Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 28 October 2024 – Friday 1 November 2024
Friday, 3 January 2025

Virtual Hearing

Name of Registrant:	Lynne Preston
NMC PIN:	90K0074E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (February 1994)
Relevant Location:	Bradford
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair, Lay member) Vivienne Stimpson (Registrant member) David Anderson (Lay member)
Legal Assessor:	Natalie Byrne
Hearings Coordinator:	Charis Benefo (Monday 28 October 2024 – Friday 1 November 2024) Samantha Aguilar (3 January 2025)
Nursing and Midwifery Council:	Represented by Sahara Fergus-Simms, Case Presenter (Monday 28 October 2024 – Friday 1 November 2024) Represented by Jane Carver, Case Presenter (3 January 2025)
Mrs Preston:	Present and represented by Claire Robinson, Counsel instructed by Irwin Mitchell Solicitors
Facts proved by admission:	Charges 1b and 1c

Facts proved:	Charges 1a and 2
Fitness to practise:	Impaired
Sanction:	**Suspension order with a review (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application for hearing to be held in private

At the outset of the hearing, Ms Fergus-Simms, on behalf of the Nursing and Midwifery Council (NMC), made a request that this case be held partly in private [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Robinson, on your behalf, indicated that there was no objection to the application. She requested that the application be extended, such that any references to [PRIVATE] should also be held in private.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to hold in private the parts of this hearing that involve reference to [PRIVATE], as and when such issues are raised, in order to protect each party's privacy. It was satisfied that this course was justified and that the need to respect each parties' respective right to privacy outweighed any prejudice to the general principle of public hearings.

Details of charge

That you, a registered nurse:

1. Accessed Patient A's clinical records without clinical justification, on
    a. 29 February 2020
    b. 1 March 2020
    c. 2 March 2020

2. On one or more occasion on or after 29 February 2020 disclosed Patient A's confidential medical information to third parties, without clinical justification and/or consent.

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

At the outset of the hearing, the panel heard from Ms Robinson, who informed the panel that you made admissions to charges 1b and 1c.

The panel therefore found charges 1b and 1c proved, by way of your admissions.

Background

The NMC received a referral in respect of you on 5 September 2020. You first entered onto the NMC's register on 8 February 1994.

The allegations in this case arose whilst you were employed by Bradford District Care NHS Foundation Trust (the Trust). You worked as a Community Staff Nurse in the District Nursing Team at Kilmeny Surgery (the Surgery). You began employment at the Trust on 29 September 2019.

It is alleged by the referrer, Patient A, [PRIVATE], that you accessed his medical records on three separate occasions (29 February 2020, 1 March 2020 and 2 March 2020) and read up to five years of his sensitive medical history.

You then allegedly disclosed Patient A's confidential medical information to third parties, (namely an unknown friend, and [PRIVATE]) without clinical justification and/or consent on one or more occasion on or after 29 February 2020.

On 1 March 2020, Patient A alleged that he had received a call from [PRIVATE] because you had disclosed to [PRIVATE] that Patient A was being seen by the District Nursing Team. Patient A then made a data subject access request for an audit trail of the access of his medical records, which indicated that his medical records had been accessed on three occasions.

Patient A alleged that you knew full well who he was and had no professional reason to access his records. The Trust confirmed that you were not involved in Patient A's clinical care.

On 20 April 2020, you left your employment at the Trust.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Fergus-Simms under Rule 31(1) to allow the following hearsay documents into evidence:

- An email from Colleague A dated 6 March 2020, attaching the notes of her conversation with you about the allegations on 5 March 2020; and
- A '*Patient Complaint*' document comprising of a table with columns titled '*Date record accessed*', '*Duration record open*' and '*Comments*', and corresponding details for each time you allegedly accessed Patient A's records.

Ms Fergus-Simms referred to the cases of *NMC v Ogbonna* [2010] EWCA Civ 1216, *R (Bonhoeffer) v GMC* [2011] EWHC 1585 (Admin) and *White v Nursing and Midwifery Council* [2014] EWHC 520 (Admin). She submitted that this hearsay evidence was not the sole and decisive evidence for any of the charges.

Ms Fergus-Simms submitted that Colleague A, who was a District Nurse Community Team Leader at the Trust, provided a detailed chronology of the conversation she had with you in the presence of Colleague B. She submitted that given the nature of this

document and its relevance to the proceedings, the panel should admit it into evidence. Ms Fergus-Simms submitted that this document would also assist the panel in understanding the context of the advice and complaints procedure at the Trust, which had already been provided to the panel in evidence.

Ms Fergus-Simms submitted that the '*Patient Complaint*' table provided a record of each time Patient A's records were accessed between 29 February 2020 and 2 March 2020 and your comments in response. She submitted that this document appeared to have been sent as part of the bundle.

Ms Robinson made submissions in respect of each of the documents in turn.

In relation to Colleague A's email and the notes of her conversation with you on 5 March 2020, Ms Robinson submitted that whilst it was hearsay evidence, it was relevant. She submitted that having had the opportunity to read the notes, you accepted that the conversation had taken place, and whilst it was not verbatim or a complete record, it was "*more or less*" what was said. Ms Robinson submitted that it was a matter for the panel to decide whether to admit this evidence.

In relation to the '*Patient Complaint*' table, Ms Robinson submitted that it appeared to have been put together to set out when Patient A's records were accessed, with your comments pasted in. She submitted, however, that it was "*anonymous*" hearsay as it was not clear who had prepared this document. Ms Robinson submitted that the table was not necessarily referred to in Colleague A's email on 6 March 2020 and you did not recognise it. Ms Robinson submitted that in the absence of information as to who produced the table and when it was produced, it would not be fair to rely on it. She therefore invited the panel to reject the application in relation to this document.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far

as it is '*fair and relevant*', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel first considered the application in respect of Colleague A's email dated 6 March 2020, and the notes of her conversation with you on 5 March 2020. This document had been provided by Colleague A, who was involved in the local investigation into the allegations, but was not an NMC witness and had not given live evidence as part of these proceedings. The panel had not been provided with an explanation as to why Colleague A had not been called as an NMC witness, or any information on the steps taken to secure her attendance, if at all. However, the panel took into account your acceptance that you had a conversation with Colleague A on 5 March 2020 about the allegations. You also accepted that the note of this conversation, although not verbatim and not a complete account, was "*more or less*" what was said. The panel noted that there was no objection to the admission of this document into evidence.

In these circumstances, the panel came to the view that this hearsay evidence of Colleague A was relevant to the charges and that it would be fair to accept it into evidence. The panel would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

In relation to the '*Patient Complaints*' table, the panel considered that this document was relevant to the charges and included information that was consistent with your evidence. However, it noted that there was no information as to the author of this document and there was no clear audit trail. The panel considered that there was no fair way of testing this evidence. It was unclear who had produced it, what the purpose was in the context of the local investigation, what it was used for, and what steps the NMC had taken to identify the author and secure their attendance as a witness. The panel therefore concluded that it would not be fair to admit this document into evidence, and in these circumstances, the panel refused the application in respect of it.

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 Fergus-Simms on behalf of the NMC, and by Ms Robinson on your behalf.

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

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

- Patient A: [PRIVATE] a patient of the District Nursing Team at the Surgery.

The panel took account of the witness statements from the following witnesses on behalf of the NMC:

- Witness 1: Complaints Investigator at the Trust at the time of the concerns; and

- Witness 2: Clinical Systems Dev/Ops Manager at the Trust at the time of the concerns.

The panel also heard evidence from you under affirmation.

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

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

Charge 1a

That you, a registered nurse:

1. *Accessed Patient A's clinical records without clinical justification, on*
    a. *29 February 2020*

This charge is found proved.

In reaching this decision, the panel took into account your admission at the outset of the hearing and in your oral evidence, that you accessed Patient A's clinical records on 29 February 2020, but that this was done with clinical justification.

You told the panel that you were advised by a district nurse at a different practice to gather patient information from your colleagues' case lists, in order to identify patients with specific treatment needs in wound management. You said that this was to enable you to speak to your colleagues about working with them on these cases so you could obtain the relevant competencies. You stated that during this process, you were "*not really looking at the names*". You clicked on Patient A's name, without initially registering that it was [PRIVATE]. After this, you said that you felt subconsciously that it might be [PRIVATE], so you clicked again to check the date of birth to confirm that it was him. You said that you realised that Patient A was [PRIVATE] once you saw his date of birth.

The panel had sight of the table setting out the audit of your access to Patient A's clinical records on 29 February 2020. It noted that you accessed the record at 19:01, and that there were numerous entries indicating different screens and actions until 19:22. This included an entry at 19:18 which indicated that you had accessed a field in the record titled '*Anxiety disorder (E200.)*'. You did not dispute this audit and it was accepted as an accurate record of what occurred when you accessed Patient A's records that day.

The panel was therefore satisfied on the evidence that you accessed Patient A's clinical records on 29 February 2020.

The panel next considered whether or not you did so without clinical justification. It took into account Patient A's witness statement dated 25 April 2022, which stated:

> '*The audit trail highlighted that she clicked on anxiety disorder... The date of that record is 19 October 2015*'.

You told the panel that once you accessed Patient A's clinical record, you called Colleague C (Staff Nurse at the Surgery) to inform her that Patient A was [PRIVATE]. It was your evidence that you were "*twiddling with the mouse*" and "*scrolling*" while also speaking to Colleague C on the telephone about other patients whose records you also had open on your screen. You said that you did not realise that you still had Patient A's clinical record open. You advised Colleague C of this and she told you that you should "*get out of that record*". You also confirmed Colleague C advised you that Patient A would not be allocated to your list.

The panel had regard to Witness 2's witness statement dated 30 June 2022, which stated:

> '*The NMC told me that one of the concerns the referrer raised was that the audit shows that the registrant was in his records back to 2015. If a user clicks on tab journal to bring up the whole history, it shows the most recent date first, you'd have to physically scroll down the record back to 2015. It's an intentional action.*'

The panel noted that you were not one of Patient A's clinicians at the Surgery, nor had he been identified as a patient with a specific treatment need that necessitated adding him to your case load.

The panel considered that once you realised that Patient A was, in fact, [PRIVATE], you went beyond your initial check by remaining on the record for a total of 21 minutes and at one point accessing a part of his record that displayed information about his anxiety disorder from 2015. The panel accepted Witness 2's evidence and was not satisfied that the numerous entries on the audit were as a result of you unintentionally and inadvertently clicking the mouse whilst on the telephone to Colleague C. The panel found your explanation to be implausible.

On this basis, the panel determined, on the balance of probabilities, that your access of Patient A's clinical records on 29 February 2020 was without clinical justification. It therefore found charge 1a proved.

Charge 2

That you, a registered nurse:

2. *On one or more occasion on or after 29 February 2020 disclosed Patient A's confidential medical information to third parties, without clinical justification and/or consent*

This charge is found proved.

In reaching this decision, the panel took into account Patient A's evidence that based on information provided to him by [PRIVATE] and by the Trust, you had disclosed his confidential medical information to numerous third parties, [PRIVATE] and your '*friend*'.

The panel also took into account your evidence. You accepted this charge, but to the limited extent that you had only spoken to [PRIVATE], and only mentioned that Patient A was "*on the books*" or "*registered at [your] Practice*".

The panel therefore considered the evidence in respect of each alleged third party, to determine whether on the balance of probabilities, you had disclosed Patient A's confidential medical information without clinical justification and/or consent.

In relation to [PRIVATE], the panel had regard to your account that you only told him about Patient A being "*on the books*", and did not disclose any other medical information about Patient A. In response to panel questions, you confirmed that when you said "*on the books*", you meant that Patient A had "*been brought across onto our service*". You were also asked whether you had described it in those terms to [PRIVATE]. You stated that you did not say Patient A was on the district nurses' books, just that he was on "*our*" books. In oral evidence, you stated that [PRIVATE] knew that you were a Community Nurse and in response to panel questions, you confirmed that this was a specialist service.

In the panel's view, it could be inferred that any patient registered on your books in this context had a specific medical need requiring nursing intervention.

The panel considered Patient A's evidence that he was not in communication with [PRIVATE] and they had been estranged for a number of years. Patient A was clear that he did not want anyone to know about his medical history. He also informed the panel that he was not aware that you were a District Nurse at the Surgery. Patient A's witness statement dated 25 April 2022 stated that he was contacted by [PRIVATE] on 1 March 2020, saying that '*he understands that I've been seen by the district nurse*' and that '[PRIVATE] *had been told by* [PRIVATE] *(the registrant)*'. Patient A told the panel in oral evidence that he then felt he had to disclose the nature of his medical condition to [PRIVATE] and the treatment he was receiving.

The panel found that you had told [PRIVATE] that Patient A was on your books and it determined that it could be reasonably and logically inferred that this meant a patient registered with the district nurse service, as opposed to being registered generally with the Surgery.

The panel had no evidence to suggest that Patient A had consented to this information being shared with [PRIVATE], or that you were clinically justified in sharing it. The panel was therefore satisfied that on one or more occasion on or after 29 February 2020, you disclosed Patient A's confidential medical information to [PRIVATE], without clinical justification and/or consent.

In relation to Patient A's [PRIVATE], the panel noted that the only evidence before it was Patient A's account of [PRIVATE] had told him. It noted Patient A's letter of complaint to the Trust dated 16 March 2020, which stated:

> '*Later in the evening* [PRIVATE] *text me again at 5.12pm and followed up with a phone call stating that his* [PRIVATE]*had turned up at Airedale Hospital and started to tell him that i was being seen*'.

You told the panel that you saw [PRIVATE] at the hospital on 1 March 2020, where you discussed and had an argument with him about other matters. You stated that you did not discuss Patient A's confidential medical information with him.

The panel did not have direct evidence from Patient A's [PRIVATE] about the content of your conversation with him, or the details that were discussed, if at all. The panel was therefore not satisfied that there was sufficient evidence to support the allegation that, on the balance of probabilities, you disclosed Patient A's confidential medical information to [PRIVATE].

The panel next considered the allegation in respect of your '*friend*'. You stated that the '*friend*' you contacted was Colleague C.

The panel noted Patient A's '*timeline of events*' document detailing information he had received from the Trust. This document included an excerpt from the Trust's final report, with two added annotations which stated:

‘*Staff nurse 1 then spoke with another colleague asking “what do you think I should do?* [PRIVATE] *is registered at the surgery and is seeing the DN team. Should I drop him a courtesy call to say I’m working there?”*

[Colleague A], did she recall what the other colleague/friend said?

This was a friend, not a colleague at work. I don’t have the outcome of that conversation.’

The panel did not have before it the full context of this document, and so it placed limited weight on it.

The panel also took into account the notes, admitted as hearsay evidence, of Colleague A’s conversation with you on 5 March 2020, which stated:

‘*01/03/2020 – Lynne states she rang and said the same as what had said to [Colleague C], to which, ... replied that’s fine, we won’t put you to see him. Lynne then spoke with her friend asking “what do you think I should do?* [PRIVATE] *is registered at the surgery and is seeing the DN team. Should I drop him a courtesy call to say I’m working there?*’

In addition, it considered the Trust’s investigation report dated 5 May 2020, which stated:

‘*Staff Nurse 1 advised that she had contacted a friend for advice. The investigation was unable to determine what advice was given as staff Nurse 1 has left the Trust*’.

You told the panel that you were not provided with either of these documents at the time, nor had you been given an opportunity to respond to them. The panel also considered that it had not heard directly from the author or authors of these documents, and so it placed limited weight on the reliability of this evidence. The panel therefore found that there was

insufficient evidence to support the allegation that, on the balance of probabilities, you disclosed Patient A's confidential medical information to your '*friend*'.

In relation to Patient A's [PRIVATE], the panel noted Patient A's witness statement dated 25 April 2022, which stated:

> '*I was so upset by her response last May, with the initial screening decision and then she then sent that text to my* [PRIVATE]*, who has nothing to do with this at all.*'

There was very limited information before the panel about your correspondence with Patient A's [PRIVATE]. It therefore found that there was insufficient evidence on which it could make a finding that you disclosed Patient A's confidential medical information to her.

In light of all the evidence before the panel, it found charge 2 proved on the balance of probabilities, [PRIVATE].

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the

facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Fergus-Simms invited the panel to take the view that the facts found proved amounted to misconduct. She asked the panel to have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2015)' (the Code), and submitted that you had breached parts 5.1, 5.2, 5.4, 5.5, 20.1, 20.3, 20.4, 20.5 and 20.6 of the Code.

Ms Robinson submitted that you accepted and acknowledged that the facts found proved amounted to misconduct, although this was a matter for the panel's own professional judgement.

Submissions on impairment

Ms Fergus-Simms moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Ms Fergus-Simms invited the panel to find that your fitness to practise is impaired. She referred to the panel's decision on the facts and submitted that it was clear you had sought to conceal your true motives and to mislead the panel over the extent to which you accessed Patient A's clinical records. Ms Fergus-Simms submitted that this amounted to a flagrant disregard of Patient A's privacy on a deeply personal and sensitive matter.

Ms Fergus-Simms acknowledged your acceptance in oral evidence that your conduct was wrong and regrettable, as well as your reflective account which, she submitted, spoke more broadly and generally about the impact of confidentiality breaches on patients.

However, Ms Fergus-Simms submitted that you failed to directly address the level of harm and the impact of your actions on Patient A, which included him feeling compelled to share further information with [PRIVATE]. She submitted that you minimised your actions by saying that you only had good intentions for Patient A, but then went on to make disparaging remarks about Patient A in evidence. Ms Fergus-Simms submitted that this casted doubt as to whether you actually had good intentions when accessing Patient A's clinical records.

Ms Fergus-Simms referred to the case of *General Medical Council v Meadow* [2007] QB 462 (Admin) and the "*test*" set out by Dame Janet Smith in her Fifth Report from the Shipman Inquiry. She submitted that your actions put Patient A at risk indirectly because he no longer feels able to seek medical services from that area of district nursing. Ms Fergus-Simms submitted that your actions brought the nursing profession into disrepute and breached one of the fundamental tenets of the profession to respect people's right to privacy and confidentiality. In addition, she submitted that you acted in such a way that your integrity could no longer be relied upon due to your desire to minimise your actions and mislead the panel in evidence.

Ms Fergus-Simms also referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Nicholas-Pillai v General Medical Council* [2009] EWHC 1048 (Admin). She submitted that public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances of this case.

Ms Fergus-Simms submitted that your misconduct related to sustained and repeated breaches of confidentiality on three separate dates, as well as a disclosure of Patient A's confidential information to a third-party from whom he was estranged. She submitted that your misconduct was made all the more serious, given the context of your [PRIVATE] issues. Ms Fergus-Simms submitted that in your oral evidence, you tried to distance yourself from the conduct by making excuses that you were not able to operate the IT

systems correctly, despite admitting during questions from the panel that you had undergone the relevant information governance training.

Ms Fergus-Simms submitted that it would have been far more credible had you owned up to your mistake, rather than seeking to conceal the reasons for accessing Patient A's records. She submitted that this demonstrated limited insight and that you sought to minimise the conduct itself, even four years after the event. Ms Fergus-Simms submitted that the panel may may take the view that there is an attitudinal problem in that you sought to conceal the true extent of the breach and sought to blame, for example, the lack of training and support from your superiors.

Ms Fergus-Simms submitted that only three of the seven testimonials you provided made direct reference to these proceedings or your breach of confidentiality, so it was unclear whether the other referees were actually aware of the full extent of your conduct at the time that they wrote them. She submitted that this could also demonstrate a lack of transparency by you as to what you had in fact disclosed to your referees. Ms Fergus-Simms invited the panel to give less weight to those testimonials that did not make direct reference to these proceedings. She submitted that it was unclear whether these referees would still be willing to provide such references if they knew that, in fact, you had acted without clinical justification.

Ms Fergus-Simms therefore invited the panel to conclude that a finding of impairment is required in this case on public protection and public interest grounds.

In response to Ms Fergus-Simms' submissions that you sought to conceal, mislead and minimise your conduct, Ms Robinson reminded the panel of its decision on the facts and invited it to take real caution before adopting such strong language.

Ms Robinson then addressed Ms Fergus-Simms' reference to the "*test*" set out by Dame Janet Smith in her Fifth Report from the Shipman Inquiry. She acknowledged that the fourth limb of this test referred to '*integrity*' rather than '*dishonesty*' as set out in the case

of *CHRE v NMC and Grant*. Ms Robinson submitted that in any event, there had been no charge or finding of dishonesty or a lack of integrity, and so the fourth limb of either "*test*" was not relevant in this case.

Ms Robinson asked the panel to apply caution when placing any weight on any submission relating to disparaging remarks about Patient A. She submitted that wherever you provided evidence about your [PRIVATE] and issues, this was because you were responding to questions asked.

Ms Robinson referred to the case of *CHRE v NMC and Grant* and submitted that the question of whether you in have '*in the past acted and/or [are] liable in the future to act so as to put a patient or patients at unwarranted risk of harm*' would be a matter for the panel to decide. She acknowledged Patient A's evidence about how your conduct affected him, but also invited the panel to consider his evidence that what bothered him most was the Trust "*trying to cover up*" in relation to the 52 times his records had been accessed by members of staff at the Trust (information which had arisen following his data access request). Ms Robinson submitted that whilst this had stemmed from your actions, she would invite the panel to consider the context and complete picture of what Patient A said in evidence. Ms Robinson submitted that this was quite an unusual situation that arose at a time of great emotional turmoil [PRIVATE]. She reiterated the need for the panel to consider the context of what happened and the short time frame in which it took place.

In relation to future risk, Ms Robinson addressed the panel on your insight. She referred to your reflective account, which in her submission, showed insight into the importance of privacy and the trust that patients and individuals should have in healthcare professionals. Ms Robinson submitted that in your oral evidence and written reflection you acknowledged that as soon as you saw [PRIVATE] record, you should have shut it down immediately, and that it was not acceptable to tell [PRIVATE] that [PRIVATE] was a patient at the Surgery or "*on the books*". She referred to your reflections on what you say you should have done differently in the circumstances. Ms Robinson submitted that your admissions also demonstrated some insight.

In relation to remediation, Ms Robinson referred the panel to your mandatory training record and training certificates in data security, the duty of candour, information governance and data security awareness. She then referred to the references and testimonials from various colleagues, both former and current, who spoke highly of you, with one in particular referring specifically to patient confidentiality, and another indicating that he has always found you to be trustworthy, to respect patients, and to understand patient confidentiality and practise within the NMC code of conduct.

Ms Robinson highlighted that there have been no previous referrals, and most importantly, no repetition of what took place four and a half years ago in February and March 2020. She submitted that there was no evidence before the panel of an attitudinal problem.

Ms Robinson submitted that looking at the whole context of what took place, as well as your references, testimonials, training undertaken, insight and reflection shown, there was no risk of the conduct being repeated. She therefore invited the panel not to make a finding of impairment on public protection or public interest grounds. Ms Robinson submitted that a well-informed member of the public, knowing all of the circumstances of this case, would not automatically expect a finding of current impairment in order to maintain confidence in the profession.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cheatle v GMC* [2009] EWHC 645 (Admin), *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *CHRE v NMC and Grant*, and *Cohen v General Medical Council*.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

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

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times'.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel noted that you had accessed Patient A's clinical records without clinical justification on three separate occasions, and disclosed his confidential medical information to a third party without clinical justification or consent.

The panel considered that Patient A had a right to trust that the practitioners with access to his medical information would treat this information with respect and confidentiality. However, your conduct breached Patient A's right to privacy and by his account, caused him significant distress and psychological harm. The panel determined that by doing so, you failed to uphold the proper standards expected of you as a registered nurse. It was of the view that your actions would be regarded as deplorable by fellow practitioners.

The panel also took into account your acceptance that your actions amounted to misconduct.

In all the circumstances, the panel was satisfied that your actions at charges 1 and 2 fell seriously short of the conduct and standards expected of a registered nurse and therefore amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

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

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

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

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

The panel determined that limbs a), b) and c) are engaged in this case. The panel found that Patient A was caused emotional and psychological harm as a result of your misconduct. It determined that Patient A was put at risk of harm as he felt he could no longer receive treatment from the district nursing team at the Surgery following these concerns. In addition, the panel considered that wider harm was caused to Patient A's wife, who worked at the Surgery at the time and Patient A's evidence that [PRIVATE] felt that she could not go back to work there. Your misconduct had breached the fundamental tenets of the nursing profession, by failing to uphold patient dignity and privacy and to handle patient information securely and professionally, and therefore brought its reputation into disrepute.

In respect of Ms Fergus-Simms and Ms Robinson's submissions on limb d), the panel was not satisfied that you had acted dishonestly. It therefore did not find limb d) engaged in this case.

The panel acknowledged the context of the concerns in this case. It noted that there had been a long-standing estrangement between you and Patient A. Further, your misconduct took place at a stressful and deeply emotional time when [PRIVATE] was in hospital. The panel considered that the personal nature of this context may have affected your judgement at the time of the misconduct.

The panel considered the factors set out in the case of *Cohen v General Medical Council*:

- whether the misconduct is capable of being addressed;
- whether it has been addressed; and
- whether the misconduct is highly unlikely to be repeated.

The panel determined that the misconduct in this case is capable of being addressed. It considered that whilst you had accessed Patient A's clinical records on three occasions without clinical justification, there had not been a pattern of misconduct. The panel noted that it related to a single patient over a short period of three consecutive days and a single disclosure to a third party. The panel took into account that the misconduct was linked to [PRIVATE] and although serious, it determined that this could be addressed through a willingness to engage in further reflection, develop your insight and undertake relevant training. The panel was encouraged by your expressed willingness in your reflective account to use this experience as a '*learning opportunity*'.

Regarding insight, the panel considered that you had demonstrated limited insight. In your oral evidence and undated reflective account, you indicated that you regretted your actions, that you would not do it again and that you had let yourself and the nursing profession down. However, the panel was concerned that you had not addressed the impact of your actions on Patient A. You did not demonstrate an understanding of how your actions caused Patient A harm, nor did you provide an apology to him in your reflective account. The panel took account of the context and your estrangement from Patient A, but was of the view that you had not yet taken a step back from the situation

and looked at it objectively. On this basis, the panel determined that you had demonstrated insufficient insight.

In addition, the panel noted that in oral evidence, you passed comments about matters you had identified in Patient A's records and in its view, you were quite judgemental and unprofessional in some of these remarks. The panel was not satisfied that this pointed to an attitudinal problem that went beyond this particular set of circumstances. The panel was concerned, however, that you minimised your behaviour and sought to place some blame for your actions on your superiors due to lack of training on IT systems.

The panel also took into account the seven testimonials from your former and current colleagues, which suggested that you had an otherwise positive professional record and there were no concerns with your clinical practice. It noted that there was positive reference to you maintaining patient confidentiality from a current staff nurse colleague. However, the panel considered that these testimonials did not sufficiently address the specific concerns set out in the misconduct identified.

In respect of training, the panel noted your evidence that you have always been up to date with your mandatory information governance training. Despite this, you still accessed Patient A's clinical records and disclosed his confidential information without clinical justification. The panel had sight of your mandatory training record and your training certificates in data security, the duty of candour, information governance and data security awareness. However, it had no evidence that you have undertaken wider relevant training to consolidate your understanding of appropriate information governance and what to do when there is a breach.

As such, the panel could not conclude that it is highly unlikely that your misconduct would be repeated in the future. It therefore found that there is some risk of repetition and that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required to mark the unacceptability of your misconduct and to uphold proper professional standards. The panel considered that a well-informed member of the public would be concerned if a finding of impairment were not made in a case where you had carried out serious breaches of confidentiality in respect of a patient, and had not developed sufficient insight.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also found your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was not satisfied that you can practise kindly, safely and professionally and therefore determined that your fitness to practise is currently impaired.

Interim order

Having reached the end of the allocated time before the conclusion of the case, the hearing went part-heard on 1 November 2024.

Pursuant to Rule 32(5), the panel considered whether an interim order is required in 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 your own interests.

Submissions on interim order

The panel took account of the submissions made by Ms Fergus-Simms. She submitted that there was no application by the NMC for an interim order at this stage.

The panel also took into account the submissions of Ms Robinson. She endorsed Ms Fergus-Simms' submission and asked the panel not to make an interim order. She submitted that having seen the panel's decision so far, an interim order is not necessary on the grounds of public protection or otherwise in the public interest.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel considered its finding of impairment on public protection and public interest grounds. However, it had regard to the necessity test and found that the threshold for making an interim order was not met. The panel did not consider it necessary to impose an interim order at this stage. It was satisfied that there is no real risk to patients, colleagues or other members of the public if an order were not made and you were permitted to practise unrestricted, pending further determination of this case.

The panel was therefore satisfied that an interim order is not necessary for the protection of the public nor is it otherwise in the public interest or your own interests.

The panel has not imposed an interim order.

This case is now adjourned.

The hearing resumed on 3 January 2025.

The panel heard submissions from Ms Carver on behalf of the NMC, and Ms Robinson on your behalf.

Sanction

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

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

Submissions on sanction

Ms Carver, on behalf of the NMC, informed the panel that in the Notice of Hearing, dated 19 September 2024, the NMC had advised you that it would seek the imposition of a striking-off order, if the panel found your fitness to practise currently impaired. She also submitted that remained the position today.

Ms Carver referred the panel to the relevant guidance and addressed the aggravating features of this case. Firstly, abuse of a position of trust in that you accessed Patient A's clinical records without clinical justification on three separate occasions and disclosed

Patient A's confidential information to a third party without any clinical justification or consent. Ms Carver submitted that Patient A had a right to trust that the practitioners with access to his medical information would treat this information with respect and confidentiality. However, you abused this position and breached Patient A's right to privacy, thereby causing Patient A significant emotional and psychological harm. Ms Carver submitted that not only did this cause a risk of harm, as he felt that he could no longer receive treatment from the Surgery, but also wider harm was caused to his wife, who worked at the Surgery at the time and felt that she could not continue to work there.

Ms Carver submitted that your limited insight is also an aggravating feature of this case. She referred the panel to your oral evidence and submitted that you indicated that you regretted your actions and had let yourself and the profession down. However, Ms Carver submitted that you did not demonstrate an understanding of how your actions caused Patient A harm or provide an apology to him. Further, Ms Carver submitted that you passed comments about matters you had identified in Patient A's records, and you were noted to have been judgmental and unprofessional in these remarks. You allegedly minimised your behaviour and sought to place some blame on others, namely your superiors, due to a lack of IT system training.

Ms Carver submitted that in your new written reflective piece (which was submitted today, 3 January 2025), you stated that you had apologised to Patient A in an earlier reflective piece. However, having checked the documents you sent, Ms Carver informed the panel that there was no apology then, and in a case of this nature, an apology should be at the forefront and at the outset, and not in this late stage. Ms Carver submitted that anything less is a reflection of an attitudinal concern. Your conduct placed people receiving care at risk of suffering harm. Patient A was put at risk of harm, as he felt he could no longer receive treatment from the district nursing team at the Surgery.

In terms of the consideration of mitigating features in this case, Ms Carver acknowledged that there was some evidence of insight and understanding of your actions. You appeared to have kept up to date with mandatory information governance training and provided

testimonials. However, Ms Carver submitted that whilst you followed principles of good practice and kept up to date with training at the time of the incidents, you went on to access Patient A's clinical records and disclosed confidential information without clinical justification. There is no evidence that you have undertaken wider relevant training to consolidate your understanding of appropriate information governance and what to do when there is a breach, which remains the situation despite your recent reflective piece.

In terms of personal mitigation, Ms Carver submitted that the panel acknowledged within its determination that the misconduct took place during a stressful and emotional time which may have affected your judgment.

Ms Carver referred the panel to the relevant NMC Guidance. She submitted that taking no action and a caution order would not be appropriate in this case given the nature and seriousness of your misconduct.

Ms Carver submitted that a conditions of practice order would not mark the seriousness of the case, and it would be insufficient to maintain the high standards within the profession or the trust that the public places in the profession. Moreover, Ms Carver submitted that the misconduct in this case represents deep seated attitudinal problems. She submitted that there has been no evidence of wider training to consolidate your understanding of appropriate information governance or when there is a breach. Additionally, there are no workable conditions which could be formulated as any conditions would have to limit access to medical records. Ms Carver submitted that such an order would not sufficiently protect the public or patients from psychological harm, nor would it adequately satisfy the public interest test that medical records are safe and confidential and would not be unnecessarily accessed.

Ms Carver referred the panel to the relevant NMC Guidance on a suspension order. Ms Carver submitted that there was a repeated access on three occasions of Patient A’s record for no logical or clinical reason. You further made some remarks that were considered as judgmental and unprofessional. Ms Carver submitted that it is

acknowledged that the panel was not satisfied that this pointed to attitudinal problems beyond this set of circumstances. However, the NMC would submit that it does reflect deep seated personality or attitudinal problems within these set of circumstances.

Ms Carver submitted that whilst there has not been a repetition of the behaviour, you demonstrated insufficient insight and therefore, it cannot be said that you do not pose a risk of repeating your behaviour. Therefore, she submitted that the sanction bid in this case is a striking off order. The conduct is of the utmost seriousness and raises fundamental questions about your professionalism and therefore, such a sanction is required to maintain public confidence in the profession and to protect patients, members of the public and maintain professional standards.

Ms Carver submitted that records were accessed without any clinical justification over three days. By the third day that Patient A raised a complaint, you told your father that Patient A was *"on the books".* Ms Carver submitted that there is a sanctity in medical records because even if this information is disclosed to just one third party, there is no longer any sanctity over that information, which is why it is so serious and why nothing less than a strike off is appropriate. Patients provide their most personal and sensitive information to medical professionals with the expectation that it will remain confidential and only accessed for legitimate reasons. There is an expectation that [PRIVATE] would not be able to access even in a professional capacity. She submitted that you have breached one of the most fundamental tenets of the profession by looking at Patient A's notes without clinical justification and disclosing that information to a third party. This undermines public protection, and as a result of the harm caused, undermines public interest.

Ms Carver referred to *Bolton v the Law Society* [1994] WLR 512 EWCA and submitted that your conduct is fundamentally incompatible with continued registration. The only appropriate order for public protection and in the public interest is that of a striking off order.

The panel also bore in mind Ms Robinson's submissions. Ms Robinson invited the panel to have regard to the testimonials which were provided to the panel during the earlier stages of this hearing and the two new testimonials provided today, 3 January 2025. Ms Robinson submitted that the latest testimonials are important because they are from current colleagues. You have been a nurse since 1994 and there have been no concerns for your practice except for this case.

Ms Robinson submitted that these testimonials commented on your professionalism and your conduct as a nurse. She submitted that the testimonials were from colleagues who are fully aware of these proceedings and the charges against you. The testimonials before the panel refer to your usual practice in terms of patient confidentiality. Ms Robinson invited the panel to have regard to these testimonials which are positive about your general nursing practice, but also speak of the way you normally deal with confidentiality.

Ms Robinson invited the panel to give these testimonials careful consideration in the context of a long nursing career. Ms Robinson submitted that since these allegations, there has been no repetition, which is confirmed by the testimonials.

In addressing your insight, Ms Robinson invited the panel to consider your admission of disclosing to a third party that Patient A was "*on the books*", which may go towards demonstrating your insight. Further, your most recent reflective piece demonstrates a developing insight and perhaps more of an understanding of the effect that it can have on Patient A or any other patient. You were deeply sorry for the distress and harm that your actions have caused Patient A.

Ms Robinson invited the panel to consider the length of time since the incidents took place. Although you formally retired, you are still working two shifts a week on an acute medical ward as a nurse. There has been no repetition since. Ms Robinson submitted that there is no evidence of a deep seated or personality or attitudinal problem.

Ms Robinson invited the panel to consider the least restrictive order and in the event that it found that a caution order is not appropriate, she invited the panel to consider a conditions of practice order. She submitted that there are identifiable areas that you could work on in relation to clinical governance. Ms Robinson submitted that your line manager would be in support of conditions. You could work with your line manager or a designated person to develop a personal development plan to consider the following areas:

- Clinical governance.
- Patient confidentiality and the appropriate way to deal with matters if there is a breach.
- Report from your line manager setting out your understanding of the rules and around patient confidentiality.

Ms Robinson submitted that in a case where there are no deep-seated attitudinal problems and no evidence of general professional incompetence, a conditions of practice order warrants some consideration.

Ms Robinson submitted that a striking off order would be disproportionate. She submitted that there is no fundamental question regarding your professionalism when looking at your career, your recent testimonials and the short time frame of what happened back in 2020. It is not one that is fundamentally incompatible of remaining on the register.

Ms Robinson submitted that in terms of a Suspension Order, she invited the panel to consider that there is no evidence of repetition and of a deep seated attitudinal problem in your practice as a whole. However, if the panel were minded to impose this, a short period would be proportionate.

The panel asked for clarification regarding the training that you intended to participate in around November 2024/December 2024. You told the panel that the information governance training is a mandatory course which is not due to be undertaken until July 2025. The training that you attended was a three-day course which relates to decision making councils.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Abuse of a position of trust in that you breached confidentiality in accessing confidential information without clinical justification and passing this on to a third-party without clinical justification.
- Your misconduct, in accessing Patient A's records, took place on three separate occasions, including after you were instructed not to access Patient A's records again by a colleague.
- Incomplete insight. Although, the panel noted you now appear to accept the severity of your actions in a general clinical context, the panel did not consider you had sufficiently demonstrated an understanding of the specific impact your actions had on Patient A, [PRIVATE], whilst you were working in a role as a nurse.
- Patient A suffered emotional and psychological harm in that he was distressed that you had accessed the information without his consent. He was also put at risk of harm as he felt he could no longer seek treatment from the District Nursing Team at the Surgery. The panel noted that your behaviour also caused harm to [PRIVATE] in that she was reluctant [PRIVATE].

The panel also took into account the following mitigating features:

- Personal mitigation in that the incidents took place during a deeply emotional and stressful time for you, which may have affected your judgment at the time.

- You made early admissions to Charges 1b and 1c. The panel had also accepted your version of events in relation to Charge 2, which you had put forward at the outset of the hearing.
- The submission of your most recent written reflection (submitted on 3 January 2025) indicates that your insight is developing.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the nature and seriousness of the case. 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 nature and seriousness of the case an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*

- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel gave careful consideration to Ms Robinson's submissions and suggestions of conditions to address information governance. However, the panel acknowledged that you had been a nurse with a career spanning over 25 years and had completed your mandatory training (which included information governance) at the time the misconduct took place. The panel determined that the misconduct identified in this case was not related to your competencies but was a serious lapse in judgment during a difficult period in your life due to prevailing [PRIVATE] matters. The panel was of the view that there are no practical or workable conditions that could be formulated to address the attitudinal nature of the concerns.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel acknowledged that confidentiality, trust, dignity and respect are rooted within the Code. Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. The panel gave careful

consideration whether your actions in these circumstances amounted to being fundamentally incompatible with remaining on the register.

The panel acknowledged that this was a single event which took place on three separate occasions on consecutive days, pertaining to one person, and within the [PRIVATE] context. The panel noted that your actions amounted to a serious error in your judgment, one which affected not only Patient A but also his wife. The panel took into account your long and previously unblemished career as a nurse and the testimonials from current colleagues. It also took account of your willingness to engage and your developing insight, including your recent reflective piece which said:

> *'I broke that trust to the detriment of him and others who expect better of the nursing profession. I sincerely hope that this remains a one-off incident in my career, if at any time I find myself in a position where I am feeling too emotional I will seek the support of a colleague and ask them to take over the care. I will cooperate with the NMC and others to return to the high standards of practice expected of me.'*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. In addition, the panel noted that it has been five years since the incident and this, together with your developing insight, satisfied the panel that you do not pose a significant risk of repeating the harm.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction. In the panel's careful regard to the NMC Guidance, the panel found no evidence of deep-seated attitudinal issues (although it

accepted that there were elements of attitudinal concerns at the time of the incidents), no evidence of repetition since the event, and your developing insight, the panel was satisfied that a suspension order would protect the public and satisfy the wider public interest.

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

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

In making this decision, the panel carefully considered the submissions of Ms Carver in relation to the sanction that the NMC was seeking in this case. The panel took the view that a striking off order would be wholly disproportionate given that you have demonstrated developing insight during the course of these proceedings.

The panel determined that a suspension order with a review for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by:

- Evidence of your further insight in relation to:
    - Privacy, dignity and respect of patients.
    - Personal boundaries in dealing with patients, [PRIVATE] and the public.

- Demonstration of a deeper understanding of the impact of your behaviour on Patient A and how your actions could impact the public's confidence in the nursing profession.
- Evidence of further online reading, training and an updated written reflective piece.

This will be confirmed to you in writing.

Interim order

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

The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Carver. She invited the panel to impose an interim suspension order for 18 months. She submitted that an interim suspension order would be appropriate in light of the panel's decision on sanction. Ms Carver submitted that an interim suspension order would cover the appeal period, should you decide to lodge an appeal. She invited the panel to impose the interim suspension order on the grounds of public protection and the wider public interest.

Ms Robinson submitted that the decision ultimately lies with the panel and informed the panel that you acknowledged the panel's decision on sanction. Ms Robinson invited the panel to carefully consider the grounds on which it imposes an interim order.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that 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 on the grounds of public protection and the wider public interest.

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

That concludes this determination.