Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday, 27 February 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Miss Poppy Bonsall**
NMC PIN	21I0273E
Part(s) of the register:	Nursing, Sub part 1 RNC: Children's nurse, level 1 (26 October 2021)
Relevant Location:	Yorkshire
Type of case:	Misconduct Lack of competence
Panel members:	Louise Guss (Chair, lay member) Janet Fitzpatrick (Registrant member) Jane Malcolm (Lay member)
Legal Assessor:	Juliet Gibbon
Hearings Coordinator:	Bartek Cichowlas
Consensual Panel Determination:	Accepted
Facts proved:	Charges 1(a), 1(b), 2, 3(a), 3(b), 4, 5(a), 5(b), 6(a)(i), 6(a)(ii), 6(a)(iii), 6(b), 6(c), 6(d), 7(a), 7(b), 8(a), 8(b), 9, 10, 11, 12(a), 12(b), 13(a), 13(a)(i), 13(a)(ii), 13(a)(iii), 13(a)(iv) 13(a)(v), 13(a)(vi). 13(a)(vii), 13(b)(i), 13(b)(ii), 13(b)(iii), 13(b)(iv), 13(b)(v).
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Miss Bonsall's registered email address by secure email on 26 February 2025. The panel had sight of an email from Miss Bonsall's representative at the Royal College of Nursing stating that she agreed to waive the 28-day notice period.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, and that the meeting would take place on or after 27 February 2025. The panel noted that there was an inconsistency between the CPD, which stated that the case was to be considered at a hearing, and the Notice of Meeting which stated that it was to be considered at a meeting. The panel, however, considered correspondence contained in the notice and was satisfied that Ms Bonsall had agreed for her case to be considered at a meeting.

In the light of all of the information available, the panel was satisfied that Miss Bonsall was aware that the meeting would take place on or after 27 February 2025 and that she had waived her right to the 28-day notice period.

Details of charge

That you, a registered nurse:

1) On or about 17 – 18 June 2022:

    a) accessed Patient A's medical records without clinical justification;
    b) after obtaining information about Patient A's attendance at A&E, sent a text message to the patient without clinical justification

2) Incorrectly stated during a Trust meeting on 22 August 2022 that you had accessed Patient A's medical records accidentally

3) Your conduct as specified in charge 2 was dishonest in that:

    a) you knew you knew that you had intentionally accessed Patient A's records without clinical justification;
    b) you intended to deceive the Trust into believing that you had accidentally accessed Patient A's records

4) Incorrectly stated during a Trust meeting on 22 August 2022 that you had not sent a text message to Patient A

5) Your conduct as specified in charge 4 was dishonest in that:

    a) you knew that you had sent a text message to Patient A;
    b) you intended to deceive the Trust into believing that you had not contacted Patient A

6) During a night shift on 1 – 2 August 2022 whilst caring for Patient C:

    a) did not monitor Patient C's heart rate accurately in that you:
        i. did not set the alarm on the 'high flow' monitor correctly so that it would alert if Patient C's heart rate fell below 70bpm;
        ii. did not attend to and/or review Patient C whenever the 'high flow' monitor alert sounded;
        iii. did not set the 'high flow' monitor to take readings more frequently than every 2 hours;
    b) did not record Patient C's manual heart rate readings adequately or at all;
    c) incorrectly stated to Colleague A that you had taken manual heart rate readings;

d) did not ensure that Patient C was repositioned every 2 hours

7) Your conduct as specified in charge 6c) was dishonest in that:

a) you knew you did not take manual heart rate readings;
b) you intended to mislead Colleague A into believing you had taken manual heart rate readings for Patient C

8) During a night shift on 15 – 16 August 2022 whilst caring for Patient B:

a) did not escalate Patient B's critically low blood glucose reading of 2.5mmol/L to a senior colleague in a timely manner or at all;
b) incorrectly recorded in Patient B's notes that you informed a senior colleague about Patient B's blood glucose reading at approximately 21:30 on 15 August 2022

9) Incorrectly stated during a Trust meeting on 22 August 2022 that you had escalated Patient B's blood glucose reading to a senior colleague at 21:00 on 15 August 2022

10) Your conduct as specified in charge 8b) and/or charge 9 was dishonest in that you knew you did not inform a senior colleague until approximately 07:00 on 16 August 2022

11) On 30 March 2022 provided to the Trust an image of a positive Covid-19 test which did not relate to you

12) Your conduct as specified in charge 11 was dishonest in that:

a) you knew that the image did not relate to a test that you had taken;
b) you intended to mislead the Trust to believe that the positive Covid-19 test was your own

13) Between 27 May 2022 and 16 August 2022, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:

a) Whilst subject to an informal capability process between approximately 27 May 2022 and 28 July 2022, failed to meet the following objectives:
    i) IV competency;
    ii) Team working;
    iii) Management of higher acuity ('HDU') patients;
    iv) Medicines management;
    v) Documentation;
    vi) Communication;
    vii) Time management

b) Whilst subject to a formal capability process between approximately 29 July 2022 and 16 August 2022, failed to meet the following objectives:
    i) IV competency;
    ii) Team working;
    iii) Management of higher acuity ('HDU') patients;
    iv) Documentation;
    v) Communication;

Consensual Panel Determination

At the outset of this meeting, the panel was made aware that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the Nursing and Midwifery Council (NMC) and Miss Bonsall.

The agreement, which was put before the panel, sets out Miss Bonsall's full admissions to the facts alleged in the charges, that her actions amounted to misconduct and a lack of

competence, and that her fitness to practise is currently impaired by reason of that misconduct and lack of competence. It is further agreed between the NMC and Miss Bonsall in the agreement that the appropriate sanction in this case would be a striking-off order.

The panel has considered the provisional CPD agreement reached by the parties.

The panel considered the references in the CPD agreement to Miss Bosnall being content for her case to be dealt with by way of a CPD hearing whereas she subsequently agreed for it to be dealt with in a meeting. The panel therefore amended paragraphs 1 and 2 of the provisional CPD agreement to reflect this. It also noted the reference to mental health nursing in paragraph 48 and determined that this must be an administrative error which it deleted.

The amended CPD agreement reads as follows:

'The Nursing & Midwifery Council ("the NMC") and Poppy Bonsall ("the Registrant") PIN 21I0273E ("the Parties") agree as follows:

1. *The Registrant is content for her case to be dealt with by way of a CPD [meeting].*

2. *The Registrant […] is content for it to proceed in both her absence and that of her representative. Both will endeavour to make themselves available by telephone should clarification on any point be required by the Panel, or should the Panel wish to make amendments to the provisional agreement.*

3. *On 16 January 2025 the NMC wrote to the York and Scarborough Teaching Hospitals NHS Foundation Trust ("the Trust") to ascertain whether they agreed with the content of the CPD provisional agreement. On 20 January 2025 the Trust confirmed that a striking off order would be a sensible and safe outcome.*

Preliminary issue

4. *There is reference within this agreement to private and confidential matters concerning the Registrant's private life. The parties agree that those matters set out within this agreement should remain wholly private in accordance with Rule 19(3) of The Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ("the 2004 Rules"). This is justified by the interests of the Registrant per Rule 19(3) of the 2004 Rules. Such references within this document have been marked '**PRIVATE**' […] as required.*

The charges

5. *The Registrant admits the following charges:*

That you, a registered nurse:

1) *On or about 17 – 18 June 2022:*

a. *accessed Patient A's medical records without clinical justification;*
b. *after obtaining information about Patient A's attendance at A&E, sent a text message to the patient without clinical justification*

2) *Incorrectly stated during a Trust meeting on 22 August 2022 that you had accessed Patient A's medical records accidentally*

3) *Your conduct as specified in charge 2 was dishonest in that:*

a. *you knew that you had intentionally accessed Patient A's records without clinical justification;*
b. *you intended to deceive the Trust into believing that you had accidentally accessed Patient A's records*

4) *Incorrectly stated during a Trust meeting on 22 August 2022 that you had not sent a text message to Patient A*

5) *Your conduct as specified in charge 4 was dishonest in that:*

a. *you knew that you had sent a text message to Patient A;*
b. *you intended to deceive the Trust into believing that you had not contacted Patient A*

6) *During a night shift on 1 – 2 August 2022 whilst caring for Patient C:*

a. *did not monitor Patient C's heart rate accurately in that you:*
    did not set the alarm on the 'high flow' monitor correctly so that it would alert if Patient C's heart rate fell below 70bpm;
    did not attend to and/or review Patient C whenever the 'high flow' monitor alert sounded;
    did not set the 'high flow' monitor to take readings more frequently than every 2 hours;
b. *did not record Patient C's manual heart rate readings adequately or at all;*
c. *incorrectly stated to Colleague A that you had taken manual heart rate readings;*
d. *did not ensure that Patient C was repositioned every 2 hours*

7) *Your conduct as specified in charge 6c) was dishonest in that:*

a. *you knew you did not take manual heart rate readings;*
b. *you intended to mislead Colleague A into believing you had taken manual heart rate readings for Patient C*

8) *During a night shift on 15 – 16 August 2022 whilst caring for Patient B:*

a. *did not escalate Patient B's critically low blood glucose reading of 2.5mmol/L to a senior colleague in a timely manner or at all;*

b. incorrectly recorded in Patient B's notes that you informed a senior colleague about Patient B's blood glucose reading at approximately 21:30 on 15 August 2022

9) Incorrectly stated during a Trust meeting on 22 August 2022 that you had escalated Patient B's blood glucose reading to a senior colleague at 21:00 on 15 August 2022

10) Your conduct as specified in charge 8b) and/or charge 9 was dishonest in that you knew you did not inform a senior colleague until approximately 07:00 on 16 August 2022

11) On 30 March 2022 provided to the Trust an image of a positive Covid-19 test which did not relate to you

12) Your conduct as specified in charge 11 was dishonest in that:

a. you knew that the image did not relate to a test that you had taken;
b. you intended to mislead the Trust to believe that the positive Covid-19 test was your own

13) Between 27 May 2022 and 16 August 2022, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:

a. Whilst subject to an informal capability process between approximately 27 May 2022 and 28 July 2022, failed to meet the following objectives:
i. IV competency;
ii. Team working;
iii. Management of higher acuity ('HDU') patients;
iv. Medicines management;

v. *Documentation;*
vi. *Communication;*
vii. *Time management*

b. *Whilst subject to a formal capability process between approximately 29 July 2022 and 16 August 2022, failed to meet the following objectives:*
i. *IV competency;*
ii. *Team working;*
iii. *Management of higher acuity ('HDU') patients;*
iv. *Documentation;*
v. *Communication;*

AND in light of the above, your fitness to practise is impaired by reason of your misconduct at charges 1 – 5 and 8b) - 12 and lack of competence at charges 6a), 6b), 6d), 8a), 13a) and 13b).

The facts

6. *The agreed facts upon which the Registrant's admissions to the charges are based are as follows:*

7. *The Registrant appears on the register of nurses, midwives and nursing associates maintained by the NMC as a registered nurse (children's nurse). She was admitted to the register on 26 October 2021.*

8. *On the relevant dates the Registrant was a Band 5 staff nurse within the paediatrics department at the Trust. The NMC received a referral from the Interim Associate Chief Nurse at the Trust on 27 January 2023. The referral resulted in an investigation by the NMC which identified the following concerns: breaching patient confidentiality, failing to preserve patient safety in respect of the volume of feeds given to an infant patient, recording that the patient had received more than they had, and underfeeding resulting in low blood sugar (as well as failure to escalate the low blood sugar*

reading). Concerns were also identified relating to failure to adequately monitor and record a patient's heart rate and ensure repositioning every 2 hours.

9. *Dishonesty concerns were also identified because when asked for evidence of a positive Covid-19 test the Registrant provided an image she had taken from the internet. She also provided a false account of circumstances in which she contacted a patient, this was in order to conceal that she had contacted them after seeing their notes. The Registrant also falsely claimed to have escalated a patient's low blood sugar reading knowing that she had not done so and also knowingly recorded incorrect information regarding the volume of the feeds given to a patient (to conceal that the patient had not been given the amount recommended in their feeding plan).*

10. *The Registrant was suspended by the Trust on 16 August 2022. At the Trust's disciplinary hearing on 16 January 2023 the Trust determined that had the Registrant not resigned that day she would have been dismissed for gross misconduct.*

Charges relating to misconduct, including dishonesty

Charge 1) a) & b)

11. *On 17 June 2022 the Registrant accessed the electronic patient record for Patient A without clinical justification (Patient A was known to the Registrant). Patient A was being treated in the emergency department of the hospital where the Registrant worked. The Registrant then contacted Patient A by text message in relation to what she had seen. She did this whilst she was on duty in the children's ward and the patient was not under her care.*

Charge 2)

12. *During a Trust meeting on 22 August 2022 the Registrant incorrectly stated that she had accessed Patient A's medical records accidentally.*

Charge 3) a) & b) - dishonesty

13. *The Registrant's conduct specified in Charge 2 was dishonest in that she a) knew she had intentionally accessed Patient A's records without clinical justification and b) intended to deceive the Trust into believing she had accidentally accessed Patient A's records. The Registrant knew that she had intentionally accessed Patient A's records without clinical justification. During the course of the Trust investigation the Registrant eventually admitted this conduct. However, at a Trust meeting on 22 August 2022 she stated that she had accessed Patient A's records accidentally and that she had not sent a text message to Patient A. The Registrant knew that she had sent a text message to Patient A but intended to deceive the Trust into believing she had accidentally accessed the records and had not contacted Patient A.*

Charge 4)

14. *During a Trust meeting on 22 August 2022 the Registrant incorrectly stated that she had not sent a text message to Patient A. The Registrant stated that she had accessed Patient A's records accidentally and that she had not sent a text message to Patient A. The Registrant knew that she had sent a text message to Patient A but intended to deceive the Trust into believing she had accidentally accessed the records and had not contacted Patient A by text message.*

Charge 5) a) & b) - dishonesty

15. *The Registrant's conduct as specified in Charge 4 was dishonest in that she knew she had sent a text message to Patient A and intended to deceive the Trust into believing she had not contacted Patient A.*

Charge 6) c)

16. *During the night shift of 1-2 August 2022 whilst caring for Patient C, the Registrant incorrectly stated to Colleague A that she had taken manual heart rate readings.*

Charge 7) a) & b) - dishonesty

17. *The Registrant's misconduct as specified in Charge 6) c) was dishonest in that the Registrant knew that she did not take manual heart rate readings and she intended*

to mislead Colleague A into believing she had taken manual heart rate readings for Patient C.

Charge 8) b)

18. *During the night shift of 15-16 August 2022, the Registrant was caring for Patient B (a baby) whose blood sugar level dropped to an abnormally low level. The Registrant incorrectly recorded in Patient B's notes that she had informed a senior colleague about Patient B's blood glucose reading at approximately 21:30 on 15 August 2022.*

Charge 9)

19. *At a Trust meeting on 22 August 2022 the Registrant incorrectly stated that she had escalated Patient B's blood glucose reading to a senior colleague at 21:00 on 15 August 2022.*

Charge 10) - dishonesty

20. *The Registrant's conduct as specified in Charge 8) b) and/or Charge 9 was dishonest in that she knew she did not inform a senior colleague until approximately 07:00 on 16 August 2022. The Registrant dishonestly told colleagues that she had escalated Patient B's low blood sugar, when she had failed to escalate this. The Registrant recorded in Patient B's notes that she had escalated the matter to the doctors and nurses at around 21:00 on 15 August 2022. The on-call registrar and the nurse in charge did not have any recollection of this happening. At the Trust meeting on 22 August 2022 the Registrant sought to represent to the Trust that she had made the escalation when she had not.*

Charge 11

21. *On 30 March 2022 the Registrant provided to the Trust an image of a positive Covid-19 test which did not relate to her. The Registrant sent the image of the positive Covid-19 test to the Trust after her request for leave to attend a family event was refused. She then called in sick and was asked to produce evidence of the positive test. During the Trust investigation the Registrant admitted that this was an image*

from the internet and not her own test. On 8 August 2022 the Trust therefore issued a written warning to the Registrant for a period of 12 months.

Charge 12) a) & b) – dishonesty

22. *The Registrant's conduct as specified in Charge 11 was dishonest in that she knew the image did not relate to a test she had taken and she intended to mislead the Trust to believe that the positive Covid-19 test was her own. This was an act of deliberate dishonesty because the Registrant knew that the image did not relate to a test that she had taken and she intended to mislead the Trust to believe that the positive Covid-19 test was her own.*

Charges relating to competency

Charge 6) a) i) ii) & iii), b) and d)

23. *During the night shift of 1-2 August 2022, the Registrant was asked by a doctor to closely monitor Patient C's (a baby) heart rate and maintain an accurate record of Patient C's heart rate monitoring. However, the Registrant failed to do so because she did not set the alarm on the 'high flow' monitor correctly so that it would alert if Patient C's heart rate fell below 70bpm. She also did not attend to or review Patient C whenever the 'high flow' monitor alert sounded. She did not set the 'high flow' monitor to take readings more frequently than every 2 hours. The Registrant failed to ensure that Patient C was repositioned every 2 hours.*

Charge 8) a)

24. *During the night shift of 15 -16 August 2022 the Registrant was caring for Patient B (a baby) whose blood sugar level dropped to an abnormally low level. The Registrant dishonestly told colleagues that she had escalated Patient B's low blood sugar, when she had failed to escalate this. The Registrant recorded in Patient B's notes that she had escalated the matter to the doctors and nurses at around 21:00 on 15 August 2022.*

Charge 13) a) i)-vii) and b) i)-v)

25. *Between 27 May 2022 and 16 August 2022, the Registrant failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse. Whilst subject to an informal capability process between approximately 27 May 2022 and 28 July 2022, she failed to meet the following objectives:*

    (i) IV competency;

    (ii) Team working;

    (iii) Management of higher acuity ('HDU') patients;

    (iv) Medicines management;

    (v) Documentation;

    (vi) Communication; and

    (vii) Time management.

26. *Whilst subject to a formal capability process between approximately 29 July 2022 and 16 August 2022, she failed to meet the following objectives:*

    (i) IV competency;

    (ii) Team working;

    (iii) Management of higher acuity ('HDU') patients;

    (iv) Medicines management;

    (v) Documentation; and

    (vi) Communication.

Misconduct

27. *The parties agree that the Registrant's conduct specified in charges 1 – 5, 6c) and 8b) - 12 amounts to misconduct. The Registrant accepts that her conduct fell seriously short of what was expected and required of a registered nurse in the*

circumstances of the case and acknowledges that fellow practitioners would consider her actions to be deplorable.

28. *NMC guidance on misconduct (FTP-2a) states that the NMC Code sets out the professional standards of practice and behaviour for nurses, midwives and nursing associates, and the standards that the public tell the NMC they expect from those professionals. Nurses, midwives and nursing associates must act in line with the NMC Code. If their conduct falls short of the requirements of the Code, what they did or failed to do could amount to serious professional misconduct.*

29. *The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 provide some assistance when seeking to define misconduct:*

> *'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances'.*

30. *As do the comments of Jackson J in Calhaem v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), respectively:-*

> *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'.*
>
> *And*
>
> *'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by a fellow practitioner'.*

31. *With reference to the Code, the Parties agree that the following provisions are engaged:*

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately. To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

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:

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

20 Uphold the reputation of your profession at all times

20.2 act with honesty and integrity at all times…

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

20.6 stay objective and have clear professional boundaries at all times with people in your care

32. *Applying the facts of this case to the question of misconduct, the Parties agree that the following features put beyond doubt that the Registrant's actions amount to misconduct:*

a) *The Registrant accessed Patient A's medical records without clinical justification. This was inappropriate, unprofessional and a breach of confidentiality. The Registrant contacted Patient A by text message with regard to the clinical information she had accessed. This was a breach of confidentiality and a breach of professional boundaries.*

b) *At the Trust meeting on 22 August 2022 the Registrant then sought to represent to the Trust that she had accessed Patient A's medical records accidentally when this was not true. She also informed the Trust at this meeting that she had not sent the text message to Patient A when in fact she had. She therefore failed to act with honesty and integrity and acted in breach of her duty of candour by seeking to prevent her misconduct from coming to light during the Trust meeting on 22 August 2022.*

c) *The Registrant incorrectly recorded in Patient B's notes that she had informed a senior colleague about Patient B's blood glucose reading at approximately 21:30 on 15 August 2022. She also incorrectly stated during the Trust meeting on 22 August 2022 that she had made the escalation to the senior colleague when she had not. She therefore failed to act with honesty and integrity and acted in breach of her duty of candour by seeking to prevent her misconduct from coming to light during the Trust meeting on 22 August 2022.*

d) *The Registrant stated to Colleague A that she had taken manual heart rate readings for Patient C when she had not and in doing so she intended to mislead Colleague A. She therefore failed to act with honesty and integrity.*

e) *The Registrant provided an image of a positive Covid-19 test to the Trust, seeking to represent that it was a test that she herself had taken when in fact she had not. She intended to mislead the Trust into thinking that the positive test was hers and in so doing she failed to act with honesty and integrity and in breach of the duty of candour.*

Lack of competence

33. *The parties agree that the Registrant's conduct specified in charges 6a), 6b), 6d), 8a), 13a) and 13b) amounts to a lack of competence. The Registrant accepts that her conduct fell seriously short of what was expected and required of a registered nurse in the circumstances of the case.*

34. *NMC guidance on lack of competence (FTP-2b) states that lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.*

35. *With reference to the Code, the Parties agree that the following provisions are engaged:*

Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

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

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

36. *The Registrant has demonstrated an unacceptably low standard of professional performance judged on her past conduct, in particular her care of Patient B and Patient C and her performance during the informal and formal capability processes between 27 May–16 August 2022. With regard to Patient B, during the night shift of 15-16 August 2022, the Registrant failed to escalate Patient B's critically low blood glucose reading to a senior colleague. With regard to Patient C, during the night shift of 1-2 August 2022 the Registrant failed to accurately monitor Patient C's heart rate and did not record manual heart rate readings. She also failed to ensure that Patient C was repositioned every 2 hours.*

37. *Despite support being provided with supervision and support during her period of performance improvement the Registrant was unable to rectify the concerns which related to her practice and which placed patients at risk of harm. The Registrant was subject to an informal performance improvement plan from May 2022, from which she progressed to a stage 1 formal performance improvement plan in July 2022. During her period of performance improvement, the Registrant was supervised and supported via regular meetings with her managers, peer feedback and being asked to complete reflections. However, she failed to improve her performance to the required standard to be able to practice without supervision.*

Impairment

38. *The Registrant's fitness to practise is currently impaired by reason of her misconduct and lack of competence.*

39. *The NMC's guidance suggests the following question should be considered when deciding whether a professional's fitness to practise is impaired:*

    'Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'

40. *The parties have considered that question and the factors set out by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) by Cox J, before concluding that the Registrant's fitness to practise is currently impaired.*

41. *Having regard to the questions set out in Grant, the Parties agree that the Registrant's conduct:*

    a. *Placed Patients B and C at an unwarranted risk of harm due to her lack of competence and the failings that she demonstrated in carrying out their care. She failed to practice effectively and take measures to ensure that patients involved were safe. She also failed to communicate effectively, escalate issues as necessary and accordingly created a risk to vulnerable infant patients in her care.*

    b. *The Registrant has in the past acted dishonestly and based on past misconduct is liable to act dishonestly in the future.*

    c. *The Registrant has breached the fundamental tenets of the profession by failing to meet the standards of competence and honesty and integrity required of a registered nurse.*

d. *The Registrant has in the past and is liable in the future to bring the medical profession into disrepute.*

42. *The Parties note that impairment is a forward looking exercise and have considered the questions described as 'highly relevant' to the prospective aspect of current impairment in Cohen v General Medical Council [2008] EWHC 581 (Admin).*

43. *The Parties agree that breaching professional boundaries, seeking to prevent misconduct from coming to light by misleading the Trust and acting without integrity and contrary to the duty of candour is not conduct which is not easily remediable.*

44. *In this light, the Parties have considered the Registrant's attempts at remediation, which are as follows:*

    a. *The Registrant has submitted some certificates evidencing training that she has undertaken which is of some relevance to the conduct in the case; and*

    b. *The Registrant has completed corresponding reflective accounts which are of some relevance to the conduct in the case. The reflective accounts demonstrate some insight into the importance of being open and honest.*

45. *Overall, the Parties agree that the attitudinal failings arising out of the Registrant's dishonesty in this case are difficult to remediate and that the Registrant's limited insight and training mean that they have not been remedied. It cannot be said the Registrant is highly unlikely to repeat her misconduct.*

46. *With regard to the Registrant's lack of competence the Registrant's limited insight and lack of training mean that the issues have not been remediated and accordingly that there remains a significant risk of repetition with regard to the competency failings admitted by the Registrant.*

47. *In the light of the Parties' agreement that the misconduct and lack of competence is not highly unlikely to be repeated, the Parties agree that a finding of current impairment should be made to protect the public.*

48. *In addition, a finding of impairment is necessary in the public interest to uphold proper professional standards and maintain confidence in the profession. The maintenance of professional boundaries is important in any healthcare relationship […]. The duty of candour and the responsibility on healthcare professionals to act with honesty and integrity is the bedrock of professional trust. Where, as the Parties agree has happened here, those aspects of a professional's practice fall seriously short of the standards expected of them a finding of current impairment is required in the public interest.*

Sanction

49. *The appropriate sanction in this case is a striking off order.*

50. *The aggravating features of this case are as follows:*

    a. *The Registrant abused her position of trust by accessing Patient A's records without clinical justification and subsequently sought to represent to the Trust that she had accidentally accessed the records. She has carried out multiple acts of dishonesty, some of which created a direct risk to patients because the acts related to her clinical practice.*

    b. *During the Trust meeting on 22 August 2022 the Registrant attempted to mislead the Trust in respect of her conduct. She therefore failed to act with honesty and integrity and acted in breach of her duty of candour by seeking to prevent her misconduct from coming to light during the Trust meeting on 22 August 2022.*

51. *The mitigating features in this case are as follows:*

    a. *[PRIVATE]*

    b. *The Registrant does not have a prior regulatory or disciplinary history since she qualified in September 2021.*

52. *The Parties agree that taking no further action or imposing a caution order would not be appropriate in the light of the public protection issues which have not been satisfactorily remediated.*

53. *The Parties agree that a conditions of practice order would not adequately mark the seriousness of this case.*

54. *The Parties further agree that a suspension order would not be the appropriate sanction in this case. With regard to the NMC's guidance on this type of disposal the Parties note:*

    a. *The case does not involve a single isolated instance of misconduct.*

    b. *There is evidence of attitudinal problems which are very difficult to remedy, given the repeated instances of dishonesty in this case.*

    c. *The Registrant has demonstrated some insight. However, it remains limited at the current time.*

55. *Accordingly, the Parties consider a striking off order to be the most appropriate and proportionate sanction taking into account all the circumstances of the case. Given that there are attitudinal problems that are not easily capable of remediation, as well as there being limited insight and lack of remediation of her lack of competency failings, the parties agree that confidence in the profession could not be maintained by way of a lesser sanction.*

Maker of allegation comments

56. *On 16 January 2025, the NMC asked the referrer whether they agreed with this provisional agreement. On 20 January 2025 the referrer confirmed that they do agree and that they have no further comments to make.*

Interim order

57. *The Parties agree that an interim suspension order is required in this case pending any appeal that may be made. The interim order is necessary for the protection of the public and otherwise in the public interest for the reasons given above. The interim order should be for a period of 18 months in the event that the Registrant seeks to appeal the panel's decision.*

58. *The Parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings, impairment and sanction is a matter for the panel. The Parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.'*

Here ends the provisional CPD agreement between the NMC and Miss Bonsall. The provisional CPD agreement was signed by Miss Bonsall on 31 January 2025 and the NMC on 18 February 2025.

Decision and reasons on the CPD

The panel decided to accept the CPD agreement as amended.

The panel heard and accepted the legal assessor's advice. She referred the panel to the 'NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. She reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Miss Bonsall. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the profession and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel noted that Miss Bonsall admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of Miss Bonsall's admissions as set out in the signed provisional CPD agreement.

Decision and Reasons on Misconduct, Lack of Competence and Impairment

The panel then went on to consider whether Miss Bonsall's actions amounted to misconduct and lack of competence, and whether her fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Miss Bonsall, the panel has exercised its own independent judgement in reaching its decision on impairment.

The panel considered the NMC guidance and the cases referred to in the CPD agreement. The panel also accepted the breaches of the Code that were agreed to in the CPD agreement.

In respect of misconduct the panel determined that there has been misconduct in relation to all of the charges and in total. The panel found that the charges proved fell far below the standards expected of a nursing professional and put patients at a significant risk of harm. The panel also considered that the charges relating to Ms Bonsall's dishonesty occurred on numerous occasions.

In respect of the charges relating to lack of competence, the panel determined that the clinical failings were sufficiently serious to meet the threshold for a lack of competence. The panel considered that inaccurate monitoring of heart rate, not escalating critically low levels of blood glucose and failing to meet capability objectives was likely to put patients at a significant risk of harm and fell far below the competence level expected of a registered nurse.

In this respect, the panel endorsed paragraphs 27 to 37 of the provisional CPD agreement in respect of misconduct and lack of competence.

The panel then considered whether Miss Bonsall's fitness to practise is currently impaired by reason of her misconduct and lack of competence. In coming to its decision, the panel had regard to the Fitness to Practise guidance reference DMA-1, '*Impairment'*, updated on 27 February 2024, which states:

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

The panel determined that Miss Bonsall's fitness to practise is currently impaired on both the ground of public protection and of public interest. The panel found that the clinical failings led to a risk of significant harm to patients. The panel also considered the repeated dishonesty in the charges found proved. The panel determined that this was a deep seated attitudinal issue. The panel also found that the data breaches in charges 1 – 5 were seriously unprofessional. Therefore, the panel found that Miss Bonsall could not practise kindly, safely or professionally and she is therefore impaired on the grounds of public protection. The panel also considered that if a finding of impairment were not made, given the seriousness of the charges found proved, the public confidence in the profession and the NMC as a regulator would not be upheld. The panel therefore determined that a finding of impairment on the grounds of public interest was also necessary.

In this respect the panel endorsed paragraphs 38 to 48 of the provisional CPD agreement.

Decision and reasons on sanction

Having found Miss Bonsall's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind

that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The Registrant abused her position of trust by accessing Patient A's records without clinical justification and subsequently sought to represent to the Trust that she had accidentally accessed the records. She has carried out multiple acts of dishonesty, some of which created a direct risk to patients because the acts related to her clinical practice.
- During the Trust meeting on 22 August 2022 the Registrant attempted to mislead the Trust in respect of her conduct. She therefore failed to act with honesty and integrity and acted in breach of her duty of candour by seeking to prevent her misconduct from coming to light during the Trust meeting on 22 August 2022.

The panel also took into account the following mitigating features:

- The Registrant has raised that she [PRIVATE] and that she struggled to manage this at the same time as transitioning from a student nurse to a qualified nurse during the Covid-19 pandemic

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

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

was unacceptable and must not happen again.' The panel considered that Miss Bonsall's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Bonsall's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Bonsall's registration would not adequately address the seriousness of this case and would not protect the public and would not be in the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel determined that the conduct was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the

fundamental tenets of the profession evidenced by Miss Bonsall's actions is fundamentally incompatible with her remaining on the register.

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

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

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

Miss Bonsall's misconduct and lack of competence was a significant departure from the standards expected of a registered nurse, and, in the panel's view, is fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Bonsall's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

Decision and reasons on interim order

The panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Bonsall's own interest. The panel heard and accepted the advice of the legal assessor.

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

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

That concludes this determination.