# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Monday, 6 January 2025 – Tuesday, 14 January 2025**

Virtual Hearing

| | |
|---|---|
| **Name of Registrant:** | Geraldine Bamford |
| **NMC PIN:** | 87I1893E |
| **Part(s) of the register:** | Registered Nurse: Sub Part 1<br>RN1: Adult nurse, level 1 (5 February 2006)<br>RN2: Adult nurse, level 2 (6 November 1989) |
| **Relevant Location:** | Chester |
| **Type of case:** | Misconduct |
| **Panel members:** | Gregory Hammond (Chair, Lay member)<br>Carol Porteous (Registrant member)<br>Anne Rice (Lay member) |
| **Legal Assessor:** | Nigel Mitchell |
| **Hearings Coordinator:** | Eyram Anka |
| **Nursing and Midwifery Council:** | Represented by Shoba Aziz, Case Presenter |
| **Mrs Bamford:** | Not Present and unrepresented |
| **Facts proved:** | Charge 4c(i), 4c(ii), 4c(iii) (except in respect of the dose of Morphine Sulphate administered) |
| **Facts not proved:** | Charge 1a, 1b, 1c, 1d, 2, 3a, 3b, 4a, 4b |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Conditions of practice order (12 month)** |

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

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Mrs Bamford was not in attendance and that the Notice of Hearing letter had been sent to Mrs Bamford's registered email address by secure email on 6 December 2024.

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

The panel accepted the advice of the legal assessor.

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

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

**Decision and reasons on proceeding in the absence of Mrs Bamford**

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

Ms Aziz referred the panel to a letter from the RCN dated 5 December 2024 stating,

*‘Please note that we are no longer acting for Geraldine Bamford. Please ensure that our name is removed from the record and that all future correspondence is sent directly to the Registrant.’*

Ms Aziz also referred to an email from Mrs Bamford dated 12 December 2024 stating,

*‘…have decided to not attend the hearing. I was given certain choices to make and I chose cease to engage with all NMC proceedings. My mental health has been affected by all of the above and I feel I cannot go through with it. I hope the NMC is understanding of my position…’*

Ms Aziz submitted that the NMC has made all reasonable efforts to enable Mrs Bamford to attend this hearing, but she has voluntarily absented herself. Ms Aziz told the panel that there is nothing to suggest that Mrs Bamford would attend on another occasion. It was Ms Aziz’s submission that there is a public interest in the expeditious disposal of this case. She told the panel that not proceeding may potentially inconvenience witnesses who are scheduled to give evidence. Ms Aziz therefore invited the panel to proceed in Mrs Bamford’s absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *‘with the utmost care and caution’*.

The panel decided to proceed in the absence of Mrs Bamford. In reaching this decision, the panel considered the submissions of Ms Aziz, the representations from Mrs Bamford, and the advice of the legal assessor. It had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Bamford.

- Mrs Bamford has informed the NMC that she will not be attending this hearing.
- There is no reason to suppose that adjourning would secure Mrs Bamford's attendance at some future date.
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services.
- The charges relate to events that occurred between 2019 and 2023.
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events.
- There is a strong public interest in the expeditious disposal of the case.

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

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

**Details of charge (as amended)**

That you, a registered nurse:

1) On 8 February 2019:

    a) Did not put a double signature on a handwritten MAR chart.
    b) Did not date boxes of medication with date opened.
    c) Did not carry forward balances undertaken at the start of the monthly cycle.
    d) Missed signatures and entries on MAR charts.

2) On 26 February 2021 gave an unknown Resident Lorazepam PRN when it was no longer prescribed as PRN and the Resident had already had their prescribed evening dose.

3) On 8 April 2023:

    a) Documented the MAR chart for Resident A incorrectly.
    b) Failed to have the MAR chart for Resident A witnessed and/or countersigned by another member of staff.

4) On 28 May 2023 in relation to Resident B:

    a) Put a Fentanyl 12mcg patch back in place despite the GP advising that it be removed.
    b) Having put the 12mcg patch at charge 4a) back in place failed to record the reason for doing so.
    c) Gave 2 x Morphine Sulphate ampoules (10mg each) and 3 x Glycopyrronium vials (200mcg each) medication subcutaneously as a stat dose –
        i. Without a witness being present
        ii. Not via a syringe driver as prescribed and instructed on the box.
        iii. Not over a 24-hour period.

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

**Background**

Mrs Bamford was referred to the NMC on 31 May 2023 by Springcare Ltd where she worked as a registered nurse in Kingscourt Nursing Home ('the Home').

On 8 February 2019, Witness 3 supervised Mrs Bamford and it was observed that there were no double signatures on handwritten MAR chart entries; boxes of medication were not dated with 'date opened'; and no carried forward balances undertaken at the start of the monthly cycle as well as gaps and missing signatures on MAR charts.

On 26 February 2021, Mrs Bamford allegedly gave an unknown Resident Lorazepam PRN when it was no longer prescribed as PRN and the Resident had already had their prescribed evening dose.

On 8 April 2023, it is alleged that a handwritten MAR chart for Resident A had been documented incorrectly by Mrs Bamford. It had not been witnessed and/or countersigned by another member of staff.

On 9 May 2023, Resident B had been deemed end of life ('EOL') and a 'blue book' (book to supplement MAR chart for EOL patients) was put in place. A General Practitioner (GP) saw Resident B on 23 May 2023 and prescribed Fentanyl 12mcg patch. On 27 May 2023, due to family concerns about Resident B's continued drowsiness, Mrs Bamford called the out of hours (OOH) GP at midday. The GP called back at midnight on 28 May 2023 and advised that the Fentanyl patch should be removed, which it was.

On 28 May 2023, Mrs Bamford called the OOH GP again around 14:00 as Resident B's health had deteriorated. The GP visited at 16:00 and prescribed end of life medication. At the time, the GP noted that the Fentanyl patch had been put back in place. It is alleged that Mrs Bamford said that she put the Fentanyl patch back in place because Resident B was in pain during repositioning and there were no other drugs prescribed for their pain.

The Home stated that there was no documentation to say that Resident B had been in pain or the reasons for the EOL drugs to be administered.

During the GP's visit, it was noted that Resident B was actively dying and would not make the next eight hours. The GP went to his car and came back with two Morphine Sulphate ampoules (10mg each) and three Glycopyrronium vials (200mg each). Mrs Bamford allegedly asked the GP what dose to give Resident B, and the GP told her to give Resident B all of it. Mrs Bamford gave Resident B all the medication subcutaneously as a stat dose without a witness being present and not via a syringe driver as prescribed and instructed on the medication box. This dosage was for a syringe driver to be administered over 24 hours. At the time, there was no syringe driver at the Home. Mrs Bamford was deemed to have failed to work with colleagues to ensure controlled drugs were checked and administered safely.

**Decision and reasons on facts**

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 Ms Aziz on behalf of the NMC.

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

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

- Witness 1: Home Manager from 2022

- Witness 2: Deputy Nurse Manager on call on 23 April 2023

- Witness 3: Home manager from 2018 - 2020

- Witness 4: Out of hours General Practitioner who attended Resident B

**Decision and reasons on application to amend the charge**

Following the completion of the NMC's evidence, the panel heard an application made by Ms Aziz, to amend the wording of charge 4c under Rule 28 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The proposed amendment was to correct a typographical error in charge 4c. Ms Aziz submitted that the amendment would reflect the evidence that has been given by Witness 4 and the correct dosage of Glycopyrronium. It was submitted by Ms Aziz that the proposed amendment would provide clarity and more accurately reflect the evidence. Ms Aziz submitted that this amendment is in the interests of justice and would not prejudice Mrs Bamford.

Original charge 4c

*"That you, a registered nurse,*

*On 28 May 2023 in relation to Resident B:*

*…*

c) *Gave 2 x Morphine Sulphate ampoules (10mg each) and 3 x Glycopyrronium vials (200mg each) medication subcutaneously as stat dose."*

Proposed amendment to charge 1g

*"That you, a registered nurse,*

*d) On 28 May 2023 in relation to Resident B:*

*…*

*c) Gave 2 x Morphine Sulphate ampoules (10mg each) and 3 x Glycopyrronium vials (200~~mg~~**mcg** each) medication subcutaneously as stat dose."*

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

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

**Decision and reasons on facts**

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

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

**Charges 1a), 1b), 1c) and 1d**

"That you, a registered nurse:

On 8 February 2019:

a) Did not put a double signature on a handwritten MAR chart.

b) Did not date boxes of medication with date opened.
c) Did not carry forward balances undertaken at the start of the monthly cycle.
d) Missed signatures and entries on MAR charts."

**These charges are found NOT proved.**

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel took into account Mrs Bamford's supervision record from Witness 3 dated 8 February 2019, which identified the list of issues in the charges above and was signed by both Witness 3 and Mrs Bamford on that date. In her written statement Witness 3 said,

> *'On this date, whilst supervising Ms Bamford, I observed a number of medication errors that she had made, where several could have been avoidable. For example, there were no double signatures on handwritten Medication Administration Record ("MAR") chart entries; boxes of medication were not dated with 'date opened'; no carried forward balances undertaken at the start of the monthly cycle; and there were gaps and missing signatures on the MAR charts.*
>
> *Therefore, these were addressed with Ms Bamford and actions were set following this session for regular spot checks of MAR charts and weekly and monthly medication audits to be maintained.'*

However, the panel had no other evidence to support this record. Specifically, no MAR charts were provided showing a lack of double signatures, or missing signatures or entries; no pictures of the boxes of medication were provided; and no medication records showing a failure to carry forward balances at the start of the monthly cycle were provided. Although the panel found Witness 3 credible, during her oral evidence she stated that she

could not recall details about the incident which is alleged to have occurred nearly six years ago and was working entirely on the basis of what she had written in the supervision record.

The panel determined that there was insufficient evidence to find this charge proved. As such, it concluded that the NMC had not discharged its burden of proof. For these reasons, charge 1 is found not proved in its entirety.

**Charge 2**

> "That you, a registered nurse, on 26 February 2021 gave an unknown Resident Lorazepam PRN when it was no longer prescribed as PRN and the Resident had already had their prescribed evening dose."

**This charge is found NOT proved.**

In reaching this decision, the panel took into account Mrs Bamford's supervision record dated 26 February 2021 which states,

> *'Medication error – Lorazepam given PRN when no longer prescribed as PRN and instead prescribed as regular, with the resident already having their prescribed evening dose.'*

The panel noted that this supervision record is incomplete and unsigned, and was created by a supervisor who is not a witness in this case. The panel found no other evidence to support this charge. Consequently, it was not satisfied that the NMC had discharged its burden of proof. The panel therefore found charge 2 not proved.

**Charges 3a) and 3b)**

> "That you, a registered nurse:

On 8 April 2023:

a) Documented the MAR chart for Resident A incorrectly.

b) Failed to have the MAR chart for Resident A witnessed and/or countersigned by another member of staff."

**These charges are found NOT proved.**

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

The panel had regard to Witness 1's NMC statement which states,

> *'On 08 April 2023, it was noted that a handwritten MAR chart for Resident A had been documented incorrectly and had not been witnesses / countersigned by another member of staff. A copy of the MAR chart for Resident A is produced at Exhibit CB/04.'*

The panel then examined the MAR chart and noted that the date had been redacted but considered it more likely than not that the MAR chart was for 8 April 2023.

The panel took into account that when the MAR chart was put before Witness 1, she could not identify anything wrong with it and did not identify what it was that was 'incorrect' and was not able to identify what should have been witnessed and/or countersigned by another member of staff. Witness 1 said that the 'o' (potentially for 'omitted') against Edoxaban should have been explained but the explanation would be on a separate page which the panel has not been provided with.

In Mrs Bamford's reflection dated 12 April 2023, she admitted that she had not administered Edoxaban to Resident A when she should have done, but does not make any reference to the documentation. The panel found that Mrs Bamford's admission is not relevant to that which is charged.

The panel decided that the NMC had not discharged its burden of proof in relation to charges 3a and 3b. It therefore found these charges not proved.

**Charge 4a)**

"That you, a registered nurse:

On 28 May 2023 in relation to Resident B:

a) Put a Fentanyl 12mcg patch back in place despite the GP advising it be removed."

**This charge is found NOT proved.**

The panel took account of Resident B's patient notes from 27 – 28 May 2023. At 13:50, Mrs Bamford recorded that,

*'Resident B's family came to visit today & spoke to me regarding Resident B new Fentanyl patch. They feel it is making her too drowsy and can we think about another course of action. At present I have phoned 111 and am expecting a call back for advice.'*

At 18:15 Mrs Bamford noted, *'111 contacted again regarding advice with Fentanyl patch.'*

The panel further considered the entry at 00:05 on 28 May 2023 which states,

*‘Received a call back from 111 regarding Resident B patch and advised that the patch can be taken off if family thinks it makes less drowsy…’*

The panel also took account of Mrs Bamford’s admission to reapplying the Fentanyl patch. In Resident B’s patient notes, at 14:30 on 28 May 2023 Mrs Bamford noted,

*‘Earlier I re-applied the Fentanyl patch (a new one) to provide some pain relief to Resident B as the only other thing available is paracetamol liquid and Resident B is struggling to swallow this. As we are re-positioning Resident B she appears to be in a lot of pain.’*

The panel had no doubt that Mrs Bamford reapplied a Fentanyl patch based on the evidence. However, the panel determined that the advice from 111 indicated that removing the Fentanyl patch was a potential course of action dependent on whether Resident B’s family felt it was making her too drowsy. The panel interpreted the advice as an option to remove the Fentanyl patch as opposed to a medical direction from a GP. Therefore, it concluded that Mrs Bamford was not disobeying instructions in reapplying a patch when she considered it beneficial to Resident B who was in pain. The evidence was ambiguous about whether she reapplied the old patch or applied a new one, but the panel did not consider this relevant to the charge.

For these reasons, the panel found charge 4a not proved.

**Charge 4b)**

“That you, a registered nurse:

On 28 May 2023 in relation to Resident B:

a) Having put the 12mcg patch at charge 4a) back in place failed to record the reason for doing so.”

**This charge is found NOT proved.**

In reaching this decision, the panel took into account Mrs Bamford's entry in Resident B' patient notes at 14:30 on 28 May 2023. She wrote,

> *'Earlier I re-applied the Fentanyl patch (a new one) to provide some pain relief to Resident B as the only other thing available is paracetamol liquid and Resident B is struggling to swallow this. As we are re-positioning Resident B she appears to be in a lot of pain.'*

In light of the above, which the panel considered to be clear reasoning, it found charge 4b not proved.

**Charge 4c)**

"That you, a registered nurse:

On 28 May 2023 in relation to Resident B:

b) Gave 2 x Morphine Sulphate ampoules (10mg each) and 3 x Glycopyrronium vials (200mcg each) medication subcutaneously as a stat dose –
   i. Without a witness being present
   ii. Not via a syringe driver as prescribed and instructed on the box
   iii. Not over a 24-hour period."

**This charge is found proved except for the dose of Morphine Sulphate.**

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

The panel had regard to Witness 1's NMC statement, in which she states,

> *'During the GP's visit, it was noted that Resident B was actively dying, and she would not make the next 8 hours. The GP went to his car and came back with 2x Morphine Sulphate ampoules (10mg) and 3x Glycopyrronium vials (200mg each). Ms Bamford asked the GP how much does to give and the GP responded saying give all of it. After the GP left, Ms Bamford gave all of the medication subcutaneously as a stat dose without a witness present and not via a syringe driver as prescribed and instructed on the box. This dosage was for a syringe driver to be administered over 24 hours. At the time, there was no syringe driver at the Home. A copy of Resident B patient notes is produced at Exhibit CB/05.'*

The panel also considered Witness 4's NMC statement, which states,

> *'I saw Resident B following a request made by the Home asking for a review of the patient who was deteriorating and was already on the end-of-life pathway. Prescription of anticipatory medicine were done however, there were no medications in the Home.*
>
> *…*
>
> *Ms Bamford informed me that she had put a fentanyl patch on for the patient to control pain. This was revised by another out of hour's GP previously the day before and she was advised to remove the fentanyl patch as it was making the patient sleepier. I explained to Ms Bamford that she needed to remove the fentanyl patch and start morphine via a syringe driver. I dispensed medications (including morphine sulphate, and glycopyrronium) from the emergency bag and gave them to Ms Bamford.'*

The panel then reviewed Resident B's 'blue book' entries: Record of Schedule 2 and 3 Controlled Drugs Stock and Subcutaneous Administration dated 28 May 2023. The panel found that Mrs Bamford gave Resident B one of the two Morphine Sulphate ampoules (10mg) and 3 x Glycopyrronium (200mcg each). There is no evidence to suggest that Mrs Bamford had a witness present when administering the medication. Witness 2 stated that Mrs Bamford should have known the Home's Medication Policy that two signatures are required in the relevant boxes of the paper record.

The panel further noted that Mrs Bamford recorded that she administered the medication subcutaneously and not via syringe driver as prescribed by the out of hours GP. The panel observed that this medication provided by the out of hours GP was provided in an emergency in contrast with the medication preauthorised by the Home's GP in the 'blue book', which included the same medications and to be administered subcutaneously. The panel heard from Witnesses 2 and 3 that there was no syringe driver in the Home at the time. However, Witness 2 said that one could have been sourced from another Home, a 30 minute drive away. In addition, it is clear from the entries in Resident B's 'blue book' that Mrs Bamford did not administer the medication over a 24-hour period as instructed but administered it all straight away as a stat dose.

Accordingly, the panel found charge 4c(i), (ii) and (iii) proved, except in respect of the dose of Morphine Sulphate administered which the panel found to be one 10mg ampoule which was the upper level of dose prescribed in the Anticipatory Drug Authorisation to Administer form.

**Fitness to practise**

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

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

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

**Submissions on misconduct**

Mrs Aziz drew the panel's attention 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.'*

Ms Aziz invited the panel to take the view that the facts found proved amount to misconduct. She drew the panel's attention to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)'(the Code).

Ms Aziz referred to the NMC's guidance, 'How do we determine seriousness' (FTP-3) and took the panel through relevant case law, including *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), and *Grant* [2011] EWHC 927 (Admin).

Ms Aziz submitted that the facts that have been found proved are in breach of the NMC's guidance and the Code. Therefore, it was Ms Aziz's submission that Mrs Bamford's actions in charge 4c amount to misconduct.

**Submissions on impairment**

Ms Aziz 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 uphold 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), Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Grant* [2011] EWHC 927 (Admin).

Given the panel's findings in respect of charge 4c, Ms Aziz submitted that there is sufficient reason to believe that Mrs Bamford's practice is impaired and poses a risk to patient safety. It was her submission that Mrs Bamford has not demonstrated any insight and has tried to justify her behaviour. Ms Aziz submitted that Ms Bamford's behaviour breached professional standards and impacted her ability to practise safely and effectively. Ms Aziz stated that Mrs Bamford has not provided any evidence of relevant training and is unwilling to accept the seriousness of the concerns identified.

Ms Aziz took the panel through the four limbs set out by Dame Janet Smith in the Fifth Shipment Report and set out in the case of *Grant*:

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) *...'*

Ms Aziz submitted that limbs a, b and c of *Grant* have been engaged. She submitted that Mrs Bamford's conduct in charge 4c has brought the profession into disrepute and breached the NMC Code. Ms Aziz submitted that public confidence in the profession would be undermined if the concerns were not addressed.

Ms Aziz submitted that it is for the panel to consider Mrs Bamford's insight into the gravity of her actions and assess on the evidence if there remains a risk of repetition of behaviour.

Ms Aziz invited the panel to find Mrs Bamford's fitness to practise currently impaired.

The panel accepted the advice of the legal assessor which included reference to the NMC's guidance on 'Impairment' (DMA-1) and a number of relevant judgments. These included: *Roylance*, *Cohen* and *Grant*.

**Decision and reasons on misconduct**

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

The panel was of the view that Mrs Bamford's actions fell short of the standards expected of a registered nurse, and that Mrs Bamford's actions amounted to a breach of the Code, specifically the following:

> ***'18 Advise on, prescribe, supply, dispense or administer medicines within the limit of your training and competence, the law, our guidance and other relevant policies, guidance and regulations'***
>
> ***'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'*

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

The panel found that Mrs Bamford administered Morphine Sulphate (a controlled drug) without a witness being present. It determined that securing a witness before administering a controlled drug is basic knowledge and a fundamental requirement that Mrs Bamford failed to do. The panel therefore found that limb (i) of charge 4c amounted to misconduct in relation to her administration of the controlled drug (Morphine Sulphate) without a witness being present.

In respect of charges 4c(ii) and 4c(iii), the panel found that Mrs Bamford's actions did not amount to serious misconduct. In the panel's view, Mrs Bamford made a mistake with the dose of the Glycopyrronium, which is not a controlled drug and therefore a witness is not required. The panel noted that Mrs Bamford administered both drugs subcutaneously as a stat dose and not via a syringe driver over a 24-hour period. However, it found that this was in the context of a confusing discussion with the GP and the Anticipatory Drug Authorisation to Administer form supported the subcutaneous route. The panel also heard from Witnesses 2 and 3 that a syringe driver was not immediately available in the Home at the time. In the panel's view, Mrs Bamford made a mistake and was doing her best in the circumstances.

The panel acknowledged that Mrs Bamford gave a triple dose of the Glycopyrronium, but this mistake does not cross the bar of seriousness to amount to misconduct. Further, the panel determined there was ambiguity in the conversation Mrs Bamford had with the GP in that he instructed her to give the whole dosage, which Mrs Bamford proceeded to do in respect of the Glycopyrronium but not the Morphine Sulphate. The panel noted that Mrs Bamford did not give Resident B the entire prescription of Morphine Sulphate, but gave

the maximum dose permitted for Resident B in the Anticipatory Drug Authorisation to Administer form.

The panel decided that Mrs Bamford's actions in respect of charges 4c(ii) and 4c(iii) were not sufficiently serious as to amount to misconduct. However, it found that Mrs Bamford's actions in 4c(i), in administering a controlled drug (Morphine Sulphate) without a witness being present, fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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) *...'*

The panel determined that limbs *a, b* and *c* of *Grant* are engaged both as to the past and the future. The panel found that Mrs Bamford's actions in charge 4c(i) had the potential to cause patient harm. Although Mrs Bamford administered a prescribed dose of Morphine

Sulphate, it was the upper level of the dose prescribed in the Anticipatory Drug Authorisation to Administer form. The panel took the view that having a witness present would have mitigated the unwarranted risk of harm to Resident B. The panel found that Mrs Bamford's misconduct had breached fundamental tenets of the nursing profession in administering a controlled drug without a witness and therefore brought its reputation into disrepute.

The panel considered Mrs Bamford's misconduct to be remediable because it is a drug administration error without a witness present, as required. However, Mrs Bamford has not demonstrated an understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession. The panel had regard to the local investigation meeting notes dated 31 May 2023 and found no evidence of Mrs Bamford's understanding of the importance of having a witness present when administering controlled drugs.

During the hearing, the panel heard Witness 1 describe Mrs Bamford as *"a very caring nurse who lacked confidence but would ask if she was unsure"* and Witness 2 describe her as *"an amazing lady, very empathetic, very kind, a good nurse who would ask for advice".* Both Witness 1 and Witness 2 are practising registered nurses who supervised Mrs Bamford at the relevant time.

Mrs Bamford has not engaged in this hearing, so the panel could not determine her level of insight. The panel had no updated information as to what Mrs Bamford is currently doing. Further, the panel has no evidence of relevant training and no recent reflective statement. Without evidence of remediation, the panel could not be confident that matters of the kind found proved would not be repeated in the future. It therefore decided that a finding of impairment is necessary on the ground of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because of Mrs Bamford's misconduct and the risk of repetition. The panel concluded that, given the breach of fundamental tenets of the profession, public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore finds her fitness to practise impaired on public interest grounds.

Having regard to all of the above, the panel was satisfied that Mrs Bamford's 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 12 months. The effect of this order is that Mrs Bamford's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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

**Submissions on sanction**

Ms Aziz informed the panel that in the Notice of Hearing, dated 6 December 2024, the NMC had advised Mrs Bamford that it would seek the imposition of a 12-month conditions of practice order with review if the panel found Mrs Bamford's fitness to practise currently impaired.

Ms Aziz told the panel that several of the legal principles and submissions at the impairment stage are applicable when considering sanction. She took the panel through the NMC's guidance on seriousness and submitted that there is no evidence of comprehensive insight, remorse or strengthened practice.

When assessing how remediable Mrs Bamford's conduct is, it was Mrs Aziz's submission that the panel will be guided by *Nicholas-Pillai v General Medical Council* [2009] EWHC 1049 (Admin) which states that,

> *'In the ordinary case such as this, the attitude of the practitioner to the events which would give rise to the specific allegations against them in principle is something which can be taken into account either in his favour or against him by a panel, both at the stage when it considers whether his fitness to practise is impaired, and at the stage of determining when sanction should be imposed upon him.'*

Ms Aziz also referred the panel to *Fuglers LLP & Others v Solicitors Regulatory Authority* [2014] EWHC 179 (Admin), specifically the following paragraphs,

> '***29.*** *In assessing seriousness, the most important factors will be (1) culpability for the misconduct in question and (2) the harm caused by the misconduct. Such harm is not measured wholly, or even primarily, by financial loss caused to any individual or entity. A factor of the greatest importance is the impact of the misconduct upon the standing and reputation of the profession as a whole. Moreover, the seriousness of the harm may lie in the risk of harm to which the misconduct gives rise, whether or not as things turn out the risk eventuates. The assessment of seriousness will be informed by (3) aggravating features (e.g. previous disciplinary matters) and (4) mitigating factors (e.g. admission at an early stage or making good any loss)…*
>
> ***30****. At the second stage, the tribunal must have in mind that by far the most important purpose of imposing disciplinary sanctions is addressed to other*

*members of the profession, the reputation of the profession as a whole, and the general public who use the services of the profession, rather than the particular solicitors whose misconduct is being sanctioned…*' .

Ms Aziz invited the panel to take into account what she said were the aggravating features, which included abuse of position of trust, lack of insight into failings, conduct which put patients at risk of harm, acting against GP direction without recording reason for doing so and serious medication errors.

Ms Aziz submitted that Mrs Bamford has not provided any evidence of insight and her actions represent multiple breaches of the NMC Code. She submitted that it is unclear whether Mrs Bamford has sought to remedy the concerns because she is not present at this hearing and has not provided any evidence of remediation.

For these reasons, Ms Aziz submitted that the only proportionate sanction is a conditions of practice order for 12 months, with a review, given the high risk of repetition and Mrs Bamford's lack of insight.

**Decision and reasons on sanction**

Having found Mrs Bamford'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:

- Lack of insight into failings.
- Conduct which put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- Open and honest about the incident at the local investigation.
- Witness 1 and Witness 2 speaking highly of Mrs Bamford as a kind and caring nurse.
- The context of Mrs Bamford doing her best to make an *'actively dying'* resident comfortable, in the presence of their family, despite the Home not having the correct equipment on site; alongside caring for other residents as the only registered nurse on shift.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the public protection considerations in this 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 public protection issues identified, an order that does not restrict Mrs Bamford's practice would not be appropriate in the circumstances. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *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.*

The panel found that a conditions of practice order would be the most suitable and effective sanction. When considering the misconduct in this case, the panel determined that it would be possible to formulate appropriate and practicable conditions which would address the failings highlighted and protect the public. The panel heard from two witnesses that Mrs Bamford is fundamentally a good nurse. Although the panel did not have evidence of Mrs Bamford's willingness to respond positively to retraining, it took the view that her misconduct is in an area of practice that is easily remediated. It concluded that a conditions of practice order would allow Mrs Bamford the opportunity to demonstrate safe practice.

Balancing all these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order would be wholly disproportionate and punitive, and would not be a reasonable response in the circumstances of Mrs Bamford's case. The panel took the view that there is a public interest in returning an otherwise competent nurse to the register.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will 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 are directly supervised by another registered nurse any time you are engaged in the administration of medication until assessed and deemed competent to do so by another registered nurse.

   Thereafter, you must ensure that you are working at all times on the same shift as, but not always directly observed by another registered nurse when administering medication until deemed competent by your mentor or supervisor.

2. You must create a Personal Development Plan (PDP) you’re your line manager, mentor or supervisor demonstrating your progress during this period, focused on safe medication administration.

3. You must meet monthly with your line manager, mentor or supervisor to discuss your PDP. Prior to any NMC review, you must send your case officer a copy of your PDP.

4. You must limit your practice to a single substantive employer, which must not be an agency.

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 agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) 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 12 months, which the panel considered was sufficient time for Mrs Bamford to secure employment and remediate the concerns highlighted.

Before the order expires, a panel will hold a review hearing to see how well Mrs Bamford has 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.

The panel encourage Mrs Bamford to return to practice. Any future panel reviewing this case would be assisted by:

- Mrs Bamford's attendance at any future review.
- A reflective piece demonstrating her insight into safe medicines management, including controlled drugs.
- Evidence of relevant training in medicines management and administration, including controlled drugs.
- Testimonials.

This will be confirmed to Mrs Bamford 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 or in Mrs Bamford's own interests until the conditions of practice sanction takes effect.

**Submissions on interim order**

Ms Aziz invited the panel to impose an interim conditions of practice order for 18 months to cover the appeal period. She submitted that an interim order is necessary for patient safety until the sanction comes into effect.

The panel accepted the advice of the legal assessor.

**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 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, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to allow for the appeal period. In making this order, the panel considered the impact this order will have on Mrs Bamford and was satisfied that this order, for this period, is appropriate and proportionate.

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 Mrs Bamford is sent the decision of this hearing in writing.

That concludes this determination.