

**Fitness to practise
annual report
2003–2004**

**NURSING &
MIDWIFERY
COUNCIL**

Fitness to practise annual report 2003–2004

Protecting the public through professional standards

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Foreword



Jonathan Asbridge



Professor Mary Hanratty

This is the second Fitness to Practise annual report of the Nursing and Midwifery Council (NMC). The report provides information about the NMC's work in considering allegations of misconduct and unfitness to practise due to ill health.

Members of the NMC, registrants and lay panellists make up the committees that consider allegations and make judgements based on those allegations. The work of these committees is very important in ensuring that the public is protected from practitioners who may be unsafe.

We had hoped that new fitness to practise rules under the Nursing and Midwifery Order 2001 would be in place during this reporting year, but the introduction of these rules was delayed. They will be in place during the next reporting year, and the 2004-2005 report will carry an overview of any changes. In the meantime the professional conduct rules, which governed the proceedings of the former United Kingdom Central Council for Nursing, Midwifery and Health Visiting, continued to apply during 2003-2004.

Much work has taken place during this year to ensure that once the new rules do come in, the necessary procedures will be in place to implement them. A programme has been under way for members, panellists and staff to train them in the requirements of the new legislation and the consequent changes to fitness to practise procedures. There have been a number of summits with key stakeholders in the four countries of the United Kingdom to discuss the impending changes.

A smooth transition from one system to the other is vital so that protection of the public continues seamlessly, and to ensure that cases are dealt with as efficiently and speedily as possible.

Jonathan Asbridge
NMC President
Chair of the Professional Conduct Committee

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Trends and issues

The NMC's remit, like that of its predecessor the UKCC, is to protect the public. The current Council is a transitional body. In 2005 a new Council will be elected, which is expected to take over from the current Council in 2006.

For the year under report, the NMC's Professional Conduct Committee (PCC), Preliminary Proceedings Committee (PPC) and Health Committee (HC) dealt with allegations of misconduct and unfitness to practise due to ill health.

New allegations of misconduct

The number of allegations of misconduct against registered nurses, midwives and specialist community public health nurses rose considerably this year. In 2003-2004, the NMC received a record 1,460 complaints.

UKCC 1999-2000	UKCC 2000-2001	UKCC 2001-2002	NMC 2002-2003	NMC 2003-2004
1,142	1,240	1,304	1,301	1,460

Who makes the complaints?

Anyone can make a complaint, but in practice the largest number (48%) come from employers, usually in association with disciplinary proceedings at the workplace.

The NMC also receives complaints from the police, who are obliged to inform the regulatory body of any criminal conviction received by a practitioner on the NMC register. Last year the NMC was notified of 298 convictions – many of which were minor matters unlikely to lead to any further action. However, the NMC is also notified of serious convictions involving rape, other violent crimes and dishonesty.

Complaints are also received directly from patients, the public, colleagues, supervisors of midwives, the National Care Standards Commission and others.

Where do the complaints come from?

While complaints are received from all four countries of the United Kingdom the majority are from England.

Country	Number of complaints	% of practitioners resident in each country	% of complaints in each country
England	1,304	79.1%	89.3%
Wales	42	4.6%	2.9%
Scotland	92	10.2%	6.3%
Northern Ireland	19	2.7%	1.3%
Outside the UK	3	3.4%	0.2%
Total	1,460		

What happens to new complaints?

When a complaint is received it is considered by a panel of the PPC. The panel decides whether there is a case to answer and whether there is enough evidence to support the complaint. The PPC takes, as its starting point, the fact that the professional conduct procedures are, as set out in the legislation, '... proceedings for removal from the register'. Some complaints will be closed at an early stage by the PPC. This could be because they are trivial, not supported by evidence or relate to matters that would not call into question the registrant's fitness to practise. Many convictions may fall into this category, for example, minor motoring offences.

However, if the allegations are serious and the PPC believes they could lead to removal from the register, solicitors will investigate and report on the strength of the evidence available to support the charges. The criminal standard of proof is applied, and solicitors will advise as to whether this standard of proof can be reached. This is a higher standard of proof than is required in, for example, employers' disciplinary hearings.

During 2003-2004, the PPC considered 1,511 cases and made the following decisions as shown in the table below. The comparative NMC figures for 2002-2003 are also given.

Judgement	NMC 2002-2003	NMC 2003-2004
Case closed	819	875
Further investigation required	418	393
Referred to professional screeners (for consideration of health cases)	66	53
Cautioned	42	30
Referred to the Professional Conduct Committee	240	160
Total	1,585	1,511

The above figures include some cases that will have been considered twice.

Cautions

A caution may be issued by the PPC if the following three criteria are satisfied:

- ▶ The offences are serious enough to lead to removal from the register
- ▶ The registrant admits the facts of the charges and that they constitute misconduct
- ▶ The registrant provides mitigation that persuades the committee that they are not a risk to the public, and that removal would not be appropriate.

However, the PPC will still refer a case for a hearing if it decides that removal is appropriate.

Recording action taken

Records of cautions are retained for five years. Any employer or member of the public who checks the practitioner's registration with the confirmation service during that period is informed of the caution. If the practitioner is referred again to the PPC or the PCC during that five-year period, the committee will be informed of the caution.

Professional Conduct Committee

Professional Conduct Committee (PCC) hearings are held in public. This reflects the Council's commitment to transparency and accountability in its fitness to practise work. The press is usually present, as are those who wish to attend as observers. Occasionally, some respondents and their employers want proceedings to be held in private. However, the only reason the PCC may agree to hold all, or part, of a hearing in private is to protect the identity of a victim of the alleged offences in particularly sensitive circumstances, such as child abuse cases. The potential embarrassment of the respondent, or the business reputation of the respondent's employer, are never accepted as reasons for holding the hearing in private.

Location of PCC cases 2003-2004

The PCC usually sits in the country in which the case originated. In England, many cases are heard in London at the NMC's offices and at other locations in the capital. In 2003-2004, cases were also heard in Bath, Birmingham, Bolton, Bradford, Burnley, Chester, Derby, Exeter, Harrogate, Lancaster, Manchester, Nottingham, Portsmouth and Wigan. In Scotland cases were heard in Edinburgh and Glasgow; in Wales, Cardiff; and in Northern Ireland, Belfast.

During the year, the PCC sat on 380 and a half days, and considered 283 cases of alleged misconduct and 18 applications for restoration to the register.

Professional Conduct Committee decisions

Judgement	NMC 2002-2003	NMC 2003-2004
Removed from the register	154	127
Cautioned	66	45
Misconduct proven but no further action	6	2
Facts or misconduct not proven	15	13

For the year 2003-2004, 74 further cases were adjourned.

Categories of misconduct

Figures show that poor practice makes up the greatest percentage of charges at 35%. This covers failure to attend to basic needs, poor drug administration, and general unsafe clinical practice. 15% of poor practice charges relate to poor record keeping.

Unfortunately, figures also show that a large number of our cases concern the abuse of patients. During 2003-2004, abuse constituted 30% of all charges, up from 26% the previous year. This covers physical, verbal or sexual abuse of patients and clients, and theft from patients and clients.

3% of the charges were non practice-related. A registrant can be called to account for behaviour that is not related to work if it is considered that public trust and confidence in the professions would be undermined, or if such behaviour constitutes a risk to the public.

Applications for restoration to the register

During 2003-2004, the committee considered 18 applications for restoration to the register and accepted two. This compares with one successful application from a total of 19 the previous year.

Anyone who has been removed from the register can apply to have their name restored to it. In practice, it is recommended that no application should be made within 12 months of removal. Applications are discouraged from those who have clearly made little or no effort to address the issues that led to their removal in the first place. Finally, as a matter of policy, no practitioner who has been removed from the register after committing a serious criminal offence will be readmitted to the register if it is considered that this would undermine public trust and confidence in the professions.

All applications for restoration are considered by the PCC. The applicant must attend so that they can be questioned by the committee. Restoration cases are heard on a designated day and the committee is always chaired by the president. Two references must be supplied, one of which must be from a current employer who is fully aware of the circumstances surrounding the removal from the register.

The onus is on the practitioner seeking restoration to demonstrate that, having been removed, they are now a fit and proper person to be restored. The committee will take into account whether or not the practitioner:

- ▶ accepts that removal from the register was justified
- ▶ has addressed the issues that led to removal and changed their behaviour or attitudes
- ▶ shows genuine regret
- ▶ has made amends.

The committee must also consider whether public confidence in the professions is likely to be maintained if that practitioner was to be restored to the register. If the answer to any of these questions is negative, the application will be rejected. When a practitioner has been restored to the register, the previous removal will be disclosed to those confirming the practitioner's registered status for a period of five years from the date of the restoration.

Unfitness to practise due to ill health

Allegations that a registered nurse, midwife or specialist community public health nurse is unfit to practise for reasons of ill health are considered under Health Committee (HC) procedures. The main reasons for referral to the HC in the year under report were alcohol or drug dependence, mental health problems and a smaller number of physical health problems.

A person may be referred to the HC in one of two ways. It may be a direct referral, for example, by an employer. There were 81 direct referrals during the year. Alternatively, during the course of considering a professional conduct case, a referral may be made from either the PPC or the PCC if it appears that the practitioner is unwell. There were no referrals from the PCC during the year but 53 referrals came from the PPC.

The case is initially referred to a panel of screeners. If the screeners feel there may be a current health problem, then the practitioner is invited to be examined by two medical examiners. When the case is considered again, the medical evidence enables the screeners to decide whether to refer a practitioner to the HC. During the year, the screeners met on 36 occasions and considered 352 cases. 29 cases were closed and 151 were referred to the HC. The remaining cases are still in progress.

Health Committee

The HC meets in private because of the confidential nature of the medical evidence involved. During 2003-2004, there were 52 HC meetings, at which 250 cases were considered. Some of these cases were referrals from the previous year, as it can take considerable time to get a case scheduled. The HC has worked very hard to reduce this backlog, sitting 52 times this year, compared to 38 last year, and considering 250 as opposed to 205 cases. The HC has an additional option to exercise over and above that of the PCC, as it can suspend a practitioner's registration. This has the same effect as removal but the practitioner's name remains on the register. In order for the suspension to be lifted, the practitioner must apply in the same way as someone seeking to be restored to the register.

The cases considered by the HC deal with sensitive issues concerning the respondent's medical history. The committee considers matters such as a respondent's mental health or adverse life experiences such as child sexual abuse. It is for this reason that the cases are heard in private in order to keep the individual respondent's medical history confidential.

The HC has frequently used its powers to postpone judgement in respect of health cases. As an example, a practitioner may have a history of alcoholism, but is currently successfully managing this by attending an alcohol support group and being monitored by their GP. They may be practising successfully, with the support of an employer. The HC may wish to consider medical reports and reports from the employer in six or 12 months time in order to be sure that the person is maintaining good mental health before making a decision to close a case.

Of the cases dealt with by the HC, the allegations relating to fitness to practise were as follows:

Allegations	Percentage
Alcohol abuse	32%
Drug abuse	23%
Depressive illness	21.5%
Other mental illness	19%
Physical illness	4.5%

Health Committee decisions

Decision	NMC 2002-2003	NMC 2003-2004
Fitness not impaired – case closed	77	63
Fitness impaired – suspended	37	46
Fitness impaired - removed	13	13
Judgement postponed	24	41
Adjourned for further medical reports	43	54
Total	194	217

The HC also considered 14 applications to terminate suspension, of which 12 were accepted. Six further cases were referred back to the PPC where it was decided that there was no longer a health issue.

Interim suspension

The regulatory body has the power to order the suspension of registration while an investigation is under way. The committee uses this power if it appears that there is a serious risk to the public in allowing an individual to practise pending the outcome of an investigation by the regulatory body. A practitioner under police investigation for a serious criminal offence against patients would almost certainly be subject to interim suspension. It may also be imposed if it is considered to be in the practitioner's own interest. This includes situations, for example, where practitioners are accused of stealing drugs intended for patients for their own use. The practitioner who is being considered for interim suspension has the right to be present at the hearing and to be represented.

Appeals and judicial reviews

There were three appeals against NMC fitness to practise decisions during the year. One appeal was made on the basis that the reasons given for a decision to remove from the register were inadequate. The appeal was allowed and the judge stated that a PCC should give reasons for its decisions, otherwise it was not possible to assess the merits of the decision or to present an application for restoration to the register.

The Council for the Regulation of Healthcare Professionals (CRHP), exercising its powers under S29 of the National Health Service Reform and Health Care Professions Act 2002, appealed against a decision to give a caution on the grounds that it was unduly lenient. The case concerned a nurse who had been accessing pornography whilst on duty. The judge dismissed the appeal on the basis that whilst the decision was lenient it was not unduly so. The CRHP is currently appealing this decision.

There was one appeal against a decision of the HC not to terminate suspension of registration. Amongst other arguments, the unsuccessful applicant argued to the court that the HC should have terminated the suspension of her registration with particular conditions. She argued that the absence of a power to impose conditions placed her under an excessive burden. The court held that in some circumstances the absence of a power to impose conditions might pose a difficulty for the committee, but that the Health Committee rules were sufficiently flexible to allow a proportionate response by the committee to her application to terminate the suspension of her registration.

Case summaries

Three case summaries have been selected to give a flavour of those cases considered by the PCC and they are purely illustrative of the types of cases referred for a hearing.

In previous years the annual report has considered cases in themes – dishonesty, poor practice, non-practice related issues. This year the cases are varied and reflect the diversity of roles played by registrants. One case concerns a practice nurse working in a GP surgery, another involves a research nurse who was falsifying information and a third case involves failures in midwifery practice. We see relatively few cases at the PCC involving midwives, but the summary that has been included is very typical of those midwifery cases that are referred to the NMC. Common features include the interpretation of CTG traces, failure to seek medical assistance and poor record keeping.

If a midwife is suspended by the Local Supervising Authority (LSA) during an investigation into her conduct, then the case must be referred to the regulatory body. The NMC will hold an extraordinary PPC hearing in order to consider whether or not to impose interim suspension of that midwife's registration. If it decides that interim suspension is not necessary in order to protect the public then the LSA suspension must be lifted.

Registrants are encouraged to seek representation if they are facing allegations of misconduct, but many respondents neither attend the hearing nor are represented in their absence. In these circumstances the committee has no opportunity to hear the respondent's side of the case, or to hear any mitigation, in order to help it reach its decision.

Case study 1: Practice Nurse

The PCC considered the case of a registered nurse on Part 1 of the register, who was employed as a Practice Nurse. She faced allegations relating to three patients.

These allegations were:

- ▶ failing to refer a patient to a GP, increasing that patient's medication without authority and failing to make a full and adequate record of the consultation;
- ▶ administering another patient's medication by a route for which she was not trained; and
- ▶ carrying out a smear test inappropriately.

The nurse did not attend the hearing and was not represented in her absence but she had admitted in writing the facts of all the charges.

Background

The nurse worked part-time for a practice with four GPs serving a population of 8,500 patients. She was part of a three-member nursing team. Concerns relating to three patients arose over the six-month period during which the nurse was employed. The doctors felt she had demonstrated poor clinical judgement and dismissed her. The patients concerned had not suffered adverse consequences and had not made a complaint themselves.

Circumstances of the charges

The charges relating to the first patient were as follows. The patient had an appointment with the nurse for a routine smear test, but on arrival at the surgery she had suffered a worsening of her

asthmatic condition. The nurse took a brief history and advised her to increase the use of her inhalers. She made a brief record in the notes and in recording the data onto a computer template she mistakenly entered the information under the section for routine asthma follow up, instead of in the section for acute episodes.

The second set of charges concerned an elderly patient who attended for a routine blood pressure measurement. The patient was seen by the practice nurse manager who, on reading the notes, saw that the respondent nurse had administered an injection into the patient's shoulder joint to relieve pain. The medicine was prescribed, but had to be administered by someone trained in this procedure because of the skill required to position the needle correctly into the joint. Because these injections were given infrequently, only one GP at the practice administered them so that he could keep his skills up to date. The nurse admitted that she had carried out this procedure despite having received no instruction or training and that she had had to follow the patient's instructions when administering it. She had not advised the patient on any side effects.

The third allegation concerned a 14-year old patient from whom the nurse took a cervical smear. The girl had told her guardian that she had become sexually active, and the guardian had brought her to the surgery and requested a smear test. Health authority guidelines stated that routine smears should not be carried out on women under 20 years of age. There had been earlier guidelines (withdrawn in 1998) which had stated that all sexually active women should have routine smear tests. The nurse made an entry in the girl's notes that she had carried out this procedure and one of the doctors subsequently noticed this. The GPs considered that the nurse should have referred the case to them before carrying out the test which, they stated, when carried out in these circumstances can have a high false positive rate because the cervix is still undergoing developmental changes. When questioned by the GPs the nurse said she had felt it to be inappropriate to carry out the smear test but had done so because it had been requested. The partners at the practice felt that the nurse had demonstrated poor judgement and they lost confidence in her ability to treat patients unsupervised.

Decision on misconduct

The committee considered that the admitted facts of the allegations amounted to misconduct.

Previous history

The committee then heard details of the nurse's employment history from the practice nurse's manager, who was part of the practice nursing team. The respondent nurse had two years experience with another GP practice. Prior to joining this practice she had undertaken training in venepuncture, chronic disease management, cervical cytology, childhood immunisation and smoking cessation. After joining this practice she had taken courses in ear syringing and coronary heart disease.

The manager stated, however, that the nurse was not appropriately qualified to manage acute asthma as she had only attended an introductory course on asthma management. She gave evidence that in the nurse's two- week induction to the practice she had been informed that a patient should be referred to the GP or to the practice nurse manager if they had acute asthma.

The nurse had been supervised at first when administering immunisations and taking cervical smears, and had received regular external clinical supervision during her six-month period of employment.

Judgement

The committee decided to remove the nurse's name from the register because she had been found guilty of professional misconduct occurring over a period of less than six months. The committee felt she posed a risk to patients in her care and they had heard no evidence that she had learnt from her mistakes.

Case study 2: Research Nurse

The Professional Conduct Committee considered the case of a registered nurse on part 12 of the register, who was employed by a national organisation to carry out a research project. She faced allegations that on six occasions she had claimed expenses for interviews she had not carried out, and that she falsified the research data in respect of six interviewees. The nurse did not attend the hearing and was not represented, but had written to admit all the charges.

Background

The nurse was employed to assist in a five-year study involving 3,500 members of the public who had volunteered to take part in the research programme. The research was government funded and was intended to track health changes over the years, taking factors such as diet, occupation and the local environment into consideration.

Circumstances of the charges

One of the participants of the research programme contacted the research organisation to say that the nurse had failed to keep an appointment with her to carry out the interview. On investigation, a completed interview form was found in respect of the participant. This raised concerns, and so the nurse's interview records were checked, and amongst the papers were two further complaints about the nurse's failure to turn up for appointments, and in both cases there was a completed interview form. A comprehensive check was then made on all the nurse's interviews.

The research organisation could tell if an interview was genuine because only the research organisation held information about the date of birth of each of the participants. The research nurses were not given this information which had to be obtained at the interview. The six interviews that made up the charges before the PCC all had incorrect dates of birth entered. At the time of the interview, consent had to be obtained from the interviewee, who also had to fill out a health questionnaire. The signatures on all six consent forms were found to have been falsified.

Initially, on being questioned about the discrepancies by the Unit Survey Manager, the nurse denied the allegations of falsification. However, she subsequently admitted the allegations.

She had submitted claims for the hourly salary, travel and expenses for each interview, itemising the time taken to travel from her house to the interviewee and back, and the time taken for each interview.

Decision on misconduct

The PCC found the admitted charges to be misconduct because of the premeditated dishonesty, theft and breach of trust.

Previous history

Information was given by the person who interviewed the nurse for her position with the research body. She had been employed for eight months, up to her dismissal, and had been given a five-day

induction into her new role. An interview with a research participant would be expected to take about three hours during which time a nurse would enter information onto a laptop computer and measurements of height, weight and lung function would be recorded. The interviewee would complete two paper questionnaires and return these to the nurse during the interview.

Part of the contract between the organisation and the research nurse was that every three weeks the information had to be downloaded at the research offices. Initially the nurse's work was considered to be satisfactory, but after five months she was difficult to contact to make arrangements for her to come in and download the data she had collected.

Judgement

The Committee decided to remove the nurse's name from the register. The Chair said that her dishonesty was premeditated, recurrent and involved falsified consent, breach of trust, and theft. Her actions undermined trust and confidence in the professions and affected public perception of the research body and its findings.

Case study 3: Midwife working on a labour ward

The PCC considered the case of a midwife – qualified since 1997 and registered on parts 1, 2 and 10 of the register. She faced charges relating to a delivery where she failed to take action when the CTG recording showed decelerations; failed to monitor the progress of labour in an appropriate way; failed to seek medical assistance in the second stage of labour when there were foetal heart abnormalities; failed to check the dilatation of the cervix by vaginal examination; failed to replace CTG paper; and failed to keep proper and adequate records. The midwife was present and was represented and she admitted the facts of all the charges.

Background

The midwife was employed by a Trust on the labour ward. Following an internal inquiry, the Trust dismissed the midwife, taking the view that her failures in care could not be addressed by further training and supervision.

Circumstances of the charges

The solicitor did not need to prove the facts as they had been admitted by the respondent. The committee heard an outline of the case from the NMC's solicitor.

On the night in question, the midwife had been looking after one woman who was a 19 year-old primigravida and who had presented with a full-term pregnancy. The labour ward co-ordinator responsible for co-ordinating work and supervising junior staff had assessed the woman as low risk and considered the midwife to be competent to care for her. The woman was allocated to the respondent, who took over responsibility for her care between 21:30 and 01:00.

At 21:55 the respondent had informed the labour ward co-ordinator that she was proposing to carry out artificial rupture of the membranes because the labour was not progressing. The labour ward co-ordinator assumed, correctly, that this had been discussed between the midwives at the time of the hand-over, and was part of the care plan for the mother. At midnight the respondent midwife informed her that the woman had been pushing for an hour and a half, but that she had not seen the vertex. She had not confirmed full dilation by vaginal examination, and the foetal heart was satisfactory.

After 20 minutes the labour ward co-ordinator checked on the progress of the labour. The midwife said she could now see the vertex and that the foetal heart was satisfactory. The labour ward co-ordinator, who did not enter the room, said she had no reason to think that the second stage of labour was not progressing properly. However, at 01:01, as the baby was delivered, she was called for assistance. When she entered the room she saw that the baby boy was in a poor condition and being resuscitated. She immediately told the respondent to summon the paediatrician.

On checking the CTG trace, she discovered that it showed a number of abnormalities. Tragically, the baby had suffered brain damage during labour and he subsequently died.

The Committee heard that the Director of Midwifery Services considered that on the evidence of the CTG trace at 22:10 it was apparent that a life threatening degree of foetal hypoxia was present.

It also heard that an experienced supervisor of midwives had reviewed the records and considered that at 22.10 the midwife should have sought medical support because the delivery was not proceeding normally. The supervisor of midwives was also concerned about how the respondent midwife had been monitoring the progress of labour, and that the paper in the CTG machine had not been replaced when it had run out.

Although the baby was not born until after 01:00, there was no evidence of any vaginal examination having been carried out after the rupture of membranes. There were no notes for the period between 22:50 and midnight, and other notes were not made contemporaneously.

Decision on misconduct

The respondent midwife admitted that the proven facts amounted to misconduct and the Committee found her guilty of misconduct in respect of all the charges. The chairman said that she had failed to monitor the progress of labour and the wellbeing of the foetus to a standard they would expect of a competent registered midwife. There had been strong evidence that the foetus was increasingly compromised and she had not sought the advice and support of midwifery colleagues, nor had she called a doctor.

Previous history

Mitigation was presented by the midwife's representative who said that, in five years of midwifery practice, the midwife had spent only four months on the labour ward. Her husband had been in poor health, she had not been sleeping properly and on the night in question she was tired.

Judgement

The Committee decided to remove the midwife's name from the register. They had heard nothing that explained or excused her actions. She had failed to recognise the deteriorating situation and evidence of an increasingly compromised foetus. She had not taken the opportunity to call for further advice and support. The records show she did not seek help, and the care she provided was well below the standard expected of a registered midwife. The Committee had no evidence that she'd learnt from this sad experience, nor that she had updated her midwifery knowledge and practice.

Further information

Copies of all NMC publications are available from our Publications Department at 23 Portland Place, London W1B 1PZ, by e-mail at publications@nmc-uk.org or from our website at www.nmc-uk.org

Information 06.04

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