Conduct and Competence Committee
Substantive Hearing
27 - 30 June 2017

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

Name of Registrant Nurse: Becky Tonge Mukoto
NMC PIN: 06C0039C
Part(s) of the register: Registered Nurse (sub part 1)
Adult (8 March 2006)

Area of Registered Address: England
Type of Case: Misconduct

Panel Members: Maurice Cohen (Chair, Lay member)
Judith McCann (Registrant member)
John Liddington (Lay member)

Legal Assessor: Ben Stephenson
Panel Secretary: Deepan Jaddoo

Becky Tonge Mukoto: Present and represented by
Mario Anastasiades, Solicitor.

Nursing and Midwifery Council: Represented by Terence Wong, Counsel,
instructed by NMC Regulatory Legal Team.

Facts proved: 1, 2, 3
Facts not proved: N/A
Fitness to practise: Impaired
Sanction: Suspension Order (3 months)
Interim Order: Interim Suspension Order (18 months)
Details of charge (as read):

That you:

1. In October 2014 took blood from Patient A when you were not deemed competent to do so. [proved]

2. On 6 October 2014 took blood from Patient B when you were not deemed competent to do so. [proved]

3. From 9 December 2014 until 22 January 2015 insecurely stored patient identifiable information and/or confidential information relating to patients. [proved]

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

The charges arose whilst you were working as a Band 5 Staff Nurse on Lord Byron Ward ("the Ward") at Cambridgeshire and Peterborough NHS Foundation Trust ("the Trust"). You had been employed by the Trust since December 2013 until you handed in your resignation on a date which has not been specified. You have been a Registered Nurse in the UK since March 2006.

It is alleged that on two occasions you undertook venepuncture procedures unsupervised, before you completed the Trust’s competency process.

All new staff working on the Ward, as part of their role, must undergo a Trust competency process in relation to venepuncture procedures (taking blood). This requires them to complete a venepuncture theory course and carry out 10 competency assessments under direct supervision before they are deemed competent to carry out procedures unsupervised. Once they have completed 10 procedures, they must be ‘signed off’ by an appropriate, experienced supervisor. This is in line with the Trust’s venepuncture policy.

In relation to the first incident, it is alleged that in October 2014, you took a blood sample from patient A whilst you were unsupervised before you had been signed off as competent. It is further alleged that this resulted in patient A sustaining a large scratch.

In relation to the second incident, it is alleged that on 6 October 2014 you carried out a similar procedure on patient B. It is alleged that you carried out this procedure whilst you were unsupervised and when you had not been deemed competent to do so by the Trust.

It is further alleged that during an internal investigation meeting carried out by Ms 4 on behalf of the Trust, you produced from your handbag patient notes containing identifiable and confidential information.
Determination on facts and reasons:

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Mr Wong, on behalf of the NMC and heard evidence from: Ms 1, Band 5 Staff Nurse at the Trust; Ms 2, Community Nurse at Suffolk Healthcare; Ms 3, Deputy Ward Manager at the Trust; Ms 4, Neighbourhood Team Manager.

The panel also heard submissions made by Mr Anastasiades on your behalf and heard evidence from you under oath. You also provided the panel with a written statement and exhibits. The written statement of Ms 5 was accepted by all parties and taken into account by the panel.

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

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 the facts will be proved if the panel was satisfied that it was more likely than not that the incidents occurred as alleged.

The panel considered Ms 1 to be nervous and at times somewhat vague. It was apparent to the panel that there was some animosity between Ms 1 and yourself. The panel considered that Ms 1’s evidence was generally consistent and that she was trying to assist the panel.

The panel considered Ms 2 to be honest and reliable. She presented as a nervous witness who did her best to provide the panel with accurate information. The panel found that her evidence was consistent and that there was no evidence of malice.

The panel was of the view that Ms 3 was an honest witness. Her evidence was clear, straightforward and consistent. She was able to give a picture of the working environment and general culture within the hospital. The panel determined that she appeared to bear no malice towards you and had not had any previous concerns in
relation to your clinical care. Her evidence in relation to charge 1, particularly regarding the meeting held with yourself and Ms 1 in her office, corroborated Ms 1’s evidence.

The panel regarded the evidence of Ms 4 in relation to charges 1 and 2 to be limited. However, in relation to charge 3, the panel found her evidence to be consistent and credible.

The panel considered your evidence and found it to be implausible with a number of significant inconsistencies. Overall the panel found that your evidence in relation to the core issues was not credible.

**Application to amend charge under rule 28**

The panel heard an application made by Mr Wong, on behalf of the NMC, to amend the wording of charge 3.

Mr Wong referred to the evidence heard today from Ms 4. Mr Wong submitted that through hearing their evidence today, it had become apparent that the confidential information which you had allegedly provided at the investigatory meeting to Ms 4 had been shredded on the same day by Ms 4 after the meeting had concluded.

Mr Wong submitted that the proposed amendment clarified that 9 December was the only date on which the confidential information was allegedly held in your possession. Furthermore Mr Wong submitted that as the period of time the patient notes were allegedly held by you affected the severity of charge 3, the charge should be amended in the interests of justice.

The proposed amendment to charge 3 reads as follows:

“On 9 December 2014 insecurely had on your person patient identifiable information and/or confidential information relating to patients.”

Mr Anastasiades agreed to the proposed amendment on your behalf.
The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

28 (1) At any stage before making its findings of fact …

   (i) … the Conduct and Competence Committee, may amend

   (a) the charge set out in the notice of hearing …

   unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

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

**Resumed determination on facts**

The panel considered each charge and made the following findings:

That you:

**Charge 1:**

1. In October 2014 took blood from Patient A when you were not deemed competent to do so.

This charge is found proved.
In reaching this decision, the panel took into account all of the oral and documentary evidence presented in this case. The panel had specific regard to Ms 2’s oral evidence.

Ms 2 told the panel that, at the time of the incident, she was a newly qualified nurse and that she had recently completed the venepuncture theory course, but had not yet herself completed the mandatory supervised competency assessment.

Ms 2 stated that she overheard that you had been asked to take blood from a patient. She believed this request came from a GP. Ms 2 said she was concerned as she did not think that you had been signed off as competent to take blood. As she still felt unsure, she followed you to the patient’s room. In her statement, Ms 2 stated: “When I arrived she had already begun to take blood from the patient. She was attempting to take blood from the lower part of the wrist, which I though was strange as I could see a vein in the elbow. I had recently completed the venepuncture theory training and was taught to take blood from the elbow as a first point of call”.

In your oral evidence you stated, that prior to the procedure, you specifically asked Ms 2 whether she could supervise you, and you told the panel that Ms 2 had agreed to do so. The panel noted that there is no reference to this request either in your investigatory interview or in your detailed written response. The panel regards this as a significant inconsistency. Ms 2 was clear that she never had a discussion about supervising you, as she would not have been able to do so. The panel preferred the evidence of Ms 2.

The panel was satisfied that it was your professional duty as a Registered Nurse to ensure that you had a member of staff to supervise you during the procedure. The panel determined that as you had not found an appropriate person to do so you had carried out this procedure unsupervised. The panel therefore concluded that this charge is proved.
Charge 2:

2. On 6 October 2014 took blood from Patient B when you were not deemed competent to do so.

This charge is found proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence presented in this case.

Ms 1 stated that you asked her if there were any bloods that need to be taken, as you “wanted to do them.” Ms 1 asked you if you had been signed off as competent to take blood, to which you responded “yes”. Ms 1 stated that she let you take the trolley, and that a short time later you came back with a blood sample, which you showed to Ms 1.

Ms 1 stated: “Not long after this I was at the nurse’s station when the registrant came over to me and produced a sheet of paper which I saw was the competency sign off sheet and asked me to sign it. I noticed that there were no signatures on it…She asked me to sign it for her. I refused to sign this, first as she told me that she had been signed off to take blood and second I didn’t witness her take the blood”.

Ms 1 went on to say that when she was in the office later with Ms 3, you admitted that you had taken bloods alone.

You stated in both your oral and written evidence that Ms 1 accompanied you to patient B’s room to supervise you taking bloods. In your written statement you stated that Ms 1 came up to you and asked, “Do you have any bloods?”, Yes I do I responded.” In your written statement you then went on to say: “When you are ready tell me she said. I understood from her response that she knew I needed assistance. I then asked [Ms 1] if I could bring the trolley. When she agreed I took the trolley and we both went to the patient’s room. Infact (sic) she was the one who knocked on the patient’s door to announce our presence. As we got into the room I said hello and explained to the
patient why we had come then asked his consent. We both identified the patient and [Ms 1] gave me the go ahead with the procedure. I placed the toniquet (sic) on the upper arm palpated the vein with a finger infront (sic) of the elbow wiped the area and continued with the procedure with gloves and apron on. As I bent down quit (sic) concentrated being conscious that I was supervised, [Ms 1] left the room unnoticed. She went to the blood trolley, quickly picked up the venopuncture (sic) materials by hand, contrary to the clinical protocol and went to her patient. She was in such a rush that she could not wait. When I realised that [Ms 1] (sic) had left, I felt very frustrated and unhappy.”

In your written response, you state that at some stage, Ms 1 left the room “unnoticed”, yet in the same statement you state that you saw Ms 1 pick up the venepuncture materials “in a rush” from the trolley, which in your oral evidence you stated was outside the room. The panel found your version of events implausible and that your evidence contained significant inconsistencies. The panel found your account to be incapable of belief.

The panel also took into account the evidence of Ms 3, that she asked you whether you had been signed off as competent to take blood and that you told her “that nobody would help you and supervise you” and that you told her that “you would not take blood anymore”, after you admitted that you had taken blood unsupervised from a patient that morning.

You told the panel that you genuinely believed that Ms 1 had accompanied you but that you realised at some point during the procedure that she was not in the room. The panel was of the view that even if your version of events was true, it was immaterial as through your own admission, you had carried out and completed a venepuncture procedure unsupervised.

The panel accepted the evidence of Ms 1 and Ms 3 as their evidence largely corroborated each other. On the evidence before it, the panel considered that, on the balance of probabilities, it was more likely than not that on an unspecified date in
October 2014 you took blood from Patient A when you were not deemed competent to do so. It therefore found this charge proved on this basis.

Charge 3:

3. On 9 December insecurely had on your person patient identifiable information and/or confidential information relating to patients.

This charge is found proved.

Ms 4 told the panel that you had brought to the meeting multiple pages of patient notes. Ms 4 stated that you removed these notes from your handbag and provided them to her for the purpose of trying to prove the existence of discrimination on the Ward. This is consistent with her written statement: “The registrant tried to deflect by saying that she is not the only one who makes mistakes and took some documents out of her handbag. I took the documents off of her and realised they were patient records. They clearly showed patient details and personal information. The documents were not redacted. I am not sure how many pages there were but there were multiple pages”.

You stated in your evidence that you had gained verbal consent from a patient in order to copy and utilise their records to raise concerns about patient care provided by other members of staff.

In your evidence you accepted you had in your possession one page of photocopied patient records. You stated that the other pages contained an investigatory meeting letter and a thank you letter from another patient. You also told the panel that you had kept these documents in an envelope.

Mr Anastasiades, on your behalf stated that at most, you kept these notes on your person for a maximum of an hour. The panel found that through your oral evidence, you accepted that you had photocopied confidential patient information taken from the Ward.
In relation to the envelope, the panel preferred Ms 4’s evidence. Ms 4 in her oral evidence stated the Trust process in relation to taking patient information off-site is that it should be in a locked bag in a confidential envelope used by the Trust. Ms 4 explained that she is familiar with confidential envelopes used by the Trust and that she would have known if you had brought one to the interview. The panel was satisfied that you had patient identifiable information on you and that it was not secure.

For the reasons above the panel concluded that this charge is proved.

**Misconduct and impairment:**

Having announced its finding on all the facts, 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. The NMC has defined fitness to practise as a registrant’s suitability to remain on the register unrestricted.

You provided further oral evidence to the panel. The panel also received a bundle from you containing feedback forms and a letter a previous employer. You said that you started nursing in 1982 in Cameroon and explained your nursing history in detail to the panel and explained that you had been employed in a number of roles and have undertaken work across the UK since being registered in 2006.

You told the panel that whilst you felt frustrated by the way in which Ms 1 had acted on the day of the incident, you had accepted blame for the incident and told the panel that as a Registered Nurse, you were responsible for your own actions. You referred to your feedback forms and explained that prior to this case, you had never been subject to any disciplinary investigation and have always maintained a high level of excellence in your profession. You explained that you still viewed yourself as an excellent nurse and that you could work in a variety of nursing settings in the future.

You explained that you still had reservations over the way in which the internal investigation meeting notes were produced and accepted that you still blame Ms 1 for the incident involving patient A. You told the panel that both Ms 1 and Ms 2 had let you
get into this position and that if they had done what was expected of them, you would not be in this position today. You also told the panel that at the time, there was no confidentiality on the Ward.

You told the panel that since the incidents, you have realised that learning is a continuous process and that you have read several books on venepuncture and looked forward to doing a venepuncture training course in the future. You told the panel that you had in the past taken an online course on information governance at work and you previously submitted this to the NMC, which the panel accepted. You told the panel that whilst you had not yet secured or enrolled on any future training, you had looked online at the courses available.

You explained that at the time of the incidents, you were going through difficult personal circumstances and that you were also affected by issues relating to your health.

You explained that you love nursing and love your patients. You told the panel that you are a very willing and dedicated nurse and would like to have a ‘good souvenir’ of your profession. You told the panel that you would try to ensure that something like this will never happen again and that you understand the importance of owing your patients a duty of care.

Mr Wong submitted that this case engages both public protection and public interest considerations. He reminded the panel that there is no burden of proof at this stage and the decision on misconduct is for the panel’s independent judgment.

Mr Wong referred the panel to the case of Roylance v General Medical Council (no. 2) [2000] 1 AC 311 in which Lord Clyde defined misconduct “as a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the relevant field.”

Mr Wong invited the panel to take the view that your actions amount to serious breaches of The Code: Professional standards of practice and behaviour for nurses and
midwives (2008) (“the Code”). Mr Wong submitted that the charges found proved were sufficiently serious to amount to misconduct.

He submitted that by not being suitably competent to carry out venepuncture procedures, you jeopardised patients and at put them at unwarranted risk of harm. Mr Wong further submitted that in relation to the incident involving Ms 4, you had purposely photocopied confidential patient records with the intent to prove discrimination on the Ward as part of your defence. He submitted that a Registered Nurse should under no circumstances do this without clear written consent.

Mr Wong invited the panel to consider your level of insight and referred the panel to your written responses and oral evidence. Mr Wong drew the panel’s attention to your assertions that your colleagues had let you get into this position and your belief that there was no confidentiality on the Ward. Mr Wong invited the panel to take the view that your explanations do not amount to genuine insight, but rather highlighted a continuous pattern of trying to blame others and deflect responsibility. Mr Wong submitted that in light of this, your attitude should be brought into question.

Mr Wong referred the panel to the case of Nicholas-Pillai v General Medical Council [2009] EWHC 1048 and invited the panel to consider that the attitude of the practitioner to the events which give rise to the specific allegations against her is in principle something which can be taken into account either in her favour or against her by the panel.

Mr Wong therefore submitted that you have shown no insight or remorse as you have not reflected on your failings or taken accountability for them.

With regard to the issue of impairment, Mr Wong referred the panel to the case of Cohen v GMC [2008] EWHC 581 (Admin) and invited the panel to consider whether the conduct was remediable and the level of your insight and remorse. Mr Wong submitted that the allegations relating to venepuncture procedures could be easily remedied by way of training and that the allegation relating to patient records could be addressed by
way of demonstrating insight into those issues and possibly also to some extent by training.

Mr Wong submitted that whilst you had engaged and attended proceedings and had attempted to remediate your practice, your attempts at remediation had been woefully inadequate. He submitted that as no proactive or meaningful attempts had been made by you, your practice had not been remediated. He therefore invited the panel to take the view that a high risk of repetition remains in the future.

Mr Wong invited the panel to consider the public interest and referred the panel to the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin), particularly paragraph 76 of Mrs Justice Cox’s judgement, wherein she endorsed the questions formulated by Dame Janet Smith in her Fifth Shipman Report. Mr Wong submitted that the first three limbs in paragraph 76 of Mrs Justice Cox’s judgement in the case of Grant are engaged in this case.

Mr Wong submitted that in view of the breach of fundamental tenets of the profession, a finding of impairment is also necessary on the grounds of the public interest in order to uphold proper professional standards and uphold public confidence in the NMC as a regulator.

Mr Anastasiades, on your behalf, informed the panel that you accepted the panel’s earlier findings. He submitted that taking into account your difficult personal circumstances and health issues, you have done the best you can to remediate your practice by way of undertaking research into venepuncture and completing an online course in information governance.

Mr Anastasiades referred the panel to your feedback forms which showed that there were no clinical or attitudinal concerns raised by your previous supervisors. He submitted that the risk of repetition remains low in light of these comments.

Mr Anastasiades submitted that you have been honest and clear in these proceedings. He submitted that you have expressed that you would communicate more when placed
in a similar situation. He invited the panel to consider the existence of systemic failings on the Ward at the time of the incidents and stated that Ward Managers should know which nurses were deemed as competent in relation to venepuncture procedures.

Mr Anastasiades submitted that you had learnt your lesson through these proceedings and that you had never previously been subject to any disciplinary or regulatory action. He submitted that the incidents in question were closely dated and isolated and that the allegations were not sufficiently serious when compared with other referrals to the NMC. He submitted that there was no question of dishonesty and that you have been honest, clear and open throughout these proceedings.

The panel accepted the advice of the legal assessor.

The panel adopted a two-stage process in its consideration, as advised. 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.

**Decision on misconduct**

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

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that your acts amounted to breaches of the Code.

The preamble:

The people in your care must be able to trust you with their health and wellbeing
To justify that trust, you must:

- Provide a high standard of practice and care at all times

Specifically, standards:

5. You must respect people’s right to confidentiality.

6. You must ensure people are informed about how and why information is shared by those who will be providing their care.

22. You must work with colleagues to monitor the quality of your work and maintain the safety of those in your care.

24. You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues.

26. You must consult and take advice from colleagues when appropriate.

39. You must recognise and work within the limits of your competence.

47. You must ensure all records are kept securely.

57. You must not abuse your privileged position for your own ends.

61. You must uphold the reputation of your profession at all times.

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

In relation to the first two incidents involving taking blood from patient A and patient B, the panel determined that you had incorrectly undertaken two separate clinical procedures, on two separate occasions when you were not deemed competent to do so and which resulted in harm to both patients. The panel found that this amounted to you
acting outside of your scope of competence and practice. In relation to the third incident, where you had insecurely stored patient identifiable information and/or confidential information relating to patients, the panel found that you had clearly breached the Code and jeopardised patient confidentiality. This was further exacerbated by the fact that you had intended to use sensitive documents as part of your defence during investigatory proceedings carried out by the Trust and that when you were challenged on those documents, snatched them back clearly demonstrating that you realised that your actions were wrong.

Taking all the matters found proved into account, the panel concluded that your conduct fell significantly below the standard required of a registered nurse and was serious enough to amount to misconduct.

**Decision on impairment**

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

The panel was mindful of the need to consider not only whether you continue to present a risk to members of the public, 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 of your case.

The panel had regard to the guidance given in the judgment of Mrs Justice Cox in the case of *Grant*. At paragraph 74 of that judgment, 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.”
Mrs Justice Cox went on to say in Paragraph 76:

“Do our findings of fact in respect of the … misconduct… show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
d. […]”

The panel considered that your conduct had engaged the first three criteria of the guidance in Grant. The panel concluded that you have in the past acted so as to place patients at an unwarranted risk of harm, had breached fundamental tenets of the profession and had brought the profession into disrepute. The panel bore in mind that it had to look to the future and consider whether you were liable to act in such a way again. The decision about the risk of repetition in this case would be informed by consideration of the level of insight and remorse demonstrated by you and by whether your misconduct has been or is capable of being remedied.

The panel noted that as a result of your actions, by not following the correct procedure in taking bloods both patient A and B had suffered actual patient harm. The panel noted that you have offered explanations for your conduct. However there is no evidence before the panel to indicate that you appreciate the seriousness of your misconduct, nor the potential harm that was caused or could have been caused to other patients in your care. The panel found that you do not understand the impact your actions have had on the nursing profession and its reputation and that you have not fully accepted any wrongdoing.

Whilst the panel note that when giving evidence that you wanted to take the blame, this assertion was set against your further evidence in which you stated that Ms 1 and Ms 2
had let you get into this position and that if Ms 1 and Ms 2 had done what was expected of them, you would not be in trouble. The panel determined that despite claiming to accept the findings of the panel, you continued to show a pattern of reluctance to accept responsibility for your actions and behaviour.

The panel consider that your misconduct is remediable and went on to consider whether you had remediated. The panel acknowledged that whilst you had accepted the charges found proved and asserted that you would communicate more clearly in the future, you still appear reluctant fully to accept your misconduct. The panel consider that you continue to attempt to deflect blame from yourself and apportion it to others. The panel concluded that your misconduct has not been remedied and consequently, there is a high risk of repetition.

Given your very limited insight and given that you have shown no remorse or sufficient remediation, the panel concluded that you are liable in the future to act so as to put patients at unwarranted risk of harm, breach the fundamental tenets of the profession and bring the profession into disrepute. Accordingly, a finding of impairment on the grounds of public protection is necessary.

The panel bore in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding the proper standards and behaviour. In the judgement of the panel, irrespective of the risk of repetition, public confidence in the profession and the regulator would be undermined if a finding of impairment was not made in light of the seriousness of the matters found proved in this case. Having regard to all of the above, the panel determined that your fitness to practise is currently impaired.

**Determination on sanction:**

The panel has considered this case carefully and has decided to make a suspension order for a period of 3 months. The effect of this order is that the NMC register will show that your registration has been suspended.
In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case together with the submissions of Mr Wong, on behalf of the NMC. Mr Wong submitted that taking no action or imposing a caution order would not sufficiently protect the public, however he stated that ultimately sanction is a matter for the panel’s independent judgment and referred it to the Indicative Sanctions Guidance (“ISG”). He outlined the aggravating and mitigating factors in this case.

Mr Anastasiades, on your behalf, submitted that at its highest, the public would be sufficiently protected by a caution order and reminded the panel of the principle of proportionality and fairness.

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

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 ISG published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgment.

The panel first considered the aggravating and mitigating factors in this case which were summarised as follows:

The panel identified the following aggravating factors:

- The misconduct caused direct patient harm;
- There has been a lack of insight which has continued throughout these proceedings;
- There was no evidence of any meaningful remediation;
- There is a high risk of repetition;
- There are attitudinal issues;
- The issues concerned included both clinical practice and patient confidentiality;
- There was an abuse of position of trust;
• Although not isolated, occurred over a two month period.

The panel identified the following mitigating factors:

• You have worked as a nurse since 1982 without any problems;
• There have been no other referrals to the NMC in relation to your practise in the course of your 11 year career as a Registered Nurse in the UK;
• You experienced difficult personal circumstances and health issues
• You have engaged with NMC proceedings throughout;
• You have positive feedback forms, however mainly from 2015, with only two from 2017;
• You have a positive reference from 2016, from a previous employer;
• You have undertaken reading into venepuncture;
• You have undertaken an online course in information governance.

The panel then turned to the question of which sanction, if any, to impose. It considered each available sanction in turn, starting with the least restrictive sanction and moving upwards.

The panel first considered whether to take no action, but concluded that this would be inappropriate in view of the seriousness of the case. To take no action would not restrict your practice and given the risk of repetition in this case, this would not be appropriate or protect the public. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the ISG, which 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 the misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the nature and extent of the misconduct, the lack of insight, risk of repetition and the seriousness of the matters found proved. The panel decided that it would be neither proportionate
nor in the public interest to impose a caution order as it would place no restrictions on your practice and so would not protect the public.

The panel next considered a conditions of practice order. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel was of the view that although the issues identified in the charges could be remediated by conditions, your lack of insight and ability to take responsibility for your conduct preclude this sanction. The panel also determined that placing conditions on you would not adequately address the high risk of repetition, the seriousness of the matters found proved or address the high risk of repetition in this case and as such, they would be inadequate to satisfy the public interest considerations.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel took into account the ISG.

Whilst the panel noted that there were some attitudinal issues, the panel acknowledged that there was no evidence of harmful, deep seated attitudinal issues or any evidence of repetition of similar behaviour since the incidents. However this is not a single instance and it related to both your clinical practice and patient confidentiality.

The panel concluded that the seriousness of your misconduct requires your temporary removal from the register and that such an outcome would protect the public.

The panel accepted that a suspension order may have a negative financial impact on you, however, it considered that the public interest outweighed your own interests in this regard. The panel noted that you are a very experienced nurse, with an otherwise long and unblemished career. The panel therefore considered that a three month suspension order would give you the opportunity to reflect, develop insight and attempt to remediate your practice and then return to the profession which you stated that you love.

The panel went on to consider whether it should impose a striking-off order instead. The panel considered that your misconduct and impaired fitness to practise was not fundamentally incompatible with you remaining on the register. In the panel’s judgement a striking off order was not the only sanction that would sufficiently protect the public and address the public interest considerations in this case.
The panel therefore concluded that the appropriate and proportionate sanction would be a suspension order for 3 months. It considered that a lesser period would be insufficient to mark the seriousness of your departure from the standards expected of a registered nurse and in order to satisfy the public interest.

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

The panel was of the view that a future reviewing panel may be assisted by:

- Your attendance at the review hearing;
- Evidence by way of a reflective piece that demonstrates that you have insight into the impact that your misconduct had on patients, colleagues and the reputation of the profession as a whole and how you would act differently in the future;
- An up-to date course on information governance;
- An up-to date venepuncture course, online or otherwise.

The effect of this order is that the NMC register will show that your registration has been suspended for a period of 3 months.

**Determination on Interim Order:**

Mr Wong, on behalf of the NMC, submitted that an interim suspension order should be imposed on the basis of protection of the public and otherwise in the public interest. He submitted that the interim suspension order, which would take immediate effect, should be for a period of 18 months to cover the possibility of an appeal being lodged by you in the 28 day appeal period.

Mr Anastasiades, on your behalf, did not oppose the order.

The panel heard and accepted the advice of the legal assessor.
The panel had regard to the circumstances of the case and the reasons set out in its decision for imposing a suspension order.

The panel decided to make an interim suspension order for a period of 18 months. The reasons for the interim suspension order are as follows:

The panel had particular regard to its earlier finding that there remained a risk of repetition of the misconduct in this case given your limited insight. It also bore in mind the seriousness of the matters which it has found proved. The panel concluded, in light of its earlier decisions on impairment and sanction, that an interim order was necessary for the protection of the public and otherwise in the public interest in order to uphold professional standards and maintain public confidence in the profession. For the reasons already set out in detail in the decision on sanction, the panel considered that workable interim conditions of practice could not be formulated which would be adequate to address the concerns in this case so as to protect the public pending any appeal. The panel therefore concluded that it was necessary for your registration to be subject to an interim suspension order on the grounds of public protection and in the public interest. To do otherwise would be inconsistent with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by a 3 month suspension order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.