPCCC meeting on 10 March 2021. However, based on your evidence, the panel was of the view that you were not aware that you had been assigned as Patient A's care coordinator on 8 March 2021 at 16:21 via the task function on Systm One. It

also noted that you only became aware later in March, which explained why you did not raise Patient A's case at the 10 March meeting.

The panel noted that the allocation of a care coordinator was done via a task system in Systm One, but these tasks were used for various purposes and that you did not review it daily.

There was no evidence presented to demonstrate that once a patient was allocated via task that there was a checking process to ensure a nurse had read the task and ensure that they had undertaken the role of care coordinator.

The panel considered the evidence of Witness 2 who stated that it would have been *'ideal'* for Patient A to be reviewed on 8 March 2021 and discussed at MPCCC on 10 March 2021.

The panel noted that Patient A was discussed on 17 March 2021, following your wellbeing appointment with him on 16 March 2021 which suggested that Patient A was referred quickly following your review of him.

It is the understanding of the panel that this allocation system has now been improved, with daily allocation meetings during which patients are allocated to a care coordinator.

Therefore, on the balance of probabilities the panel found this charge to be not proved.

Charge 5

5. Between 1 and 23 March 2021 did not make an urgent referral to a psychiatrist or ensure that such a referral was considered in response to Patient A reporting to staff on multiple occasions that his depot injection 'was not holding him' or words to that effect.

This charge is found NOT proved.

Witness 1 in her evidence stated that when a patient with schizophrenia states that their medication is ineffective, it is a critical warning sign that should trigger an urgent psychiatric referral.

Witness 2 in his evidence stated that it was not solely your responsibility to decide on the urgency of the referral. He noted that the MPCCC meeting on 17 March 2021, as a whole decided on a routine referral, suggesting that other professionals did not see an urgent referral as necessary. The panel noted from the minutes of the MPCCC meeting that the decision to make a routine referral was a collective clinical decision made by the MPCCC, with the knowledge that his depot '*was not holding him'*.

The panel determined that although Witness 1 states that any report of a depot injection not working must result in an urgent referral, there was no clear policy mandating an urgent referral in such cases.

Therefore, on the balance of probabilities the panel found this charge to be not proved.

Charge 7

7. Did not update Patient B's risk assessment following ligature incidents on 14 and 15 July 2023.

This charge is found NOT proved.

The panel heard evidence from Witness 3 that she had checked the duty rotas and you were shown as being on duty on 14 and 15 July 2023, as Patient B's allocated nurse. The panel did not have sight of the rotas covering this period. It noted that the 72 hour incident report listed all the staff on duty during that period and that your name was not contained within this list. The panel preferred the documented evidence to the witness testimony and therefore concluded that you were not on duty at the time of the 14 and 15 July 2023 ligature incidents. It also noted that the Risk Reduction Care Plan dated 12 July 2023, confirmed that another nurse was allocated as the primary nurse for Patient B. Therefore, the panel determined that since you were not the primary nurse allocated for Patient B, the responsibility to update the risk assessment did not fall on you.

Witness 3 in her evidence stated that the risk assessment should have been updated immediately after the incidents and that as a senior nurse, you bore responsibility for ensuring this was done. Witness 3 indicated that she updated promptly the risk assessment after the incidents. However, because these were not signed the panel were unable to ascertain who had updated these. As this was done in a timely manner there was no failure to update the assessment at the time.

In addition, the panel noted that there no immediate concern raised with you about a failure to update the assessment at the time, nor was this discussed with you during supervision, as confirmed by Witness 4 in her evidence.

Therefore, on the balance of probabilities the panel found this charge to be not proved.

Charge 8

8. On or around 16 July 2023 permitted Patient B's risk items to be returned without first seeking input from the multi-disciplinary team

This charge is found NOT proved.

Witness 3 in her evidence stated that it was reported to her that you made a unilateral decision to return the risk items which was then reversed the next day following the MDT meeting. She stated that if risk items were returned without MDT consultation, it would be a serious lapse in judgment. However, the panel noted that Witness 3 gave evidence that the risk items were never actually returned and that they were locked away and the night staff were unable to find the key to the locker.

Witness 4 in her evidence stated that Patient B's risk items were indeed returned and that you made an unauthorised decision to do this. She also suggested that you had a conversation with Patient B, in which you allegedly made a '*pinky promise*' regarding returning the items. Witness 4's evidence was inconsistent with Witness 3's evidence as Witness 4 claimed the risk items were returned and then removed again.

The panel had regard to your evidence where you denied the return of the risk items. You also told the panel that the '*pinky promise*' was about allowing Patient B to go for a vape, not about returning risk items. You provided clinical reasoning for the process of returning the risk items singly and that you would never return all risk items together, nor would you permit the return of items without discussion and agreement from the MDT.

The panel noted that it had no documentary evidence to demonstrate the incident occurred. The MDT meeting minutes did not mention any discussion of this incident nor the alleged reversal of a decision to return risk items. In the absence of such record, the panel cannot be satisfied that you had returned the risk items to Patient B or permitted them to be returned to Patient B.

Therefore, on the balance of probabilities the panel found this charge to be not proved.

Charge 9

9. Following a ligature incident on 9 August 2023 did not ensure that Patient B's care plan and/or risk assessment were updated upon your return from leave.

This charge is found NOT proved.

The panel determined that the care plan and/or risk assessment should have been updated immediately by the nurse in charge, not delayed until your return from leave,

Witness 3 in her evidence stated that the care plan and/or risk assessment should have been updated immediately. She claimed that because you were a senior nurse, it was your responsibility to ensure that it was completed. However, during her cross-examination, Witness 3 acknowledged that the care plan and a risk assessment should have been updated immediately and not delayed until your return from leave.

The panel noted that when you returned to work, there was no evidence of anyone informing you that the care plan and/or risk assessment needed to be updated. The panel also noted that there was no evidence of concerns being raised with you at the

time regarding an incomplete risk assessment, until September 2023. It determined that if it was such a serious failure, it would have been flagged much earlier.

Therefore, on the balance of probabilities the panel found this charge to be not proved.

Charge 10

10. Between June 2023 and 8 August 2023 did not ensure that Patient C's risk assessment was kept up to date.

This charge is found NOT proved.

Witness 3 in her evidence stated that it was the responsibility of the named nurse to ensure risk assessments were up to date, however, the written policy was unclear as to who was responsible. The panel noted that a risk assessment was completed for Patient C on 2 August 2023 by '*Chidi with MDT input*'. It accepted Mr Burch's submission that this contradicts the charge of a failure to keep the assessment up to date and suggested that it was a shared responsibility among multiple professionals, and not your sole responsibility.

The panel were shown the risk assessment for Patient C which appeared to be up to date. However, the majority of the entries were unsigned, and it was not possible to determine who would have kept the document up to date.

Witness 4 in her evidence stated that she did not recall any concerns being raised about your documentation. The panel was of the view that if there had been a serious issue with your failure to update the risk assessment, it would have been flagged earlier.

Therefore, on the balance of probabilities the panel found this charge to be not proved.

Application to admit witness evidence on behalf of the registrant at impairment and misconduct stage.

Mr Burch applied to call Witness 5 to give evidence at this stage. Her statement had only become available in the first week of the hearing.

Her evidence related to the chaos and disarray at HMS Howell in 2021, and the difficulties in running a prison at that time.

Mr Burch submitted that it was relevant to the background against which the admitted charges arose.

Mr Choudhury submitted that the evidence should have been adduced during the fact-finding stage and that it was too late to introduce the evidence.

The panel received legal advice from the legal assessor on Rule 31.

The panel determined that the evidence was relevant, and it would be unfair not to admit it. The panel noted that her evidence dealt with general matters and did not relate to the specific charges.

The panel decided that because she had no access to a computer that she should be allowed to give her evidence by phone.

The panel heard this evidence as part of the evidence called by Mr Burch on impairment.

During his submissions on misconduct and impairment Mr Burch applied under Rule 19 to read some evidence about [PRIVATE]. This was not objected to by Mr Choudhury. The panel was then given advice by the legal assessor on Rule 19 and allowed the application.

Fitness to practise

The panel heard live evidence from yourself and Witness 5, mental health nurse, called on behalf of you. The panel also considered all the documentation presented on your behalf, including a large number of testimonials, your response and reflection, supervision notes and training certificates.

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

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

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

Submissions on misconduct

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 Choudhury first outlined the working conditions at HMP Hewell. He submitted that while you have told the panel that you were working in a challenging environment with a busy workload that has impacted your work, neither Witness 1 nor Witness 2

asserted anything regarding the systematic failure within the prison's healthcare system. He added that while Witness 2 did mentioned some technical difficulties with the Systm One electronic record, it has now been fixed and does not justify that your failures were caused by systemic disarray.

Mr Choudhury submitted that while it is accepted that hospital wards, care homes, prisons, and other healthcare environments can be busy and challenging places to work, these factors cannot serve as a defence or justification for a failure to meet professional standards. He submitted that if the argument that challenging work environments excused or mitigated failings were to be accepted, it would be difficult to hold any nurse accountable for their professional misconduct, thereby undermining public trust in the profession.

Mr Choudhury referred the panel to the case of *Roylance v General Medical Council* (No. 2) [2001] 1 AC 311 where misconduct was referred to as the conduct which falls significantly short of the standard expected of a professional.

Mr Choudhury referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision. He said that the following provisions of the Code are engaged in this case as a result of your breach of the Code:

- **1.1** Treat people with kindness, respect, and compassion.
- **1.2** Ensure that the fundamentals of care are delivered effectively.
- **1.4** Ensure that any treatment, assistance, or care for which you are responsible is delivered without undue delay.
- **20.1** Maintain the high standards of professional practice expected of you.

Mr Choudhury submitted that a breach of the Code does not automatically amount to misconduct. However, he said, your actions in this case constitute serious failings, which significantly fall below the standard expected of a registered nurse. He submitted that you have admitted several charges and these admissions are significant in assessing the seriousness of your failings.

Mr Choudhury submitted, you as a care coordinator failed to address crucial aspects of Patient A's condition, including his auditory hallucinations and his thoughts of self-harm or suicide. In addition, he submitted you failed to review key records, including the GP Summary Care Record, the LDS records, and the mental health screening conducted on 3 March 2021. He submitted that you also failed to implement a risk management plan at any time while responsible for the patient's care.

Mr Choudhury further submitted that you failed to create a care plan for Patient A, particularly given his vulnerabilities and mental health needs. He submitted that Systm One provided a template for care plans, making it clear that even a basic care plan was feasible. He submitted that the failure to produce a care plan demonstrates a fundamental neglect of your duties.

Mr Choudhury submitted that you failed to engage with Patient A adequately while he was in segregation, despite his evident need for support.

Mr Choudhury submitted that taken collectively, your conduct fell significantly below the standard expected of a registered mental health nurse, particularly given your 11 years of experience. He submitted that as a nurse working in a prison setting, you were in a position of considerable responsibility, and your failure to uphold fundamental aspects of patient care is serious. He submitted that these failings amount to misconduct. Mr Choudhury submitted that your omissions and failures in this case are not minor lapses but serious breaches of professional standards, which justify a finding of misconduct by this panel.

Therefore, Mr Choudhury invited the panel to take the view that the facts found proved amount to misconduct.

Mr Burch referred the panel to the cases of *Nandi v General Medical Council* [2004] and *Roylance v General Medical Council* [1999] and submitted that while negligent conduct can amount to serious professional misconduct, the threshold requires negligence of a high degree.

Mr Burch submitted that the all the incidents in relation to the charges occurred in a high-pressure environment—a busy remand prison with complex patient needs and multiple professionals involved in patient care. He submitted that your failures spanned a short period and must be assessed within the broader context of your professional practice. Mr Burch submitted that while the failings constitute breaches of expected standards, it is submitted that they do not meet the threshold for misconduct given that they were neither persistent nor indicative of a fundamental lack of competence.

Therefore, Mr Burch invited the panel not to take the view that the facts found proved by way of your admission does not amount to misconduct.

Submissions on impairment

Mr Choudhury 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). He submitted that in light of those authorities, the NMC submits that your actions and admissions, which have been found proved, cover fundamental aspects of safe nursing practice. The proven charges, as submitted in the misconduct stage, relate to key aspects of care and professional responsibility.

Mr Choudhury submitted that in reaching its decision, the panel will also have regard to the NMC's Fitness to Practise Library, updated on 27 March 2023. He submitted that this guidance sets out the key question in determining impairment: *Can the nurse, midwife, or nursing associate practise kindly, safely, and professionally?* If the answer is no, then their fitness to practise is impaired.

Mr Choudhury submitted that nurses hold a position of privilege and trust. They are expected to act professionally at all times, in accordance with the Code. Patients and their families must be able to trust nurses with their lives, and nurses must act with

honesty, integrity, and openness. Their conduct must justify public confidence in the profession.

Mr Choudhury referred the panel to the judgment of Mrs Justice Cox in the case of *CHRE v NMC & Grant*, where she stated that when determining impairment, the relevant panel should consider not only whether the practitioner poses a continuing risk to the public but also whether a failure to make a finding of impairment would undermine confidence in the profession.

He submitted that Mrs Justice Cox referenced Dame Janet Smith's test, which is relevant to this case:

> *'(a) Has the registrant in the past acted, or is liable in the future to act, in a way that puts a patient at unwarranted risk of harm?*
> *(b) Has the registrant in the past brought, or is liable in the future to bring, the profession into disrepute?*
> *(c) Has the registrant in the past breached, or is liable in the future to breach, one of the fundamental tenets of the profession?'*

Mr Choudhury submitted that limbs (a), (b), and (c) are engaged in this case. He submitted that your conduct fell below the expected standard, and there is a real risk of repetition.

Mr Choudhury submitted that you have expressed remorse and shown insight into your conduct which is evident from your reflective statement. In addition, he submitted that there are several positive testimonials on your behalf.

Mr Choudhury submitted that you have returned to work at HMP Hewell, in a different capacity. He informed the panel that as of September 2023, you have been working within the segregation unit, where your role involves safeguarding the well-being of patients, conducting blood tests, and performing general nursing duties. He submitted that although your current role is different from the one in which the failings occurred, the change in role does not necessarily demonstrate that your risk of repetition has been sufficiently addressed.

Mr Choudhury acknowledged that you have undertaken further training and have contributed to developing care assessment templates within the segregation unit. However, he submitted that there remains a lack of evidence of strengthened practice specifically addressing the failings identified in this case. Mr Choudhury submitted that you have indicated that you do not intend to return to the same area of work, but if you were to do so, there is a risk that similar failings could occur. Therefore, he submitted that there remains a real risk of repetition.

Mr Choudhury submitted that a finding of impairment is necessary both to protect the public and to uphold the public interest. He submitted that the public must have confidence that nurses meet the required standards of care. He submitted that a failure to make a finding of impairment in this case would undermine public confidence in the profession. Mr Choudhury submitted that your actions breached fundamental tenets of nursing practice, and an informed member of the public would rightly expect a finding of impairment to be made.

Therefore, Mr Choudhury invited the panel to find that your fitness to practise is impaired on both public protection and public interest grounds.

Mr Burch submitted that while the proven allegations constitute failings, they do not reach the threshold for current impairment. He submitted that you have demonstrated significant insight, remediation, and commitment to professional development, mitigating any ongoing risk to public safety or public confidence in the profession.

Mr Burch submitted that you have demonstrated significant insight into your failings as evidenced by your reflective account. He submitted that you acknowledge your omissions, understands their implications, and have taken steps to improve your practice. Mr Burch submitted that you have also shown deep personal remorse, stating:

> *'…My life changed on March 23rd when Patient A took his own life, I was and am still devastated. I think about it every day and attended counselling myself*

to help me come to terms with such an awful serious incident. I am so very sorry for both Patient A and his Family.

I am utterly traumatised that I find myself in this position. My patients and my nursing career mean the world to me and I have always respected my profession and my role as a nurse…'

He submitted that such expressions of remorse, coupled with your professional development, reflect a genuine commitment to learning from past events.

Mr Burch submitted that you have actively engaged in remediation, including consistent participation in monthly supervision, training and further development, including work in the segregation unit, enrolment in a master's course in nursing advocacy to support fellow nurses. He submitted that your appraisal from July 2021 reflects high competency scores, further evidencing your commitment to maintaining professional standards.

Mr Burch submitted that there have been no further concerns raised regarding your practice since the events of March 2021. He submitted that you have worked continuously and safely, with no complaints or referrals apart from the present matter. He referred the panel to the positive testimonials from colleagues which further attest to your professionalism and diligence. He submitted that given that you demonstrated growth and ongoing professional development, the risk of repetition is minimal.

Mr Burch submitted that it is not necessary to find impairment to uphold public confidence in the profession. He submitted that fully informed public would consider the passage of time since the events which happened nearly four years ago, your significant remediation your exemplary performance in your new role and the absence of any further concerns about your practice. He submitted that it is in the public interest to allow a competent, remediated, and safe nurse to continue practicing, rather than imposing an unnecessary restriction on her career.

Mr Burch submitted that there is no significant risk to public protection given your insight, remediation, and continued safe practice. He submitted that you are currently practicing safely, professionally, and competently. Accordingly, he submitted that a finding of impairment is unnecessary on the ground of public protection or public interest.

Decision and reasons on misconduct

In reaching its decision, the panel had regard to the case of *Roylance v General Medical Council (No 2)* [2000] 1 A.C. 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"* as well as 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 that your actions amounted to breaches of the Code. Specifically:

1. Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

10. Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen

and the steps taken to deal with them, so that colleagues who use the records have all the information they need.

13. Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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:

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

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

In reaching its decision, the panel had regard to the NMC Guidance, "*Misconduct*" (FTP-2a) and "*How we determine seriousness*" (FTP-3). The panel considered each of the charges found proved in turn.

Charge 3a

The panel determined that you did not conduct an adequate assessment of the patient on 16 March 2021. The panel was of the view that despite the patient having a diagnosed psychiatric condition and reporting that he *'had thoughts in his heads and can hear these thoughts'* you failed to explore the nature and context of these experiences. This omission is particularly concerning given that a mental health nurse should be expected to assess whether auditory experiences indicate a worsening of psychiatric symptoms or an increased risk to the patient's safety.

Accordingly, the panel determined that this amounted to misconduct.

Charge 3b

The panel determined that you did not adequately inquire about Patient A's suicidal thoughts or self-harm, despite the patient's known vulnerabilities and psychiatric history. The panel was of the view that this failure represents a fundamental lapse in care, as the assessment of risk is a crucial element of mental health nursing, especially in a prison environment where risk factors may be exacerbated.

The panel considered these omissions to be serious breaches of expected professional practice. Accordingly, the failure to explore these critical aspects of the patient's mental state constitutes misconduct.

Charge 3c

The panel determined that accurate assessment of a patient includes reviewing the health records of a patient and is an essential part of nursing practice to ensure appropriate care is provided. Failing to review care records prior to assessing a patient means that you cannot adequately assess and understand the risk to provide appropriate care from an informed perspective.

Therefore, the panel finds that this failure amounted to misconduct.

Charge 3d

The panel determined that you did not put in place an adequate risk management plan for Patient A. The panel was of the view that a risk management plan is essential in cases where a patient presents with psychiatric vulnerabilities, particularly in a high-risk environment such as a prison. The purpose of such a plan is to share risk-related information with colleagues to ensure a collective approach to patient safety.

Therefore, the panel finds that this failure amounted to misconduct.

Charge 4

The panel determined that you did not complete a care plan for Patient A between 8 and 23 March 2021. The panel noted that your failure to implement a plan meant that Patient A's risks were not properly managed. The care plan was a requirement under the care program approach (CPA) and provided a further layer of support to recognise risk and identify and meet individual needs. The panel determined that given that you were in a position to recognise these risks and take appropriate action but did not do so, the panel finds that this failure constituted misconduct.

Charge 6b

The panel determined that on 23 March 2021, you had an opportunity to reassess the patient and rectify previous omissions in care. Notwithstanding, the challenges of the segregation unit and that it was an unplanned visit, you again failed to conduct an adequate exploration of Patient A's needs. Despite the patient's ongoing vulnerabilities, you did not take appropriate steps to ensure his safety.

The panel acknowledges your concerns regarding confidentiality. However, patient confidentiality does not outweigh the fundamental duty to protect life and ensure patient welfare. The panel was of the view that you could have taken reasonable steps to continue the conversation in a more suitable setting. The failure to act appropriately during this welfare check represents a further lapse in professional judgment and therefore, amounted to misconduct.

The panel found that the charges individually and cumulatively amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, 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.'*

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her/ fitness to practise is impaired in the sense that S/He:

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

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

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

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

The panel was satisfied that limbs (a) to (c) above are engaged in this case. The panel considered each of the engaged limbs in turn.

On whether patients were put at unwarranted risk of harm as a result of your misconduct, the panel took into account that you have put patients at risk of harm by failing to conduct adequate assessments and keep proper records and develop appropriate care plans.

The panel considered whether the concerns in this case can be addressed, and they agreed that they could, the Panel then went on to consider whether or not you have addressed those concerns.

The panel first of all considered your insight provided by your response and reflection and oral evidence and decided that taken collectively was a mixture of a narrative about the events and the working environment. You told the panel little about how far your actions fell short of meeting professional standards and how the wider impact of your failings would damage public confidence in nursing. You failed

to demonstrate how you would manage your actions should you be faced with a similar situation in another challenging environment. The panel determined that you have not fully addressed the nature of the concerns that led to the proved charges.

The panel next considered your practise strengthening, it carefully considered the evidence both documentary and oral. The supervision documents showed some recognition of what you were seeking to achieve but did not provide substantial evidence of outcomes. The training course certificates appeared to be either mandatory or generic training and little in the way of addressing the specific failings identified by the proved charges. The appraisal proffered was historic (July 2021) and provided little assistance in the consideration of current impairment.

A number of testimonials were considered and whilst they spoke highly of you, most of the authors did not speak to knowing the detail of the proved charges (although many knew of the referral, no other detail was given) and their testimonies did not fully address the failings identified by the proved charges.

The panel therefore determined that you have not satisfactorily addressed the concerns yet.

The panel next went onto consider whether or not the conduct was likely to be repeated and determined that you have not demonstrated through insight and practise strengthening that there would not be a repeat. The panel determined that there remains a risk of repetition.

The panel determined that a finding of impairment was necessary to protect the public.

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

The panel determined that a finding of impairment on public interest grounds was necessary in order to ensure that the public confidence in the profession would not be undermined.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 9 months. The effect of this order is that the NMC register will show that your registration has been subject of a conditions of practice order.

Submissions on sanction

Mr Choudhury informed the panel that in the Notice of Hearing, dated 6 January 2025, the NMC had advised you that it would seek the imposition of suspension for 12 months if it found your fitness to practise currently impaired.

Mr Choudhury submitted that the proportionate, necessary and appropriate sanction in this case is a suspension order. He reminded the panel was the key findings from its decision on impairment, particularly the risk of harm posed by the registrant's failings, the lack of full remediation, the generic nature of any practice improvements, and the ongoing risk of repetition.

Mr Choudhury submitted that a sanction of no further action was inappropriate given the seriousness of the case and the public protection concerns identified. He submitted that such an approach would neither be proportionate nor in the public interest.

Mr Choudhury submitted that while a caution order would be the least restrictive sanction, it was unsuitable because your conduct was not at the lower end of the

spectrum of impaired fitness to practice. A caution would fail to reflect the gravity of the case and could send the wrong message to the profession and the public.

Mr Choudhury submitted that any conditions must be proportionate, measurable, and workable. However, he submitted that given the nature and seriousness of the case, there were no practicable or workable conditions that could sufficiently protect patients or address public confidence concerns. He submitted that your return to work had not fully resolved the identified issues, reinforcing the view that a conditions of practice order would be inadequate.

Mr Choudhury submitted that a suspension order of 6 to 12 months, with a review, would be the most suitable sanction. He submitted that this would allow you additional time to develop further insight and address the concerns raised. Mr Choudhury submitted that a suspension would cause you financial and reputational hardship. However, he submitted that this was outweighed by the need to protect the public and uphold public confidence in the nursing profession.

Mr Choudhury further highlighted that while your conduct did not involve dishonesty, financial misconduct, or criminal convictions, it nonetheless reached a sufficient threshold of seriousness to warrant regulatory action. He invited the panel to rely on its own reasoning as set out in its impairment findings, particularly the identified risks and ongoing concerns regarding the registrant's fitness to practice.

Accordingly, Mr Choudhury submitted that a suspension order for 6 to 12 months was the appropriate and proportionate sanction in this case.

The panel also bore in mind Mr Burch's submissions.

Mr Burch submitted that a suspension would be wholly disproportionate given the committee's findings. He acknowledged that lower sanction levels, such as no further action or a caution order, would not be appropriate but strongly argued that a conditions of practice order would be the most suitable sanction.

Mr Burch emphasised that this was your first professional misconduct finding in a 25-year healthcare career and that the process itself had already been a form of punishment. He highlighted your acceptance of the committee's determination, acknowledgment of the need for further remediation, and willingness to undertake necessary steps for improvement.

Mr Burch submitted that you have admitted all proven allegations, demonstrating responsibility and remorse. He submitted that there was no evidence of deep-seated personality or attitudinal problems. He told the panel that the misconduct occurred over a short period (approximately one week) and was not part of a recurring pattern. He informed the panel that you have practiced under interim conditions since 2023 without issue and had shown commitment to improving your practice, particularly in record-keeping and patient assessments.

Mr. Burch submitted that a suspension would not serve the public interest, as it would deprive you of your livelihood and potentially cause financial hardship, including the loss of your home.

Mr Burch invited the panel to impose a conditions of practice order saying this would be proportionate, which would allow you to continue working while addressing the identified concerns.

He referenced the NMC's guidance on sanctions (San 3C), which suggests conditions are appropriate when areas needing improvement are identifiable, there is no evidence of general incompetence, and the registrant is willing to undertake necessary training. He pointed out that interim conditions had already been successfully monitored and assessed, demonstrating their effectiveness.

Addressing the committee's findings on insight, practice strengthening, and risk of repetition, Mr. Burch submitted that these concerns could be effectively managed through structured conditions to protect the public while enabling you to strengthen your practice. He stressed that you were committed to your role, had demonstrated improvement, and was willing to take further steps to ensure public protection and meet the public interest.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of developed insight into failings
- Putting vulnerable patients at risk of harm

The panel also took into account the following mitigating features:

- Early acceptance of the concerns
- Evidence of remorse to address the concerns
- Some evidence of practice strengthening

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution

order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

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

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that these incidents happened nearly four years ago. You have continued to practice as a nurse and no further concerns have been raised in that period. Other than these incidents, you have had an unblemished career of 11 years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, and as an experienced nurse that you should be allowed to continue to practise.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order for 9 months which will be sufficient time to enable you to demonstrate further practise strengthening and develop full Insight.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case and was not necessary to protect the public or act in the public interest.

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

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

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

1. You must ensure that you have monthly supervision meetings with your line manager. Your supervision must consist of:

    a) Risk assessment
    b) Care planning
    c) Escalation of concerns

2. You must send the NMC a report from your line manager in advance of the next NMC hearing or meeting from which should comment on your progress in relation to:

    a) Risk assessment
    b) Care planning
    c) Escalation of concerns

This report should include evidence that your line manager has examined samples of your work and report on how you have demonstrated a, b, and c, above.

3. You must demonstrate that you have undertaken training targeted at the areas that are identified by your misconduct.

4. You must continue to develop your insight into the misconduct proved by writing further reflective pieces detailing your understanding of the wider impact of your actions what you have learned and how you would manage yourself in a similar situation.

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

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

7. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).

c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

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

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

The period of this order is for 9 months.

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

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest

until the conditions of practice order 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 Choudhury. He submitted that an interim order is necessary on the grounds of public protection and is otherwise in the wider public interest.

The panel also took into account the submissions of Mr Burch. He submitted that as you are already operating under an interim conditions of practice order, there is no immediate risks to the public.

Therefore, he invited the panel to confirm and continue the current interim conditions of practice order.

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 the only suitable interim order would be that of a conditions of practice order for a period of 18 months with the same conditions as contained in the panel's determination at the substantive hearing, as to do otherwise would be incompatible with the hearing's findings.

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

That concludes this determination.