# Nursing and Midwifery Council

# Fitness to Practise Committee

**Substantive Hearing**
**Monday, 4 December 2023 – Thursday, 21 December 2023**
**Wednesday, 1 – Wednesday, 8 May 2024**

Virtual Hearing

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| **Name of Registrant:** | **June Denise Chambers** |
| **NMC PIN** | 76H1671E |
| **Part(s) of the register:** | Registered Nurse – Sub part 1<br>Adult Nursing – 27 November 1979<br><br>V300, Nurse Independent/ Supplementary Prescriber – 13 September 2011 |
| **Relevant Location:** | Leicestershire |
| **Type of case:** | Misconduct |
| **Panel members:** | Nicholas Rosenfeld (Chair, Lay member)<br>Patience McNay (Registrant member)<br>Anne Phillimore (Lay member) |
| **Legal Assessor:** | Nigel Pascoe (12, 14 – 21 December 2023, 1 - 8 May 2024)<br>Charles Parsley (4 – 11 December 2023)<br>Michael Levy (13 December 2023) |
| **Hearings Coordinator:** | Franchessca Nyame (1 – 8 May 2024)<br>Tyrena Agyemang (4 – 11, 18 - 21 December 2023)<br>Amanda Ansah (12 December 2023)<br>Jessie Miller (13 – 15 December 2023) |
| **Nursing and Midwifery Council:** | Represented by Ben Edwards, Case Presenter |
| **Mrs Chambers** | Present and represented by Jayesh Jotangia, instructed by the Royal College of Nursing (RCN) |
| **Facts proved:** | Charges 1a, 1b, 1c, 1d, 1f, 3a, 3b, 3c, 4a, 4b, 6, 7a and 7b |

| | |
|---|---|
| **Facts not proved:** | Charges 1e, 1g, 1h, 2 and 5 |
| **Fitness to practise:** | **Impaired** |
| **Sanction:** | **Suspension order (1 month)** |
| **Interim order:** | **No order** |

**Details of charge**

That you, a registered nurse:

1. Between 19 January 2019 and 28 March 2019 in respect of Client A failed to personally undertake a consultation or failed to document any such consultation in that you:

    a) Did not to personally carry out a clinical assessment and/or medical record check or in the alternative, did not document any purported clinical assessment or medical check. – **Found proved**

    b) Did not personally assess their expectations or in the alternative, did not document that you had personally assessed their expectations. - **Found proved**

    c) Did not take Pre-treatment photographs or in the alternative, did not document record and or document any purported Pre-treatment photographs had been taken. - **Found proved**

    d) Did not to write a patient specific direction or in the alternative, did not document and/or record any purported patient specific direction. - **Found proved**

    e) Did not take any Post treatment photographs or in the alternative, did not record or document any purported Post treatment photographs had been taken. - **Found not proved**

    f) Allowed Colleague X to purport that the following had been co-signed by you or in the alternative, did not co-sign the following with Colleague X; - **Found proved in its entirety**

        i) their consultation form;
        ii) treatment plan;
        iii) direction to administer.

g) Did not undertake any post treatment follow up care with them or in the alternative, did not document any purported post treatment follow-up care. - **Found not proved**

h) Did not undertake any post treatment follow-up conversations with Colleague X or in the alternative, did not document any purported follow up conversations with Colleague X. - **Found not proved**

2. On 19 January 2019 caused or allowed Colleague X to administer Botulinum toxin A ("Azzure") to Client A purported to be under a personal prescription for them and allowed Client A to think it was prescribed to them. - **Found not proved**

3. On 28 March 2019;

a) Retrospectively prescribed Botulinum toxin A ("Azzalure"), for Client A after it had been administered to them. - **Found proved**

b) Prescribed the following which were not required: - **Found proved in its entirety**
   i) Two vials of Botulinum toxin A ("Azzalure");
   ii) Teosyal Pure Sense Ultra Deep, Syringe (Pre-filled);
   iii) Emla Surgical Pack, 5%, Cream.

c) Confirmed to the pharmacy in respect of Client A that; - **Found proved in its entirety**
   i) You had completed a face-to-face consultation.
   ii) Appropriate clinical oversight was being carried out for their treatment plan.

4. Your actions at charge 3 above are dishonest in that you wrote the prescription for Client A:
   a) when you knew you had not consulted with them. - **Found proved**
   b) to create the impression that they had personally been prescribed the medication when they had not. - **Found proved**

5. Your actions at charge 3(b) assisted Colleague X in stockpiling medication. - **Found not proved**

6. On 22 May 2019 incorrectly informed the Nursing and Midwifery Council ("the NMC") that in relation to consulting with Client A you stated " Yes I saw [Client A] and prescribed for her, copy attached." - **Found proved**

7. Your actions at charge 6 above were dishonest in that you:

    a) Knew you had not consulted with Client A. - **Found proved**

    b) Sought to mislead the NMC in relation to an investigation into Colleague X's fitness to practise. - **Found proved**

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

**Decision and reasons on application exclude parts of Witness 1's evidence**

The panel heard an application made by Mr Pataky on behalf of Colleague X under Rule 31 to exclude parts of Witness 1's expert report from the evidence.

Mr Pataky outlined the attempts that were made to have the bundles agreed between Colleague X and the NMC before the start of the hearing, however the redactions could not be agreed. He submitted that the panel had a wide discretion to admit evidence under Rule 31 as long as the evidence was considered both relevant and fair.

Mr Pataky referred the panel to Witness 1's expert report.

In relation to the first redaction, he submitted that the word *'routinely'* should be removed from paragraph 48 of the report. Regarding the second redaction, he referred the panel to Witness 1's conclusions on page 51, specifically the fifth bullet point and he submitted that this should also be removed.

Mr Pataky submitted to the panel that Witness 1 appears to be reaching conclusions in the case, which he submitted is a matter for the panel. He further submitted that this evidence is therefore prejudicial and that the conclusion that is included goes beyond the case the NMC have brought against Colleague X. He submitted that to include the evidence as highlighted is therefore unfair and not relevant to the proceedings.

Mr Pataky therefore invited the panel to redact both from Witness 1's report if the panel should grant the application.

Mr Jotangia on your behalf, remained neutral to the application, and submitted that it is a matter for the panel's judgement.

Mr Edwards, on behalf of the NMC, submitted that the NMC agree with the first application to remove the word '*routinely'*, but he told the panel the NMC do not agree with the second application.

Mr Edwards submitted that it is alleged Colleague X saw and treated Client A on the same day without her being seen and consulted by you, so it is relevant to the panel's considerations.

Mr Edwards submitted that the NMC would not object to removing the letter '*s'* so it refers to a singular *'patient'* rather than *'patients'*. However, he submitted that there is no prejudice or otherwise, to Colleague X with this remaining in the bundle.

Mr Edwards submitted that the panel have already noted the evidence before it, however as an experienced panel, if having heard the evidence from Witness 1, the panel do not agree with her conclusions, then it can disregard that evidence when it is considering the facts in this case. He further submitted that the evidence can also be put to Witness 1, when she gives her evidence before the panel.

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 gave the first application in regard to the removal of the word *‘routinely’,* serious consideration. The panel noted that the application was unopposed by both Mr Jotangia or Mr Edwards and that was not unjust nor would there be prejudice as a result of its removal. The panel was therefore content to grant the application.

The panel went on the consider the second application.

The panel considered the submissions of both Mr Pataky and Mr Edwards and the NMC’s guidance entitled *‘Evidence’* (referenced at DMA-6, last updated on 1 July 2022). The panel was of the view that the conclusion which had been highlighted constituted an opinion. The panel would need to reach its own views and conclusions having regard to all the relevant evidence. The panel would approach with care the findings of this witness when reaching its own decision on the issues before it.

The panel was therefore of the view that it would be unjust for this section not to be redacted. The panel concluded that it would exercise its own expertise and experience as an independent panel to evaluate the experts remaining evidence.

In these circumstances, the panel came to the view that it would be fair to accede to Mr Pataky’s application.

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

During the course of the hearing, Mr Pataky made a request that parts this case be held 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).

Mr Edwards and Mr Jotangia did not object to the application.

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.

[PRIVATE], the panel determined to those parts of the hearing which related to such issues should be held in private session.

**Background**

Colleague X was referred to the NMC on 3 April 2019 by Client A in relation to her practice at Eden Skincare and Beauty Salon (the Salon), where she provided aesthetic treatments on a self-employed basis. On 19 January 2019, Client A attended the Salon for a Botox treatment whereupon Colleague X consulted and treated Client A within the same consultation.

It is alleged that Client A was not happy with the results of her treatment and contacted the Salon. It is alleged that during a telephone call with Client A, Colleague X stated that she had explained things correctly to Client A, and informed her that she did not provide two-week top ups as she did not deem these necessary. Client A went on to request a refund, but Colleague X refused.

It is further alleged that Client A asked Colleague X to provide evidence of her nursing training and insurance certificates and she provided a photograph of her nursing diploma, a certificate of attendance for a fillers course and a letter relating to insurance at a later stage.

During the course of the NMC's investigation, you informed the NMC that you had consulted with Client A on 19 January 2019. You went on to provide the NMC with a copy of the prescription you issued, dated 28 March 2019. The NMC subsequently closed the investigation and informed Client A of this outcome.

Client A, on receipt of the NMC's notification about the closure of the case, provided further information. She stated that she had never been seen by you and alleged that you were not involved in her consultation. It is alleged that Colleague X was dishonest

when providing information about your involvement to the NMC during the course of the investigation and the NMC reopened the case.

**Decision and reasons on facts**

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Edwards on behalf of the NMC and by Mr Jotangia 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 witnesses called on behalf of the NMC:

- Client A: The referrer and patient in this case;

- Witness 1: NMC Expert Witness;

The written evidence of Witness 2 and Witness 3 had been agreed between the parties with no requirement for them to be called to provide oral evidence before the panel.

The panel recognised that Witness 1 is an expert in a developing field. Witness 1 may not be experienced in drafting expert reports for proceedings nor giving expert evidence, however, it was clear to the panel that she was an expert witness in the field of aesthetics. Indeed, Mr Pataky on behalf of Colleague X, during his closing submissions, stated *'her aesthetic experience is clear'.* The panel agreed with this submission, found her to be credible, reliable and therefore both her written and oral evidence carried significant weight.

The panel also bore fully in mind your good character when making its determination on the facts.

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 Mr Jotangia, which included a document entitled *'Responsible Prescribing for Cosmetic Procedures'* by the Joint Committee for Cosmetic Practitioners dated 18 July 2019.

Central to the panel's determination of these charges is a fundamental finding of the panel on the balance of probabilities, that you were not present at the time of the treatment of Client A by registrant Colleague X on 19 January 2019.

The panel find Client A on the available evidence to have been consistent, reliable and truthful in her repeated assertions throughout all these proceedings that the two registrants were never there together at the time of her treatment.

It follows from that fundamental finding that, in so far that the registrants assert otherwise, the panel reject those assertions as untrue.

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

**Charge 1a**

1. Between 19 January 2019 and 28 March 2019 in respect of Client A failed to personally undertake a consultation or failed to document any such consultation in that you:

a) Did not to personally carry out a clinical assessment and/or medical record check or in the alternative, did not document any purported clinical assessment or medical check.

**This charge is found proved.**

The panel had regard to the Witness 1's expert witness report. In the report dated 22 June 2022, she stated:

> *'The prescribing nurse should introduce herself to the patient. Take a medical, social and psychological history to identify any medical contraindications, potential interactions with other medicines and social circumstances or activities that might act as barriers to following aftercare advice, or impact on expectations…'*
>
> *'The patient should have been assessed and consented by a professional registrant qualified to prescribe. The prescriber should document the assessment and co-sign the consent and document the treatment plan and direction to administer…'*
> *…*
>
> *'The prescribing nurse needs to assess and consult with the patient. The prescriber should not be prescribing for a patient they have not assessed and consulted…'*

The panel also had regard to the *'Guidelines for prescribing in medical aesthetics'* from the British Association of Cosmetic Nurses dated 15 August 2012, which states:

- ***The prescriber should undertake this medical history personally, rather than merely review a medical history already taken. [Emphasis added]***

- ***It is expected that this would include a comprehensive medical history and physical assessment. [Emphasis added]***

- *The assessment will include the patient/client expectations and reasons for*

*wanting treatment in the decision to prescribe.*

Given the evidence provided by the expert witness, the panel was satisfied that there was an obligation upon the prescriber to personally undertake and document a consultation. Having found in charge 6 that you did not undertake a consultation for Client A, the panel found that there was an obligation on you to carry out a clinical assessment and/or medical record check or document any purported clinical assessment or medical check, you failed to do so and therefore the panel finds this charge proved.

**Charge 1b**

1. Between 19 January 2019 and 28 March 2019 in respect of Client A failed to personally undertake a consultation or failed to document any such consultation in that you:

    b) Did not personally assess their expectations or in the alternative, did not document that you had personally assessed their expectations.

**This charge is found proved.**

The panel referred itself to Witness 1's expert witness report in which it is stated:

*'Invite the patient to identify the features that concern them and describe their expectations.'*

During the course of her oral evidence, Witness 1 stated that:

*'The patient is the patient of the prescriber.'*

The panel also had regard to the *'Guidelines for prescribing in medical aesthetics'* from the British Association of Cosmetic Nurses dated 15 August 2012, which states:

- *The prescriber should undertake this medical history personally, rather than merely review a medical history already taken.*

- *It is expected that this would include a comprehensive medical history and physical assessment.*

- ***The assessment will include the patient/client expectations and reasons for wanting treatment in the decision to prescribe. [Emphasis added]***

The panel was satisfied that there was an obligation on you to personally assess Client A 's expectations and document that you did so. Having found in charge 6 that you did not undertake a consultation of Client A, the panel found that you did not fulfil your obligation in relation to his charge.

**Charge 1c**

1. Between 19 January 2019 and 28 March 2019 in respect of Client A failed to personally undertake a consultation or failed to document any such consultation in that you:

   c) Did not take Pre-treatment photographs or in the alternative, did not document record and or document any purported Pre-treatment photographs had been taken.

**This charge is found proved.**

The panel was satisfied that there was no evidence of pre-treatment photographs having been taken by Colleague X.

The panel referred itself to Witness 1's expert witness report in which it is stated:

*'Pre-treatment and post treatment photographs are a requirement of all indemnity providers.'*

The panel noted from Colleague X's insurance document dated 16 April 2018, the following:

*'The Insured shall use best endeavours to ensure that photographs of patients are taken both before and after treatment. The Insured shall retain these photographs for a minimum period of six (6) months from the date of the treatment.*

*…*

*The Insured shall use best endeavours to obtain photographs of patients in all cases and refusal for pre and post treatment photographs should be an exception rather than the rule.'*

*The panel noted during the course of your evidence that you stated*

*'I had a walk in cupboard, my* [PRIVATE]*… he came along and shredded my certificates and records.'*

Your insurance documents were not before the panel for it to consider, however the panel inferred that a similar clause would have existed in your indemnity insurance. Furthermore, the panel drew reference to the NMC Code, which states:

***'12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom***
*To achieve this, you must:*
***12.1*** *make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice'*

Therefore, the panel determined that there would have been an obligation on you to take pre-treatment photographs or in the alternative document any purported pre-treatment photographs that had been taken. Furthermore, the panel noted in Witness 1's expert report the following:

> *'Pre-treatment photographs are an essential record of the pre-treatment state, any asymmetry, and the indications for treatment. They also serve as a tool to manage expectations and educate the patient.'*

During the course of her oral evidence, Witness 1 stated:

> *'I consider photographs to be critical.'*
>
> and
>
> *'Photographs of cosmetic treatment…your heart would sink…you kick yourself when you have not got them. Photographs are right up there.'*
>
> and
>
> *'Photographs are an essential part of good records. I consider photographs to be critical.'*

Having reviewed the expert witness report and noted the oral evidence given, the panel is satisfied that there was an obligation for you to record the pre-treatment photographs, or at the very least, ensure that these had been taken. Having found in charge 6 that you did not undertake a consultation with Client A, the panel was of the view that you failed in this obligation. Therefore, this charge is found proved.

**Charge 1d**

1. Between 19 January 2019 and 28 March 2019 in respect of Client A failed to personally undertake a consultation or failed to document any such consultation in that you:

d) Did not to write a patient specific direction or in the alternative, did not document and/or record any purported patient specific direction.

**This charge is found proved.**

Having found in charges 6 and 7 that you failed to personally undertake a consultation with Client A, the panel is satisfied that you therefore did not write a patient specific direction, nor did you document and/or record any purported patient specific direction.

The panel inferred an obligation for you to undertake this with reference to the *'Guidelines for prescribing in medical aesthetics'* from the British Association of Cosmetic Nurses dated 15 August 2012. In the document it states:

- *'It is anticipated that a patient-specific direction is the appropriate method of prescribing for patients in private aesthetic practice.*
- *The PSD shall be recorded in the patient notes in line with section 3 above.'*

Furthermore, in Witness 1's expert witness report, it was stated that:

> *'In not consulting with or assessing patients, the prescriber is not writing any patient specific direction to administer in the patient record, this leaves the non-prescribing nurse to administer without a direction and in so doing, she is in breach of regulations with every treatment.'*

Additionally, during the course Witness 1's oral evidence, when referring to the manufacturer's Patient Injection Record, she stated:

*'If the prescriber uses this as a direction, it could have served quite well. That would have been a good direction if written by 'Colleague Y' [sic], this could have been a direction to administer…'*

and

*'If someone else is going to administer it, there needs to be a direction – what, when, how. The nurse needs the direction.'*

and

*'The prescriber is directing the nurse to administer. The nurse must be directed to administer it. The direction does not appear to be written by the prescriber.'*

and

*'…like a nurse taking medicine out of a cupboard without a direction from a doctor…you just can't do that.'*

and

*'There needs to be a direction, otherwise the nurse is just making up the dosage.'*

Witness 1 stated that the patient injection record would suffice as a direction to administer, however this was not signed by the prescriber (you). Therefore, the panel finds this charge proved.

**Charge 1e**

1. Between 19 January 2019 and 28 March 2019 in respect of Client A failed to personally undertake a consultation or failed to document any such consultation in that you:

    e) Did not take any Post treatment photographs or in the alternative, did not record or document any purported Post treatment photographs had been taken.

**This charge is found NOT proved.**

The panel was satisfied that there was no evidence of post-treatment photographs having been taken by Colleague X.

The panel was not satisfied that the NMC had adduced sufficient evidence to demonstrate that there was an obligation upon the prescriber (you) to take post-treatment photographs or that there was an obligation on you to record or document whether these photographs had been taken by someone else.

The panel referred to the 'Joint Council for Cosmetic Practitioners' Guidance Statement entitled 'Responsible Prescribing for Cosmetic Procedures', which states that:

> *'Having prescribed the treatment, the prescriber may then delegate the administration to a responsible and competent person…if they do delegate, they retain an overarching and ongoing responsibility to the patient...'*

Although there is an overarching obligation on you as the prescriber to oversee treatment that you delegated to Colleague X, the panel was satisfied that as Colleague X was a competent and experience practitioner and you had discharged this obligation to her. The panel therefore finds this charge not proved.

**Charge 1f**

1. Between 19 January 2019 and 28 March 2019 in respect of Client A failed to personally undertake a consultation or failed to document any such consultation in that you:

    f) Allowed Colleague X to purport that the following had been co-signed by you or in the alternative, did not co-sign the following with Colleague X;

    i) their consultation form;
    ii) treatment plan;
    iii) direction to administer.

**This charge is found proved in the alternative.**

The panel drew reference to your witness statement in which you say in relation to:

i. *'I accept that I did not sign the consultation form.'*

ii. *'I accept that I did not sign the patient injection record/consultation form.'*

iii. *'I accept that I did not sign the patient injection record/consultation form.'*

The panel found these charges proved by admission.

In Witness 1's expert witness report, it was stated that:

> *'The patient should have been assessed and consented by a professional registrant qualified to prescribe. The prescriber should document the assessment and co-sign the consent and document the treatment plan and direction to administer (sites and dose ranges).'*

The panel also considered the '*Joint Council for Cosmetic Practitioners'* Guidance Statement entitled *'Responsible Prescribing for Cosmetic Procedures'*, it is stated:

> *'Therefore, the JCCP reminds prescribers that a* ***Patient Specific Direction*** *(PSD) is a legal method of prescribing and that, particularly when delegating, a PSD must be provided, and treatment given in accordance with it. JCCP would expect to see a PSD to include, at a minimum:*

- *Name of patient and/or other individual patient identifiers*
- *Name, form and strength of medicine (generic or brand name where appropriate)*
- *Route of administration*
- *Dose (per facial area for complex treatments such as botulinum toxin)*
- *Date*
- *Signature of prescriber'*

In addition, the *'Guidelines for prescribing in medical aesthetics'* from the British Association of Cosmetic Nurses dated 15 August 2012, states:

- *A record of the PSD and prescription details should be made in the patient/client notes.*
  *In addition the prescriber should retain a copy of these for their records.*
- *Both nurses will sign the consultation/history sheet, together, upon completion.*

The panel inferred that there was an obligation on you to either sign the patient injection record or co-sign the direction to administer documents, which includes the matters detailed in the charge.

The panel was therefore satisfied that there was an obligation for you to sign or co-sign these documents but did not do so. This charge is found proved.

**Charge 1g**

1. Between 19 January 2019 and 28 March 2019 in respect of Client A failed to personally undertake a consultation or failed to document any such consultation in that you:

    g) Did not undertake any post treatment follow up care with them or in the alternative, did not document any purported post treatment follow-up care.

**This charge is found NOT proved.**

The panel was not satisfied that the NMC had provided enough evidence to suggest that there was an obligation upon you to undertake any post treatment follow up care, nor document any post treatment follow up care.

During the course of Witness 1's oral evidence, she stated:

> *'It was reasonable for a nurse to administer it. From records I saw, treatment was administered safely. The nurse was competent to administer it. I would not find any fault with the administration of it.'*

The panel was satisfied that you have delegated to a competent nurse, being Colleague X.

The panel referred to the 'Joint Council for Cosmetic Practitioners' Guidance Statement entitled 'Responsible Prescribing for Cosmetic Procedures', which states that:

> *'Having prescribed the treatment, the prescriber may then delegate the administration to a responsible and competent person…if they do delegate, they retain an overarching and ongoing responsibility to the patient...'*

Although there is an overarching obligation on you as the prescriber to oversee treatment that you delegated to Colleague X, the panel was satisfied that as Colleague X was a competent and experience practitioner you had discharged the post-treatment follow up care to her appropriately. The panel therefore inferred that there was no obligation on you to either undertake any post-treatment follow up care or in the alternative to document any purported post-treatment follow up care.

The panel therefore finds this charge not proved.

**Charge 1h**

1. Between 19 January 2019 and 28 March 2019 in respect of Client A failed to personally undertake a consultation or failed to document any such consultation in that you:

    h) Did not undertake any post treatment follow-up conversations with Colleague X or in the alternative, did not document any purported follow up conversations with Colleague X.

**This charge is found NOT proved.**

Having found charge 1g not proved and for the same reasons, in relation to follow up conversations with Colleague X, or the requirement to document any purported follow-up conversations with Colleague X, the panel finds charge 1h not proved.

**Charge 2**

2. On 19 January 2019 caused or allowed Colleague X to administer Botulinum toxin A (“Azzure”) to Client A purported to be under a personal prescription for them and allowed Client A to think it was prescribed to them.

**This charge is found NOT proved.**

In reaching its decision, the panel focused on the consultation occurring on 19 January 2019 and what is alleged to have occurred at that time.

Having found charge 6 proved in that you were not in attendance at the consultation on 19 January 2019, the panel was not satisfied that you allowed Colleague X to administer Botulinum toxin A, nor allowed Client A to think this was prescribed to them.

**Charge 3a**

3. On 28 March 2019;

    a) Retrospectively prescribed Botulinum toxin A ("Azzalure"), for Client A after it had been administered to them.

**This charge is found proved.**

In Colleague X's oral evidence, she stated that:

> *'I made contact with 'Colleague Y' [sic]…I requested a copy of the prescription, Person A wanted a copy of it and wanted to see it. 'Colleague Y' [sic] said she was moving house and destroyed everything and did not have a copy of it.'*

Later in her evidence, she stated:

> *'…we would have no evidence of Person A being seen…we needed to have physical evidence that she was seen by a prescriber.'*

During the course of your oral evidence, you stated:

> *'I don't remember her asking for the paper prescription…*
>
> *I cannot remember the conversation…*

[Colleague X] *had the original copies*

*I did not know that 'Colleague X' [sic] had given the Botox.'*

The panel found your oral evidence to have inconsistencies and in parts to be inconsistent with the oral evidence of Colleague X. Indeed, during your evidence, you outlined normal practice when issuing a prescription following a consultation. You outlined that following a consultation you would write a paper prescription as an aide memoir which you would later enter on to the electronic prescribing system when Colleague X notified you that a treatment had been booked. You explained that this could happen several months after the initial consultation. At that point you would destroy the paper prescription as it would now be on the electronic system. You acknowledged that a request for the paper prescription would not be usual practice as it could not be used to dispense against.

Having regard to the inconsistencies in your oral evidence, and that of Colleague X, the panel on the balance of probabilities found it unlikely that such a request would have been made without a fuller discussion between yourself and Colleague X about the reasons for the request. Fundamental to those reasons would have been the administration of Botox to Client A on 19 January 2019.

Whilst the panel appreciate that you may not have known that prior to this Colleague X had administered the Botox to Client A, on 19 January 2019, the panel believe on the balance of probabilities, that you would have known this prior to issuing the prescription on 28 March 2019.

On 28 March 2019 you therefore retrospectively prescribed Botox to Client A.

Factually, the panel finds this charged proved.

**Charge 3b**

3. On 28 March 2019;

    b) Prescribed the following which were not required:
        i) Two vials of Botulinum toxin A (“Azzalure”);
        ii) Teosyal Pure Sense Ultra Deep, Syringe (Pre-filled);
        iii) Emla Surgical Pack, 5%, Cream.

**This charge is found proved.**

The panel have determined that:

1. Botulinum toxin A was administered on 19 January 2019 to Client A;
2. For the reasons outlined in 3a above, it was more likely than not, you were aware that the Botulinum toxin A had been administered to Client A by 28 March 2019; and
3. By 28 March 2019, it is more likely than not that you would have been aware that there was no planned treatment for Client A as the relationship between her and Colleague X had deteriorated.

The date the prescription for the medications identified in i), ii) and iii) was signed was on 28 March 2019.

Client A stated in her oral evidence that she:

> *‘…never mentioned filler’* [b(ii) of the charge]

Furthermore, during the oral evidence of Colleague X, she stated:

> *‘I did see it and ordered against it. I was panic stricken. I was in a panic, I just wanted to prove that she was seen.’*

It was confirmed that the items ordered on the prescription were valued between £200-£250.00 and these items were destroyed upon receipt.

In answer to questions from the NMC, Colleague X stated that she knew she was going to destroy the medications, but still ordered against the prescription.

The panel determined that the Botox had been administered on 19 January 2019, by the time of the telephone call on 28 March 2019, and that you were aware of the medication administration and that there was no follow up treatment beyond 28 March 2019. The panel further determined that it was more likely than not that you generated a prescription for items that were no longer required. Indeed, this is supported by the evidence of Colleague X where following an initial complaint by Client A there was a need to *'prove'* she had been seen, then subsequently ordering against the prescription and on its receipt destroying it.

**Charge 3c**

3. On 28 March 2019;

    c) Confirmed to the pharmacy in respect of Client A that;
        i) You had completed a face-to-face consultation.
        ii) Appropriate clinical oversight was being carried out for their treatment plan.

**This charge is found proved.**

The panel drew reference to the prescription completed on 28 March 2019, in which you signed the declaration to state that you completed:

> *'A face-to-face consultation with the patient has been completed and appropriate clinical oversight is being carried out for the patient's treatment plan.'*

The panel took into account its findings in relation to charge 6. As it found that you were not in attendance at the consultation on 19 January 2019, you could not have completed a face-to-face consultation and therefore could not confirm appropriate clinical oversight in relation to Client A's treatment plan at that time.

The panel therefore finds this charge proved.

**Charge 4a**

4. Your actions at charge 3 above are dishonest in that you wrote the prescription for Client A:

   a) when you knew you had not consulted with them.

**This charge is found proved.**

In reaching this decision, the panel took into account its findings at charges 6 and 7. The panel also referred itself to the NMC Guidance on '*Making decisions on dishonesty charges',* DMA-7, last updated 12 October 2018.

The panel was satisfied, having reviewed all the documentary and oral evidence in this case, that it had no evidence before it to support you had carried out a consultation with Client A prior to her treatment with Colleague X.

The panel applied the standards of ordinary decent people when considering whether you knew your conduct was dishonest and it concluded that it was dishonest when you wrote a prescription for Client A, when you knew you had not consulted with her.

Considering the law that dishonesty must be founded on solid ground, regrettably the panel is driven to conclude that is the position here and you must have known your conduct was dishonest by the standards of ordinary and decent people.

The panel therefore finds this charge proved.

**Charge 4b**

4. Your actions at charge 3 above are dishonest in that you wrote the prescription for Client A:

b) to create the impression that they had personally been prescribed the medication when they had not.

**This charge is found proved.**

In reaching this decision, the panel took into account the prescription dated 28 March 2019 and the oral evidence from yourself and Colleague X.

The panel have determined that:

1. Botulinum toxin A was administered on 19 January 2019 to Client A;
2. For the reasons outlined in 3a above, it was more likely than not, you were aware that the Botulinum toxin A had been administered to Client A by 28 March 2019; and
3. By 28 March 2019, it is more likely than not that you would have been aware that there was no planned treatment for Client A as the relationship between her and Colleague X had deteriorated.

Following these findings, the panel determined, applying the standards of ordinary decent people, that by generating the prescription on 28 March 2019, that you were creating the impression that Client A had personally been prescribed the medication, when clearly they had not. The panel considered under these circumstances that you would have known that your conduct was dishonest.

Considering the law that dishonesty must be founded on solid ground, regrettably the panel was again driven to conclude that this is the position here and that your conduct was dishonest by the standards of ordinary and decent people.

The panel therefore determined, whilst applying the standard of an ordinary member of the public, that your conduct was dishonest.

This charge is found proved.

**Charge 5**

5. Your actions at charge 3(b) assisted Colleague X in stockpiling medication.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the documentary and oral evidence from Witness 1, who stated the following in her report dated 20 June 2022:

> *"Medicines that have been dispensed for a named patient are not stock medicines."*

The panel also considered Witness 1's oral evidence, when she stated:

> '*That would not be considered as stock medication…*
>
> *She would not be storing medication…*
>
> *I do not believe she was storing medication.'*

Having regards to the evidence before it, the panel determined that your actions did not assist Colleague X in stockpiling medication and this charge is found not proved.

**Charge 6**

6. On 22 May 2019 incorrectly informed the Nursing and Midwifery Council ("the NMC") that in relation to consulting with Client A you stated "Yes I saw [Client A] and prescribed for her, copy attached."

**This charge is found proved.**

The panel had sight of an email from you to the NMC, dated 22 May 2019 in which you stated:

*'Yes I saw 'Colleague X'* [sic] *and prescribed for her, copy attached.'*

The panel then referred itself to a letter from Client A to Colleague X dated 13 March 2019 which stated:

*'…for my Botox treatment that **I had with you** on the 19th January 2019.'* [Emphasis added]

and

*'Please can you forward to me, any paperwork relating to my treatment **with you**. This to include my medical records and my prescriptions.'* [Emphasis added]

The panel also had regard to the text message conversations, during which Client A corresponds with Colleague X, asking for insurance certificates, copies of records and copies of any prescriptions. In one text message, Client A requests to see a copy of Colleague X's prescribing certification. The panel was of the view that Client A would have mentioned the prescriber (you) during her correspondence with Colleague X if you had been present. Client A had no hesitation in mentioning all those she had come into contact with. The absence of any reference to you was significant to the panel in its determination.

The panel reviewed an email sent from Client A to the NMC, dated 12 June 2019 in which it was stated:

*'Specifically there is a claim that a nurse 'Colleague Y' [sic] saw me and wrote out the prescription. This is a false statement and I am concerned about fraudulent activity in this whole consultation.'*

and

*As a first person witness on the day I can categorically confirm that 'Colleague Y' [sic] did not have any contact with me whatsoever. I have never heard of her until receipt of the letter.'*

and

*'The treatment was done by 'Colleague X'* [sic] *and 'Colleague X'* [sic] *alone.'*

In Client A 's witness statement, it is stated that:

*'If Colleague Y* [sic] *had been present I would have mentioned it in the first place. I never saw her, I never even spoke to her on the phone and Colleague X* [sic] *never called her when I was there. Colleague Y* [sic] *wasn't there on the second occasion I attended either. I don't know why she is saying this as it is untrue.*

The panel heard oral evidence from Client A on 5 December 2023 which it found consistent and reliable on this point. During the course of this evidence, she stated:

*'I can categorically swear, on my children's life, that she was not there. When the reports from the NMC came back, I was astounded. She was not there.'*

and

*'I have never met Colleague Y* [sic] *in my life.'*

and

*'I would know if there was another person there – she was not there.'*

and

*'I have been telling the truth.'*

and

*'I am not delusional, she was not there.'*

During the course of the oral evidence of Witness 1, she stated that:

*'There are no records that this patient was seen by the prescriber.'*

In Witness 1's expert witness report, it was stated that:

*'The patient should have been assessed and consented by a professional registrant qualified to prescribe. The prescriber should document the assessment and co-sign the consent and document the treatment plan and direction to administer…'*

The panel noted that none of the patient consultation documents were co-signed by you. In your oral evidence, you admitted that this is your normal practice, however you were unable to provide an explanation as to why, on this particular occasion, you failed to do so.

During the course of your evidence, you told the panel that you are hard of hearing and that during the consultation on 19 January 2019, which you stated lasted no less than nine minutes, that you would have needed to see Client A's face to enable you to lip read. Given this assertion, it would have been highly unlikely for Client A not to have acknowledged your presence, remember you and reference you in the complaint. The panel have inferred that it was more likely than not that you were not present during this consultation and preferred the evidence of Client A.

The panel referred itself to the evidence produced by Colleague X which outlined that on 28 January 2019, there was a transaction from Colleague X to you of *'£40.00'*. The panel noted that this was the usual payment made for providing a consultation and

prescription, however, the information contained no further detail of what the treatment was, where it was provided and on what date. The panel was of the view that there was significant detail lacking, and the evidence before it cannot be considered conclusive to demonstrate that you were present during the consultation with Client A on the date in question.

Given the evidence before it, the panel had determined therefore that on the 22 May 2019, you incorrectly informed the NMC that you saw Client A and prescribed for her.

The panel therefore finds this charge proved.

**Charge 7a**

7. Your actions at charge 6 above were dishonest in that you:

    a) Knew you had not consulted with Client A.

**This charge is found proved.**

The panel considered the NMC Guidance on '*Making decisions on dishonesty charges',* DMA-7, last updated 12 October 2018. By applying what the *'standards of ordinary, decent people'* to be, and that the *'law assumes that people from all walks of life can easily recognise dishonesty when they see it'* and having found charge 6 proved, the panel determined that you knew that you had not consulted with Client A, despite stating that you had in an email dated 22 May 2019, and deemed that this conduct was dishonest.

Considering the law that dishonesty must be founded on solid ground, regrettably the panel was again driven to conclude that this is the position here and that your conduct was dishonest by the standards of ordinary and decent people.

The panel therefore determined, whilst applying the standard of an ordinary member of the public, that your conduct was dishonest.

The panel therefore finds this charge proved.

**Charge 7b**

7. Your actions at charge 6 above were dishonest in that you:

b) Sought to mislead the NMC in relation to an investigation into Colleague X's fitness to practise.

**This charge is found proved.**

The panel referred to the email from you to the NMC dated 22 May 2019 in which you stated:

*'Yes I saw 'Colleague X'* [sic] *and prescribed for her, copy attached.'*

The panel determined that the action of sending this email was dishonest following its findings in relation to charge 6. Having determined that you did not attend the consultation, but making representations to the NMC to state that you did, the panel was of the view, applying what it understands the *'standards of ordinary, decent people'* to be, that these actions were dishonest.

Considering the law that dishonesty must be founded on solid ground, regrettably the panel was again driven to conclude that this is the position here and that your conduct was dishonest by the standards of ordinary and decent people.

The panel therefore determined, whilst applying the standard of an ordinary member of the public, that your conduct was dishonest. The consequences of your actions were that the NMC initially closed the case against Colleague X. This representation was inaccurate and the panel determined it was fundamentally dishonest.

In light of the above, the panel finds this charge proved.

Dishonesty lies on a spectrum. Without prejudice to the panel's determination of potential sanctions in this case. It is the view of the panel, that the dishonesty in the context of this case does not lie at the higher end of the scale.

**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.

**Submissions on misconduct**

Mr Edwards invited the panel to take the view that the facts found proved amount to misconduct. He identified the relevant standards where your actions breached sections of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) and amounted to misconduct, specifically sections 1.2, 2.1, 3.3, 10.1, 10.2, 10.3, 18.1, 20.1, 20.2, 23.1.

Mr Edwards submitted that your actions fell well below the standards of expected of a registered nurse. He added that honesty and integrity is expected of nurses in all aspects of their work, and, in addition to your failures, you acted dishonestly in that you sought to mislead the NMC in its investigation on two occasions. He submitted that the charges found proved are so serious that only a finding of misconduct would be appropriate in these circumstances.

Mr Jotangia referred to the case of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin). He submitted that your dishonesty is at the lower end of the spectrum. He stated that the charges do not relate to allegations of any sexual misconduct, discrimination, violence, or concerns with vulnerable patients. He also reminded the panel that Witness 1 set out that there was no risk of harm to Client A. He invited the panel to take all of this into consideration when determining misconduct.

**Submissions on impairment**

Mr Edwards moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Edwards submitted that all four limbs of the *Grant* test are engaged in this case.

Mr Edwards stated that your positive testimonials and reflective piece demonstrate what the panel may consider developing insight, but that it is insufficient to conclude that there is no risk of repetition in the future. He added that you have not adequately remedied the concerns, namely your dishonesty. He submitted that the panel's findings of fact are so serious that a finding of impairment should be made.

Mr Edwards further submitted that your actions undermined the NMC as a regulator and public confidence in the nursing profession. He said that members of the public expect nurses to act with honesty and integrity at all times and, in respect of the dishonesty charges, you clearly failed to do that.

As such, Mr Edwards invited the panel to find that your fitness to practise is currently impaired on public protection and wider public interest grounds.

Mr Jotangia submitted that the charges relate to an isolated incident which has not occurred again, and are extremely unlikely to occur again as there have been no concerns raised since the 2019 allegations. He said that you have evidenced how you are showing integrity by providing positive testimonials. He added that you have also demonstrated insight and remorse for your actions with your reflection.

However, Mr Jotangia informed the panel that, with regards to any remedial activity, you felt that you had no option but to resign after the panel's finding of dishonesty. He said you felt this was the right thing to do. He also said that you have not been practising as a nurse since then, and possibly have no intention of practising in the future.

Mr Jotangia submitted that, given the above, you have provided evidence that it is very unlikely that you will repeat such behaviour in the future.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

**Decision and reasons on misconduct**

The panel, in reaching its decision, 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 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.

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*. The also referred itself to the NMC guidance entitled 'Misconduct' referenced at FTP-2a, last updated on 27 February 2024.

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

*1.2 make sure you deliver the fundamentals of care effectively.*

***2 Listen to people and respond to their preferences and concerns***

*To achieve this, you must:*

*2.1 work in partnership with people to make sure you deliver care effectively.'*

***10 Keep clear and accurate records relevant to your practice***

*To achieve this, you must:*

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

*10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.*

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

*To achieve this, you must:*

*18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs.*

*18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines.*

***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*

*20.2 act with honesty and integrity at all times…*

***23 Cooperate with all investigations and audits****'*

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

**Charges 1b and 1c**

The panel determined that your actions described in the charges constituted poor practice. However, your behaviour was not such so as to meet the threshold of serious professional misconduct. Therefore, the panel found that these charges did not amount to serious professional misconduct.

**Charge 1a**

The panel determined it was incumbent upon you as a Nurse Prescriber to personally carry out and document the clinical assessment and/or medical record check on Client A. You failed to do this, and the panel determined that you breached the fundamental nursing tenet of preserving safety.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

**Charge 1d**

The panel considered that, as a qualified prescriber, it was your professional obligation to write patient-specific directions for Colleague X to confirm the correct dosage for

them to safely administer to Client A. You failed to do this, and the panel determined that you breached the fundamental nursing tenet of practising effectively.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

**Charge 1f**

It was your duty to co-sign the treatment plan direction on the consultation form in order to ensure Colleague X had clear instructions for the administration of Botox to Client A to ensure patient safety. In your failure to do this, the panel determined that you breached the fundamental nursing tenets of preserving safety and practising effectively.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

**Charge 3a**

You retrospectively prescribed prescription-only medication after it had been administered to Client A. The panel determined that you breached the fundamental nursing tenets of preserving safety, practising effectively, and promoting professionalism and trust.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

**Charge 3b**

The panel determined that, as a qualified Nurse Prescriber, you should not have been prescribing medication that was not required. The panel determined that you breached the fundamental nursing tenet of practising effectively.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

**Charge 3c**

The panel considered that nurses are in a position of trust and you undermined this by making representations you knew were incorrect, misleading the pharmacy in to dispensing prescription-only medication. The panel determined that you breached the fundamental nursing tenets of practising effectively and promoting professionalism and trust.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

**Charges 4a and 4b**

You wrote a prescription knowing you had not consulted with Client A. The panel determined that you breached the fundamental nursing tenet of promoting professionalism and trust.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

**Charges 6, 7a and 7b**

You provided inaccurate and misleading information to the NMC. The panel considered it to be incumbent on you to be open and transparent in communications with your regulator. Further, honesty is of central importance to a nurse’s practice, the panel therefore determined that you breached the fundamental nursing tenet of promoting professionalism and trust.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional 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 NMC guidance entitled 'Impairment' referenced at DMA-1, last updated 27 February 2024, which states:

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

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *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 found specifically that you acted dishonestly, and your misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered your reflection and determined that you have demonstrated an understanding of how your actions put Client A at a risk of harm, and an understanding of why what you did was wrong and would be handled differently in the future.

The panel took into account the positive testimonials you provided.

The panel considered that you worked for four years following the incident without further concerns being raised. The panel was of the view that it could reasonably infer that you are not liable to repeat such actions in future. The panel therefore determined that a finding of impairment is not necessary on the grounds of public protection.

However, given the nature of the panel's findings and the seriousness of the facts found proved, the panel determined that a finding of impairment on public interest grounds is required to maintain public confidence in the nursing professions and the NMC as a regulator, and to declare and uphold the proper professional standards for members of the nursing profession.

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

**Sanction**

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

In reaching this decision, the panel had regard to all the evidence adduced in this case and the Sanctions Guidance (SG) published by the NMC.

**Submissions on sanction**

Mr Edwards referenced SG SAN-2: 'Considering sanctions for serious cases', last updated on 27 February 2024.

Mr Edwards submitted that it is clear from the SG that the dishonesty in this case, is at the most serious end of the spectrum, namely deliberately breaching the professional duty of candour by covering up when things have gone wrong. Specifically, in this case, misleading or lying to the NMC when information was requested.

Mr Edwards stated that Mr Jotangia will contend that your dishonesty was a one-off incident, however, he highlighted that there were two separate incidents of dishonest actions on 28 March 2019 and 22 May 2019. He said that both occasions were clearly a deliberate breach of the professional duty of candour in that you attempted to cover up when things went wrong which was premeditated and systematic.

Mr Edwards submitted that the aggravating features in this case are as follows:

- A lack of insight into your failings
- You attempts to cover up your failings and/or dishonest conduct to the NMC

Mr Edwards submitted that the mitigating features in this case are as follows:

- The positive testimonials advising of your good practise
- That you practised after the incident without further issue

Mr Edwards submitted that the regulatory concerns in your case raise fundamental questions about your professionalism, that public confidence in nurses could not be maintained if you were not removed from the register, and that a striking-off order is the only sanction which would be sufficient to maintain professional standards given the serious nature of this case and the level of dishonesty.

Mr Edwards therefore submitted that the only proportionate and necessary sanction for the panel to impose is a striking-off order.

Mr Jotangia submitted that he was in agreement with the points made by Mr Pataky in his submissions and so would not repeat those.

Mr Jotangia submitted that, given the fact that it is unlikely that these types of allegations are to be repeated in the future, a caution could be deemed appropriate under the circumstances. He stated that a striking-off order would be appropriate if there was some evidence that these types of allegations had been repeated, but they have not. He added that you are someone of good character who has had an otherwise unblemished career, having progressed in your profession to a very senior level.

The panel accepted the advice of the legal assessor which included dishonesty lying on a spectrum. The panel also referred itself to NMC guidance SAN-2: 'Considering sanctions for serious cases', particularly the section on 'Cases involving dishonesty'. The panel took into account that '*allegations of dishonesty will always be serious…However… the Fitness to Practise Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious*.' The examples of serious dishonesty provided in the guidance include:

'*misuse of power*
*vulnerable victims*
*personal financial gain from a breach of trust*
*direct risk to people receiving care*
*premeditated, systematic or longstanding deception*'

The panel determined that none of the above apply in your case.

**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:

- You misled your regulator
- You colluded with Colleague X to mislead your regulator
- Deliberately breached duty of candour by covering up when things went wrong

The panel also took into account the following mitigating features:

- Numerous testimonials of good practise
- You practised after the incident without further issue for over four years before resigning following the panel's finding of dishonesty

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, 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 relevant, 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 determined that there are no practical or workable conditions that could be formulated, given the panel's findings at the facts stage. The misconduct identified in this case was not something that can be addressed through retraining as your actions did not relate to your clinical practice.

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

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account all the information before it, and 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.

The panel considered your actions to constitute a single incident of misconduct arising out of one treatment episode. Although your dishonesty is an attitudinal issue, the panel determined that your actions were out of character and not deep-seated. The panel found that you are not liable to repeat such behaviour in future, and there is no evidence your behaviour has been repeated since 2019.

The panel noted that you had been employed as an Advanced Health Protection Practitioner. You provided numerous references, and the panel noted, for example, a reference from the Principal Health Protection Practitioner/nurse dated 10 November 2023 which stated:

> '*I find June to be trustworthy and reliable in her attitude to work, in addition June takes on the role of deputising for the Principal…when I am on leave. I have no concerns regarding June's professionalism…*'

The panel also took into account the reference dated 20 October 2023 from the Head of Business Operations who stated:

> '*The profession would suffer a loss if June's name were removed from the register as she is an excellent trainer and mentor, and has nurtured the careers of the public health workforce in Yorkshire and Humber for over 20 years.*'

The panel noted that you were unable to provide a more recent reference because you had taken the decision to resign following the panel's finding of dishonesty in December 2023. Nevertheless, the panel was of the view that the references were of such a character as to be of real value to the panel in accessing the appropriate sanction.

Balancing all of these factors the panel determined that a suspension order would be the appropriate and proportionate sanction.

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 nursing profession and the NMC as a regulator, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of one month was appropriate in this case to mark the seriousness of the misconduct whilst also allowing a valuable nurse to return to practice.

Having found that your fitness to practise is currently impaired, the panel bore in mind that it determined there were no public protection concerns arising from its decision. In this respect it found your fitness to practise impaired on the grounds of public interest.

In accordance with Article 29 (8A) of the Order, the panel may exercise its discretionary power and determine that a review of the substantive order is not necessary.

The panel was mindful that it made the substantive order having found your fitness to practise currently impaired in the public interest. It was satisfied that the substantive order will satisfy the public interest in this case and will maintain public confidence in the profession(s) as well as the NMC as the regulator. Further, the substantive order will declare and uphold proper professional standards. Accordingly, the current substantive order will expire, without review.

This will be confirmed to you in writing.

**Interim order**

As a suspension order cannot take effect until the end of the 28-day appeal period, the panel 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.

**Submissions on interim order**

The panel considered the submissions made by Mr Edwards that an interim suspension order should be made to cover the appeal period. He submitted that an interim order is necessary to protect the public and meet the public interest. He invited the panel to impose an interim suspension order for a period of 18 months to cover any appeal period.

Mr Jotangia opposed Mr Edwards application for the panel to impose an interim order. He reminded the panel that you are already subject to an interim conditions of practice order which was continued at its last review for a period of 18 months.

Mr Jotangia highlighted that the panel has already conducted a risk assessment after the fact-finding stage. He agreed with Mr Pataky that to impose an interim order would be tantamount to a double sanction. He reminded the panel that you are no longer practising and have resigned, and he submitted that to impose an interim suspension order for a period of 18 months would be disproportionate.

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

**Decision and reasons on interim order**

The panel was satisfied that an interim suspension order is not necessary to protect the public and address the public interest. The panel had regard to the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It

considered that to impose an interim suspension order would be inconsistent with its earlier findings.

In light of reasons given by the panel, and considering the submissions made by Mr Edwards and Mr Jotangia, the panel determined it was not appropriate in the circumstances to impose an interim order.

That concludes this determination.