Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

2 September-17 October 2019

Nursing and Midwifery Council, Temple Court, 13a Cathedral Road, Cardiff, CF11 9HA

Name of registrant:	Beth Louise Williams
NMC PIN:	90A0052W
Part of the register:	Registered Nurse – Adult Nursing (23 March 1993)
Area of Registered Address:	Wales
Type of Case:	Misconduct
Panel Members:	Anne Owen (Chair – Registrant member) Kevin Connolly (Lay member) Sally Glen (Registrant member)
Legal Assessor:	Charles Parsley
Panel Secretary:	Vicky Green
Mrs Williams:	Present and not represented on days 5 and 9. Not present or represented on other dates
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Facts proved by admission:	All
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim Order:	Interim suspension order – 18 months

Details of charge:

That you, a registered nurse, whilst working at Brindavaan Care Home,

1) Between 03 September 2014 and 17 May 2015 on one or more occasion you administered Anticoagulant/Warfarin Therapy to Patient 1 without a dosing regime in place informed by a current INR result

2) Between 23 December 2014 and 02 March 2015 did not follow up on whether INR bloods for Patient 1 had been taken and/or processed.

3) After 03 April 2015 on one or more occasions failed to administer Patient 1's Anticoagulant/Warfarin Therapy without clinical justification

4) In April 2015,knowing that Patient 1's Anticoagulant/Warfarin Therapy had been interrupted you did not follow up the suitability of her continued treatment in that you

    4a) did not inform the GP

    4b) did not update the care plan

    4c) did not ensure that an INR blood sample had been successfully submitted for testing

    4d) did not follow up by contacting the Anticoagulant Clinic for a current dosing regime following taking samples of blood from Patient 1

5) Submitted blood samples in relation to Patient 1 to the Anticoagulation Clinic which were accompanied by incorrect paperwork on the following dates

    5a) between 04 March 2015 and 18 March 2015

5b) between 07 and 18 April 2015.

6) Between 03 September 2014 and 17 May 2015 you did not keep clear and accurate records of your attempts to contact the Anticoagulation Clinic.

7) On 18 March 2015 did not inform Dr Roberts of any difficulties in relation to Patient 1's Anticoagulation/Warfarin Therapy during the annual health review

8) Your conduct at Charges 3 and 4 above contributed to the death of Patient 1.

9) On 15 May 2015 you provided inaccurate information to Dr Turner about Patient 1's Anticoagulant/Warfarin Therapy treatment

10) Between 10 March 2015 and 27 July 2015 on one or more occasion you failed to administer Anticoagulant/Warfarin Therapy to Patient 2 in accordance with the dosing regime informed by a current INR result

11) On 10 April 2015 you failed to administer Patient 2's Anticoagulant/Warfarin Therapy without clinical justification

12) Knowing that Patient 2's Anticoagulant/Warfarin Therapy had been interrupted you did not follow up the suitability of her continued treatment in that you

12a) did not inform the GP in a timely manner

12b) did not update the care plan

12c) did not ensure that an INR blood sample had been successfully submitted for testing

12d) did not contact the Anticoagulant Clinic for a dosing regime informed by a current INR result.

13) Practised as a registered nurse at Brindavaan Care Home, on more than one occasion between 01 June 2014 and 01 December 2015, without having in place an indemnity arrangement to cover your practice.

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

Preliminary

It was determined at a preliminary meeting on 14 December 2018 that the referrals for Registrant C, Registrant A and Mrs Williams should be heard together at a substantive hearing of the Fitness to Practice Committee of the NMC.

Registrant C attended on day 1 and on most subsequent days of the hearing when the panel was in session, other than day 10 and part of day 12.

Registrant A did not attend, nor was she represented on any days.

Mrs Williams did not attend on the first day of the hearing. She attended on day 5 when the charges against her were re-read. She did not admit any of the charges and did not remain when the hearing proceeded. Mrs Williams re-attended on day 14, after the NMC had closed its case and Registrant C had given oral evidence. At that point, the charges were read again and Mrs Williams admitted all the charges that she faced. Mrs Williams gave oral evidence that day and on day 15 she attended by telephone for closing submissions and legal advice on facts. Mrs Williams also attended at the impairment stage on day 24 of the hearing. Mrs Williams did not attend for the sanction stage.

Decision on Service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Williams was not in attendance and that written notice of this hearing had been sent to her registered address by recorded delivery and by first class post on 2 August 2019.

The panel took into account that the notice letter provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Williams' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Kennedy submitted the NMC had complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules").

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mrs Williams has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34. It noted that the rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision on proceeding in the absence of Mrs Williams

The panel next considered whether it should proceed in the absence of Mrs Williams.

Mr Kennedy invited the panel to proceed in the absence of Mrs Williams on the basis that she had voluntarily absented herself.

Mr Kennedy told the panel that Mrs Williams has contacted the NMC about the hearing. Mrs Williams told the NMC that she intends to attend at a later stage of the hearing. Mr Kennedy submitted that Mrs Williams is aware of this hearing and chosen to not attend today. Mr Kennedy told the panel that Mrs Williams has not requested an adjournment and there was no reason to believe that an adjournment today would secure her attendance in the future. He therefore invited the panel to proceed in the absence of Mrs Williams. Mr Kennedy reminded the panel of the public interest in the expeditious disposal of cases.

The panel accepted the advice of the legal assessor who referred it to the cases of *R v Jones [2002] UKHL* and *GMC v Adeogba [2016] EWCA Civ 162.*

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

The panel has decided to proceed in the absence of Mrs Williams. In reaching this decision, the panel has considered the submissions of Mr Kennedy. It has had particular regard to the factors set out in the decision of *Jones*. It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Williams;
- Mrs Williams has indicated that she will be attending the hearing at a later stage;
- There is no reason to suppose that adjourning would secure her continuous attendance at some future date;
- A number of witnesses have been warned and are due to attend this hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Given the passage of time since the charges arose, further delay to the witnesses may negatively impact their recollection of events;
- There is a strong public interest in the timely disposal of the case.

The panel acknowledged that there is some disadvantage to Mrs Williams in proceeding in her absence. She will not be able to challenge the evidence relied upon by the NMC. There is information to suggest that Mrs Williams will attend at a later day to give evidence. However, in the panel's judgment, Mrs Williams' absence when the NMC presents its case, can be mitigated. The panel can explore any inconsistencies in the evidence which it identifies and can question the NMC witnesses.

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

Decision and Reasons on application pursuant to Rule 31

At the outset of the hearing Mr Kennedy made an application under Rule 31 of the Rules to allow the written statement of Ms 1 into evidence. Mr Kennedy submitted that Ms 1's evidence was limited to producing Patient 2's records without speaking to the contents of those records. Mr Kennedy informed the panel that the NMC had been advised by Ms 1's employers that she is currently on long term sick leave. Therefore, she was unable to attend the hearing in person in any event. Mr Kennedy submitted that Ms 1's witness statement is relevant to these proceedings and it would be fair in the circumstances to admit it into evidence.

Ms Collins, on behalf of Registrant C, did not oppose the application.

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 reference to Rule 31 which provides that, *'…subject only to the requirements of relevance and fairness a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings…*'

The panel noted that Ms 1's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph 'This statement … is true to the best of my information, knowledge and belief' and was signed by her on 18 September 2017.

The panel noted that the application was not opposed by Ms Collins on Registrant C's behalf. The panel was of the view that there is a public interest in the issues being explored fully which supported the admission of Ms 1's statement into evidence. In all the circumstances, the panel determined that it would be fair and relevant to accept into

evidence the written statement of Ms 1 but would give it the appropriate weight after hearing and evaluating all of the evidence before it.

Decision and Reasons on second application pursuant to Rule 31

The panel heard two further applications by Mr Kennedy under Rule 31 of the Rules to allow Mr 2 and Dr 3 to give their evidence via video link.

With regard to Mr 2's evidence, Mr Kennedy stated that Mr 2 who was the owner of Brindavaan Care Home (the Home), would produce the signed employment contract between the Home and Mrs Williams. Mr Kennedy informed the panel that Mr 2 is currently abroad for some time and it would be unreasonable for the NMC to facilitate his attendance in person given that his evidence relates to a discrete issue. Mr Kennedy submitted that no prejudice will be caused as Mr 2's evidence can be properly tested by the parties and the panel through video-link.

With regard to Dr 3's evidence, Mr Kennedy acknowledged that there was no statement from this witness and his evidence was in the form of an expert witness report which addressed issues of Mrs Williams' duties as a registrant. Mr Kennedy informed the panel that Dr 3, who is a Consultant Haematologist based in Manchester, was unable to attend the hearing in person due to clinical commitments. Mr Kennedy submitted that Dr 3's evidence is clearly relevant to these proceedings and no prejudice will be caused as Dr 3's evidence can be properly tested by the parties and the panel through video-link.

Ms Collins submitted that she supported the application in respect of Mr 2 and she did not oppose the application in respect of Dr 3.

The panel heard and accepted the legal assessor's advice.

The panel considered whether the registrants would be disadvantaged by it receiving the evidence of Mr 2 and Dr 3 by video link rather than attending in person. The panel determined that the evidence of Mr 2 and Dr 3 was relevant to these proceedings and there was no dispute between the parties in that respect.

The panel noted that Ms Collins supported the application in respect of Mr 2 and that she did not oppose the application in respect of Dr 3. The panel took into account the reasons given for adducing Mr 2 and Dr 3's evidence via video-link and was satisfied that there were good reasons for their non-attendance in person. The panel determined that there was also a public interest in the issues being explored fully which supported the admission of Ms 2 and Dr 3's evidence via video-link. In all the circumstances, the panel came to the view that it would be fair and relevant to accept Mr 2 and Dr 3's evidence via video-link.

Decision and Reasons a further application pursuant to Rule 31

On day six of the hearing Dr 3 was due to give evidence via video link. Due to technical difficulties, the video link could not be established. For that reason, Mr Kennedy made an application for Dr 3's evidence to be heard by telephone.

Ms Collins did not oppose this application.

The panel accepted the advice of the legal assessor.

As determined earlier, the panel still considered Dr 3's evidence to be relevant. The panel went on to consider whether it would be fair to hear Dr 3's evidence via telephone link. The panel noted that this was expert evidence and that while evidence given via video link would have enabled it to have made a better assessment of the witness, in the circumstances, it would be fair to hear his evidence by telephone.

Decision and reasons on a further application pursuant to Rule 31

On day 10 Mr 2 was expected to give evidence via video link. A consideration was the time difference, as he was in the Indian sub-continent. In attempting to establish the video link connection there were technical issues with equipment and international calling from the venue. Due to those technical issues Mr 2 was asked to give evidence on day 12.

On day 12 while the technical issues at the venue had apparently been resolved, the necessary software tests had not been carried out with Mr 2 by the NMC ahead of the hearing. Once again, it was impossible to establish the video link. The panel invited submissions from the parties in terms of proceeding with Mr 2's evidence.

Mr Kennedy invited the panel to hear Mr 2's evidence via telephone. He submitted that given the time spent trying to resolve technical issues, it would be in the interests of the hearing not to waste any more time and to hear from Mr 2 by telephone.

Ms Collins did not oppose this application.

The panel accepted the advice of the legal assessor.

The panel was conscious of the disadvantage of hearing evidence by telephone rather than video link as it limited the panel's ability to assess the presentation of the witness. The panel was also made aware of Mr 2's limited availability after this point.

As determined earlier, the panel was of the view that Mr 2's evidence is relevant. It went on to consider whether it would be fair to hear Mr 2's evidence by telephone instead of video link. Having regard to all of the circumstances, the panel determined that it would be fair to hear Mr 2's evidence by telephone.

Decision on the facts

Mrs Williams joined the hearing for the second time on day 14 of the hearing. She adduced a bundle of documents which included a written statement which she had previously submitted to the NMC, a written statement from Ms 4, a former healthcare assistant at the Home when the charges arose and another witness statement from Ms 5, the former administrative assistant at the Home.

Upon reading Mrs Williams' statement the panel noted that she had previously admitted the charges against her to the NMC, despite making no admissions at the beginning of the hearing when Mrs Williams attended on day 5. Mrs Williams, upon the charges being re-read, admitted all of the charges she faced. The panel therefore announced all of the charges against Mrs Williams as proved.

At the outset of this hearing Registrant C admitted all of the charges. In respect of charge 2.d)ii) Registrant C's admission was on the basis that he failed to follow up alternative methods of obtaining blood samples from Patient 1. The panel accepted Registrant C's admission as there was evidence to suggest that he did consider alternative methods of obtaining blood samples from Resident 1. The panel therefore announced all of the charges against Registrant C as proved.

After the close of the NMC's case, Registrant C elected to give oral evidence on affirmation to provide some contextual background about the circumstances at the Home when the charges arose.

Decision and reasons on application pursuant to Rule 19

During cross examination of Mr 2 and before Registrant C gave evidence Ms Collins told the panel that he would be making reference to matters relating to his health and personal circumstances. Accordingly, she made an application, pursuant to Rule 19 of the Rules that these parts be heard in private.

Mr Kennedy did not oppose this application.

The panel accepted the advice of the legal assessor.

Having heard that there will be reference to Registrant C's health and personal circumstances, the panel decided to hold such parts of the hearing in private. The panel determined to rule on whether or not to go into private session in connection with Registrant C's health and personal circumstances as and when such issues are raised.

Registrant C's oral evidence (Part 1)

In his oral evidence Registrant C told the panel that the Home had the capacity to take 34 residents and that it usually operated at 90-95% capacity. At the time the charges arose, Registrant C told the panel that the Home was nearly full.

The residents were typically over the age of 55, the majority of whom suffered from dementia in varying degrees. He told the panel that the residents who had severe dementia had a high level of dependency and needed maximum assistance with personal care, hygiene needs, eating, drinking, in going to the toilet and mobility. Moderate sufferers of dementia had a degree of independence. The residents with severe dementia, at times, displayed challenging and aggressive behaviour. This included resisting support from staff when tending to their needs, refusal to eat or drink, take medication and cooperate with clinical procedures. Registrant C told the panel that these residents would often have poor insight into their abilities with regard to mobility, which could lead to falls in the Home.

Registrant C told the panel that healthcare assistants would meet the day to day needs of the residents and that the residents' care would be overseen by a registered nurse. Registered nurses were responsible for liaising with agencies, wound dressing and medication.

Registrant C said that he couldn't remember specifically when he commenced employment at the Home, but he thinks that he was employed as the manager some time in 2013.

After Mr 2 acquired ownership of the Home, some time in early 2014 he introduced, simultaneously, a number of notable changes at the Home. Registrant C told the panel that under the management of the previous owner staffing was always stable and there was an experienced team of registered nurses, a deputy manager and a manager as well as an administrative assistant. Registrant C told the panel that three experienced registered nurses, one of whom was the deputy manager, left the Home when Mr 2 acquired ownership of the Home. Registrant C said that these nurses left to work with previous owner.

Registrant C was given instructions by Mr 2 to reduce the number of registered nurses to one on every 12 hour shift and not to use agency staff. He said that as a consequence he would be the only registered nurse on some shifts in addition to having managerial responsibilities.

After Mr 2 took over Registrant C told the panel that there was significant disruption to the Home during major building work which involved the communal lounge and he said that this caused a lot of difficulties. Due to the building work, the staff and residents could not access the main lounge and two smaller lounges had to be used. Registrant C said that Mr 2 oversaw the building work but he was responsible for managing the contractors on a day to day basis as well as ensuring the safety and wellbeing of the residents.

Registrant C told the panel that another change was the 'Butterfly Project'. This was an initiative in dementia care to provide a more holistic approach and enhance the experience of the residents. This scheme was administered by a company called Dementia Care Matters who Registrant C worked closely with in order to try to implement this in the Home. Registrant C said that this was a major change and a lot of

staff training was required. Due to the amount of training needed he said that not all of the staff were able to undertake the training required.

Mr 2 also introduced the electronic records for medication management (eMAR) and the recording of daily care activity. Registrant C said that he and Mr 2 believed that the introduction of this system would be a step forward at the Home. Using eMAR medication could be ordered online. The other system called Caresis was used to record information such as patient registration, care plans and risk assessments.

Registrant C elaborated on his written statement where he said that he felt like he was 'firefighting'. Registrant C said that at the time in question, he had lost a team of experienced registered nurses, had difficulties in recruiting and was trying to balance his nursing and managerial duties. During this time Registrant C also lost his administrator so he had to take on additional administrative duties. Registrant C told the panel that Mr 2 hoped that the implementation of the new electronic systems would reduce the amount of administrative support that he needed but this was not the case. Registrant C felt like he was trying to manage the issues on a day by day basis which he can now see was on a superficial level rather than going to the root cause.

Registrant C told the panel that he was advised by an external commissioning body to reinstate the post of deputy manager, Registrant A was appointed as she was the only member of staff suitably qualified to apply for this post. When questioned by the panel Registrant C acknowledged that this role should have additional responsibility to monitor the working practises of staff on the care floor. However, Registrant C confirmed that in reality the post was in *'name only'*.

[PRIVATE]

Since the closure of the Home Registrant C said that he has reflected on his practice as a nurse and as a manager. Registrant C accepted that at the time the charges arose his practice was poor, but his intentions were good. Registrant C said that he has

subsequently undertaken relevant training and has the support of his current manager. Registrant C is currently working at another care home owned by Mr 2.

During cross examination a statement was received by the NMC from Mrs Williams. Ms Collins, on behalf of Registrant C, told the panel that he will give further evidence once Mrs Williams had formally introduced this evidence and given her oral evidence.

Mrs Williams' case

Mrs Williams told the panel that she intended to give oral evidence as well as call two witnesses.

Decision and reasons on application pursuant to Rule 31 (telephone evidence)

On day 14, the panel heard an application made by Mrs Williams pursuant to Rule 31, for Ms 4 and Ms 5 to give evidence by telephone. Mrs Williams told the panel that Ms 4 was unable to take time off work as a dental nurse to attend the hearing and due to personal commitments, but she would be able to give telephone evidence between 13:00-14:00. With regard to Ms 5, Mrs Williams told the panel that Ms 5 was also unable to take time off work but she would be available to give evidence by telephone at 14:30.

Mr Kennedy submitted that the evidence of Ms 4 and Ms 5 is clearly relevant. He did not oppose the application.

Ms Collins accepted that the evidence of Ms 4 and Ms 5 is relevant. She did however observe that there was no supporting documentation from the witnesses' employers to support the application. Ms Collins submitted that it was a matter for the panel.

The panel accepted the advice of the legal assessor.

Despite not having evidence from Ms 4 and Ms 5's employers the panel determined that it would be fair and relevant to hear from Mrs Williams' witnesses by telephone. It considered that it would be fair to give all parties an opportunity to hear from and cross examine Ms 4 and Ms 5. Once it had heard from the witnesses, the panel would determine what weight to attach to this evidence, bearing in mind that it would not have had an opportunity to assess their demeanour.

Decision and reasons on second application pursuant to Rule 19

During Mrs Williams' oral evidence the panel invited her to make an application pursuant to Rule 19 as matters relating to her health and personal circumstances arose.

Mrs Williams told the panel that she intended to refer to matters relating to her health and personal circumstances during her oral evidence. Mrs Williams made an application for these parts to be heard in private.

Mr Kennedy did not oppose this application.

Ms Collins did not oppose this application.

The panel accepted the advice of the legal assessor.

The panel determined that when issues relating to Mrs Williams' health and personal circumstances arose, such information would be heard in private.

Mrs Williams' oral evidence

In her oral evidence Mrs Williams read out her written statement and provided further information where she deemed it necessary.

Mrs Williams told the panel that, since these events, she tried to attend warfarin management and international normalised ratio (INR) training courses but she has not completed any formal training on these subjects. Mrs Williams said that she has had in depth conversations with her manager about warfarin management and INR to broaden her knowledge. Mrs Williams told the panel that because of the experiences she had at the Home and the subsequent proceedings, she is not sure whether she would return to nursing in the future. Mrs Williams is currently retraining in education.

In relation to the new electronic systems at the Home Mrs Williams told the panel that there were technical difficulties. Mrs Williams said that the registered nurses would at times have to use Registrant C's login due to difficulties with their own. Mrs Williams questioned the accuracy of the electronic systems and suggested that, in relation to warfarin administration, the system had incorrectly recorded the doses. Mrs Williams told the panel that she always asked another member of staff to check medication with her before she administered it to a resident. Mrs Williams told the panel that when medication was unavailable for a resident Registrant C told her to use other residents' medication.

Mrs Williams told the panel that when she took blood samples for INR testing, she was told to take the sample, in person, to the GP surgery across the street. Mrs Williams told the panel that she now accepts that the samples were labelled incorrectly, but at the time, you did not know that this was the case. Mrs Williams said that this was not flagged to you by the GP surgery or the pathology laboratory, and because there was no other registered nurse on the same shift as her, no one at the Home could notice and draw attention to her mistakes.

Mrs Williams said that there were difficulties in obtaining blood samples from some of the residents. Mrs Williams said that she researched other ways to obtain these samples which included machines to take capillary blood tests. Mrs Williams told the panel that you discussed this with Registrant C. At the time of Mrs Williams' research

she said that these machines were priced at £800. Mrs Williams told the panel that Registrant C could not take blood samples [PRIVATE].

Mrs Williams told the panel that she had concerns about the staffing levels at the Home. She said that on a 12 hour shift, she was the only registered nurse and were required to administer medication to 35 residents, many of whom had dementia. Mrs Williams said that if warfarin was refused by a resident, she would have kept trying to administer the medication. Mrs Williams said that eMAR was a dangerous system as it would sometimes crash during a medication round. Mrs Williams also stated that she felt that Mr 2 did not invest in providing appropriate care for the residents and that he was more concerned about making financial profits. Mrs Williams said that you recall Mr 2 telling the kitchen staff that they were being wasteful with the food and giving the residents too many oats. Mrs Williams told the panel that Registrant C was living in a house that Mr 2 had purchased and that he also lived there when he was at the Home.

Mrs Williams told the panel that she was working in another Home owned by Mr 2 before she started working at the Home. Mrs Williams said that Mr 2 asked you to work at the Home as it was understaffed. Mrs Williams told the panel that during the preparation for an imminent inspection, it was discovered that she did not have a personnel file. Mrs Williams was asked to sign the contract during a busy medication round when there had been an altercation between some of the residents. Mrs Williams said that she told Mr 2 that she would not work at the Home if she had to arrange her own indemnity insurance or create her own invoices. Mrs Williams told the panel that she thought that insurance had been put in place by the Home. At the time in question, Mrs Williams told the panel that she also had two other jobs for which she did not have to arrange professional indemnity insurance and that she worked for the Home as and when they needed her.

Upon questioning by the panel, Mrs Williams claimed that in her personal life, she did not deal with such matters as household or motor insurance or any domestic accounts. Mrs Williams also asserted that her IT skills were limited.

Decision and Reasons on application pursuant to Rule 31 (to admit the written statement of Ms 5 into evidence)

On day 14 of the hearing, Mrs Williams made an application to hear evidence of Ms 5 by telephone at 14:30. The Panel Secretary made a number of attempts to contact Ms 5 by telephone at 14:30 but her efforts were unsuccessful.

After these unsuccessful attempts Mrs Williams told the panel that she had received a text message from Ms 5 shortly after 14:00, to say that she had had to take her break early so she would not be available at 14:30, as she originally thought she would be. Mrs Williams told the panel that she would try to ensure that Ms 5 was available to give her evidence by telephone at 09:00 on day 15. The panel agreed to allow Mrs Williams this time to secure her witness. Mrs Williams told the panel that she would attend on day 15.

When the panel resumed at 09:00 on day 15, Mrs Williams was not in attendance. After 09:00 Mrs Williams contacted the Panel Secretary and said that she was unable to attend because of work commitments. Mrs Williams said that Ms 5 would be available at 10:00 and asked the panel to hear from this witness in her absence. The panel agreed to allow this time and further attempts were made to contact Ms 5 who did not answer the call and a message was left on her voicemail.

Mr Kennedy did not oppose the application. However, he noted the leeway that had been extended by the panel to Mrs Williams in order to hear this witness.

Ms Collins did not oppose the application.

The panel accepted the advice of the legal assessor.

The panel was mindful of the time afforded to Mrs Williams to present her case. The panel considered that reasonable efforts had been made to contact Ms 5 and that Mrs Williams had been given ample opportunity to secure the live testimony of this witness, whether in person or by telephone.

In all the circumstances, the panel determined that it would be fair to admit the written statement of Ms 5 into evidence. The panel also determined that the written statement is relevant to the charges. The panel was mindful that the parties have not had the opportunity to cross examine Ms 5. The panel would determine what weight it could attribute to the statement after hearing and evaluating all of the evidence before it.

Registrant C's oral evidence (Part 2)

After Mrs Williams' evidence Registrant C was recalled to give further oral evidence.

In Ms 5's written statement she had said that Registrant C did not send the accident report forms and that he would hide these under his desk. Registrant C denied this. He told the panel that he always faxed any incident or accident forms. Registrant C said that he would gather evidence, complete a report and fax it to the appropriate authority and file. Due to his workload he would not always have time to file these documents and he kept them in a box under his desk.

[PRIVATE]. Registrant C told the panel that at the beginning of his career, when he worked in a hospital, he was trained to and did take blood samples from patients. Registrant C said that the positions he held after this meant that he did not have to take blood samples and, as a consequence, his skills and confidence in taking blood samples had diminished. Registrant C had not sought further training whilst at the Home.

In her evidence Mrs Williams said that Registrant C shared a house with Mr 2 close to the Home. Mr 2 had purchased this house. Registrant C denied that this was the case, stating that when Mr 2 visited the Home he would stay at a hotel and not at his property that Registrant C was renting from him. Registrant C told the panel that Mr 2 did not live in the house at any point after he moved in.

In response to Mrs Williams' evidence that Mr 2 told the kitchen staff to use fewer oats in their porridge, Registrant C said that Mr 2 had upgraded the cooking facilities and allowed him to recruit an excellent cook who had improved the hygiene rating to a score of 5. Registrant C said that the food was hot, appropriately prepared, served and met the needs of the residents. Registrant C told the panel that he had no recollection of Mr 2 ever giving any instruction to the kitchen staff not to use so many oats.

In her evidence Mrs Williams told the panel that when a resident's medication had ran out Registrant C instructed her to use other residents' medication. Registrant C told the panel that had there been a shortfall in medication, a nurse would have been expected to phone the GP surgery or the pharmacy for an emergency prescription. Registrant C told the panel that he did not instruct Mrs Williams to use medication that was not prescribed to a resident.

With regard to Mrs Williams' evidence that she was under the impression that the Home had arranged her professional indemnity insurance, Registrant C told the panel that he was not aware of such an agreement. Registrant C told the panel that Mrs Williams had not asked him to arrange her insurance, in any event, it would not have been possible for him to organise this on her behalf.

Assessment of witnesses

The panel heard oral evidence from eight witnesses called on behalf of the NMC and one witness called on behalf of Mrs Williams. In addition, the panel heard oral evidence from Registrant C and Mrs Williams.

Witnesses called on behalf of the NMC were:

- Ms 6 – Area Inspector for Care and Social Inspectorate Wales;
- Dr 3 – Consultant Haematologist;
- Ms 7 – Lead Nurse for Quality Improvement & Clinical Governance for Primary Care Nursing Division Primary & Community Directorate, Aneurin Bevan Health Board;
- Dr 8 – GP in Bryntirion Surgery;
- Ms 9 – Lead Nurse at Aneurin Bevan University Hospital;
- Ms 10 – Adult Safeguarding Co-ordinator;
- Ms 11 – Assistant Designated Nurse, National Safeguarding Team;
- Mr 2 – Owner of the Home.

The witness called on behalf of Mrs Williams was:

- Ms 4 – Former care assistant at the Home.

The panel considered the overall credibility and reliability of all of the witnesses it had heard from, including Registrant C and Mrs Williams.

The panel found Ms 6 to be a credible and reliable witness. She was motivated to help the panel and assisted the panel particularly in establishing the duties and responsibilities of the registered provider and manager of the Home.

Dr 3 gave evidence by telephone. The panel was of the view that Dr 3, the expert witness, was a credible and reliable witness. He was knowledgeable in respect of warfarin therapy. The panel found Dr 3 to be a balanced and witness who was careful to confine his evidence to the scope of expertise.

The panel considered Ms 7 to be a credible and reliable witness. While her evidence drew mainly on other sources, she did her best to assist the panel. The panel found Ms 7 to be consistent and of assistance in so far as the availability of district nurses to the Home and the interpretation of the warfarin chart.

The panel found Dr 8 to be a credible and reliable witness. She had reflected on the incident and provided clear evidence about her involvement at the Home and with Patient 1. She was able to give the panel information on changes in General Practice that had been made as a direct consequence of issues relating to anti-coagulation therapy in this case.

The panel was of the view that Ms 9 was a credible and reliable witness. When questioned, she accepted that there were limitations to the service provided by the anti-coagulation clinic at the time. She also provided evidence about the importance of the administration of warfarin to patients who had artificial valve replacement.

The panel considered Ms 10 to be a credible witness overall who did her best to assist the panel.

The panel found Ms 11 to be a credible and reliable witness. She was able to assist the panel in relation to Mrs Williams' professional indemnity insurance.

The panel was of the view that Mr 2's evidence was inconsistent at times and lacked credibility. He purported to have frequent lapses of memory when asked difficult questions. For example, when asked about when he took ownership of the Home and other matters at the Home, he was unable to answer. As a consequence, the panel found Mr 2 to be evasive. It was of concern to the panel that Mr 2 was unwilling to accept any responsibility for the failures at the Home. His statement that Registrant C *'did your best'* was undermined by his failure to take responsibility for his actions or omissions as a registered provider.

The panel considered that Ms 12's evidence was largely hearsay and, as a consequence, of limited assistance. The panel did however note that she did her best to assist the panel.

The panel found Registrant C's credibility to be undermined by his inability to recall key events. For example, the panel did not accept that Registrant C could not recall a time that Mrs Williams called him at home on 15 May 2015 as this would have been a significant, memorable event in the panel's view. Registrant C's credibility, in the panel's view, was further compromised by his previous and current relationship of dependence upon Mr 2 for his continued employment and accommodation. Whilst Registrant C has accepted responsibility himself and not sought to apportion blame to others, the effect of Registrant C's evidence has been to shield Mr 2 from his own responsibility, as the registered provider, for these events.

The panel had reservations to the extent to which you were a credible or reliable witness. In the panel's view, at times, you were contradictory and inconsistent in your presentation. For example, you were confident when you were recalling specific events such as a visit of the GP on 15 May 2015 and subsequent events, the pressures of being the sole registered nurse on shift at the Home and the pressures this brought. You were less credible and reliable when asked about issues that related to you, such as the arrangement for her professional indemnity insurance, and her role in sending off blood samples. Whilst you accepted all charges you faced, you were very critical of others' practice and used pejorative language about other staff at the Home. The panel noted that although you were not at the Home on a regular basis, there was evidence that you made entries in the records drawing attention to the issues raised in this case.

Having assessed all of the evidence adduced so far, the panel considered the written statement of Ms 5. The panel was of the view that limited weight should be attached to this statement as it was untested evidence.

Background, as accepted by the panel

At the time the charges arose Mrs Williams was working at the Home as a registered nurse. She was employed as a sub-contractor and worked at the Home as and when she was needed. The Home appeared to have had a stable workforce until the middle of 2014, when the ownership of the Home changed. During the period of transition a number of experienced registered nurses ceased working at the Home.

Mr 2, upon taking ownership of the Home, simultaneously implemented some major changes. These changes included disruptive building works, implementation of new electronic systems for medication and clinical records, the introduction of the 'Butterfly Project'. Mr 2 initially prohibited the use of agency staff until after the death of Patient 1, even though the Home was understaffed. He also sought to reduce the ratio of registered nurses and other care staff to residents. Registrant C was tasked with managing all of the changes and carrying out clinical duties in addition to managerial responsibilities.

On 3 February 2014 Patient 1 was admitted to the Home having been a patient at Ysbyty Ystrad Fawr Hospital (the Hospital) after a fall on 6 December 2013. Patient 1 was suffering from dementia, poor mobility and was receiving warfarin therapy due to an artificial valve replacement.

The Anticoagulation Clinic (the Clinic) had listed artificial valve replacement as the indication for the use of warfarin for Patient 1, with a target INR of 3-4.5. In respect of residents requiring warfarin therapy, the Home had a duty to ensure that a blood sample was taken from the resident. Once the blood sample was collected this should have been sent to the GP surgery with a blue slip. The sample would then go to the pathology laboratory and to the Clinic for testing. Once the Clinic had determined the resident's INR score this would be notified to the GP surgery and the Home to set the correct dosage of warfarin. If there was a failure to submit a correctly labelled blood sample, the Clinic would inform the Home after the second time this happened. If there

was a third failure, the Clinic informed the Home and the GP surgery and suspend the patient from the service.

Warfarin can be given for treatment of deep vein thrombosis (DVT), pulmonary embolism, or arterial thrombosis/embolism. It may also be used to prevent formation of blood clots within the heart in atrial fibrillation or for those with artificial valve replacements. In respect of Patient 1 and Patient 2, warfarin was used as preventative treatment to reduce the risk of blood clots. If warfarin is not administered correctly, or discontinued or poorly monitored there is an increased risk of blot clots.

Between February and June 2014, the Home took regular blood samples and sent them for INR testing and the correct warfarin dosing regime was followed. The process for taking blood, receiving INR results and warfarin dosage broke down after this time.

Patient 1

On 14 July 2014 no dosing instruction was provided by the Anticoagulation Clinic because the blood sample was incorrectly labelled. On 30 July 2014 the Anticoagulation Clinic (the Clinic) sent a letter to the GP surgery and to the Home informing them that two of Patient 1's INR readings had been missed. On 6 August 2014 a blood sample was sent to the Clinic, this sample was insufficient for analysis and no INR was provided. On 8 August 2014 the Clinic provided a current INR for Patient 1.

On 19 September 2014 Patient 1 was admitted into hospital and treated for a suspected chest infection. On 6 October 2014 Patient 1's GP spoke with the Home about alternative methods of obtaining INR and recommended that they speak to the Clinic. A repeat INR was not obtained by the Home on three occasions as blood samples were either insufficient or incorrectly labelled. Mrs Williams recorded that warfarin was not dosed.

On 8 October 2014 there was entry made by Registrant C in which he stated *'I will source an INR monitor'*. On 9 October Patient 1 was admitted to hospital with bradycardia, a raised temperature and reduced mobility after Mrs Williams contacted HealthCall. Bloods for INR were taken and Patient 1 was monitored daily until she was discharged on 15 October 2014.

On 17 October 2014 you recorded in Patient 1's notes that a sample was not taken for an INR blood sample due to 'poor vein condition'. On 28 October Mrs Williams recorded that she sent an INR but no record of this was found. On 30 October 2014 in a daily handover of Patient 1 there was an entry which stated that no results from the INR had been received at the Home. On 30 October 2014, a nurse not connected with these proceedings, recorded that she had not given the warfarin to Patient 1 as she could not find the correct dosage.

On 3 November 2014, in a handover entry in Patient 1's records, there was a note to say that there was no result for the INR. On 1 December 2014 a letter was received by Patient 1's GP from the Clinic stating that Patient 1 had missed two INR checks. On 9 December a letter was sent from the Clinic to the Home about two missed appointments for the INR check. Mrs Williams recorded that a blood sample was taken from Patient 1 for an INR on 26 December 2014, however no record of this was found. On 6 January 2015 an entry was made by Registrant C which stated 'No change. Warfarin given. Another entry was made by a registered nurse, not connected with these proceeding, at the Home on 8 January 2015 which stated that warfarin was given to Patient 1.

On 26 February 2015, in Patient 1's handover notes, Mrs Williams recorded *'Was for 4mg warfarin but no 1mg. There was in diary for yesterday to chase up but not done.'* On 27 February 2015 Mrs Williams made a diary entry which stated:

> *'There are no 1mg tablets of warfarin for Patient 1. On looking back this should have been chased up but it wasn't carried forward to the 26 February, so I did not*

do it either I gave her 3mg, so can you please let the GP know and order 1mg tablets.'

On 2 March 2015 there was a diary entry by Mrs Williams which stated: *'Please need blood bottles urgently!! No blood bottles available.'* On 3 March 2015 an INR blood sample was taken from Patient 1, but according to the GP records this was an insufficient sample. The GP requested a further sample which was not received until 11 March 2015. Mrs Williams recorded that she was unable to administer 4mg of warfarin as correct denomination were not ordered as previously requested.

On 11 March 2015 Patient 1 was seen by the GP when an INR was taken and recorded in the GP records. No dosing instructions were sought from the Clinic. On 13 March 2015 Mrs Williams recorded in the diary: *'We really need to find out what to do with warfarin. I tried coag clinic all day no answer.'*

On 26 March 2015 a GP recorded that a blood sample had been taken from Patient 1 and to continue with the 3mg while this is looked into. On 31 March 2015 Patient 1 was seen by the GP and the issue of warfarin was not raised by Mrs Williams who accompanied the GP.

On 1 April 2015 warfarin was withheld by Mrs Williams as *'no instruction'*. Warfarin was also withheld from Patient 1 on 2 April 2015, it was noted that *'Warfarin withheld until bloods are back.'* On 3 April Registrant A entered in the patient record *'warfarin was omitted as per instruction via to INR* clinic'. On 21 April 2015 an entry stated that there was no blue slip for Resident 1.

On 8 May 2015 a letter from the Clinic was sent to the Home stating that Patient 1 had missed two INR samples. A letter was also sent to the GP by the Clinic stating that Patient 1 had missed three appointments and had been suspended from the Clinics service. This letter was forwarded to the incorrect GP surgery.

Between 31 March 2015 and 14 May 2015 inclusive, with the exception of two occasions, the only registered nurse to have administered warfarin to Patient 1 would appear to be Registrant C. There was no current INR dosage in place at this time.

On 15 May 2015 Mrs Williams recorded that Patient 1 was complaining of calf pain and a DVT was suspected. Mrs Williams contacted Patient 1's GP. The GP attended the Home and examined Patient 1. Upon examination the GP did not think that there was evidence of a DVT in Patient 1's leg. The GP also recorded that warfarin had been stopped by the hospital. Mrs Williams telephoned Registrant C while he was at home to check whether Patient 1 was having warfarin and he confirmed that he had been giving it. This was confirmed by Mrs Williams' notes. Mrs Williams contacted the GP again to tell her that warfarin had not been stopped and that Patient 1 had been receiving this throughout.

On 16 May 2015 Patient 1 became more lethargic and unresponsive. She was examined by an out of hours GP and no action was taken. On 18 May 2015 Patient 1 was admitted to the Cwm Taf University Health Board Hospital and diagnosed with an ischaemic right leg. In the medical admission, warfarin was recorded as being recently stopped. On 19 May 2015 Patient 1 died. It was certified that her cause of death was:

> *'1a Acute Kidney Injury.*
> *1b Rhabdomyolysis*
> *1c Ischaemic Limb*
> *2 Mitral Valve replacement'*

While Mrs Williams admitted charge 8, the panel considered that it needed to determine how Mrs Williams' conduct contributed to the death of Patient 1.

Ms 9 described the risks associated with stopping warfarin in patients with artificial heart valves. Dr 3's expert evidence was that stopping warfarin for patients who have an artificial heart valve replacement increases the risk of blood clots. Dr 3's conclusion was

that on the balance of probabilities the death of Patient 1 was caused by the omission of warfarin from 3 April 2015 until her admission into hospital.

Patient 2

Following the investigation into Patient 1's care, further concerns arose in relation to the Home's management of warfarin therapy for Patient 2. Patient 2 was a resident at the Home from 10 March 2015. She had a medical history of vascular dementia and Type 2 diabetes. Patient 2 suffered from atrial fibrillation which also required life-long anti-coagulation therapy. Patient 2 was required to have a daily dose of warfarin informed by her INR result, as determined by regular blood samples.

Upon reviewing Patient 2's care plan it was found that there were no risk assessments in place for the management of Patient 2's warfarin therapy and monitoring. Furthermore, there was no evidence of a named nurse who had overall responsibility for Patient 2's care.

Between 19 March 2015 and 7 July 2015 five blood samples were taken by Mrs Williams. None of these blood samples were processed by the Clinic because they did not have a blue slip attached. On three occasions no blue slip was sent because there were no blue slips available at the Home. As a consequence, Patient 2's dosage was not informed by a current INR. Delays in the blood samples being taken were due to a shortage of staff suitably trained in phlebotomy at the Home.

The GP actioned the INR results that were processed incorrectly and contacted the Clinic on 27 March 2015, 9 April 2015 and 20 May 2015. The GP arranged for dosing slips to be sent to the Home. At the GP's request, on three occasions between 31 March 2015 and 17 July 2015, Registrant A, Mrs Williams and another registered nurse not connected with these proceedings, contacted the Clinic for advice. This was not followed up appropriately.

On 18 March 2015 and 10 April 2015 Mrs Williams withheld Patient 2's warfarin without any recorded clinical justification for stopping it. Furthermore, Patient 2's eMAR indicated that on 14 June 2015 Mrs Williams administered 9mg of warfarin to Patient 2. The panel was of the view that this was an anomaly associated with how the eMAR recorded the dosage given.

On 9 April 2015 the GP saw Patient 2 and was informed that warfarin had been stopped by Registrant A. There was no entry made in the nursing notes about the clinical justification. Further, it is not documented that the GP was informed that warfarin had been stopped since 1 April 2015. Warfarin was withheld from Patient 2 on 1 April 2015 and 5 April 2015 by Registrant A and another registered nurse not connected with these proceedings. Warfarin was also withheld from Patient 2 on 8 and 9 April 2015 by Registrant A and Mrs Williams.

From 9 April 2015 a current dosing regime was being used and Registrant C incorrectly continued to administer 3mg of warfarin instead of 2mg. A blood test was due to be taken on 23 April 2015.

Context/Wider system failures

It was evident that the Home was working in a context of wider system failures in that:

- The Clinic discharged patients when three adequate blood samples were not received for a patient. This practice was applied to all patients, including vulnerable patients such as Patient 1 (with an artificial valve replacement), who required lifelong warfarin therapy.

- The Clinic sent some letters relating to non-receipt of blood samples for Patient 1 to her previous GP surgery.

- The GP surgery was informed on a number of occasions that neither Patient 1 nor Patient 2 had up to date INR dosages but continued to prescribe warfarin them.

- There was an absence of professional curiosity on the part of the GP surgery, during annual reviews and notably when Patient 1 was seen with a petechial rash on 31 March 2015.

- The GP surgery failed to identify anomalous INR results for their patients on warfarin therapy.

- No alternatives were offered by the GP surgery or the Clinic to the Home when they were aware that there were difficulties in obtaining blood from Patient 1.

Professional indemnity insurance

The sub-contractor agreement between the Home and Mrs Williams is dated 1 June 2014. This agreement was signed by Mrs Williams and Registrant C on 21 June 2014. Neither Mrs Williams nor Registrant C could say to whom the witness signature belonged. Mrs Williams worked at Ty Pentwyn care home which was owned by Mr 2. Mr 2 asked Mrs Williams to work at the Home as it was short staffed.

During an investigatory interview on 21 October 2016, Mrs Williams stated that she was self-employed at the Home between 1 October 2014 and 9 May 2015. Mrs Williams also stated that she did not have a contract. In the interview, Mrs Williams said that she did not have indemnity insurance. In her evidence, Mrs Williams stated that she told the Home that she would not work there if she had to arrange her own indemnity insurance and submit her own invoices.

While Mrs Williams had admitted charge 13, the panel considered that it needed to determine the circumstances in which Mrs Williams came to have no professional

indemnity insurance. The panel was of the view that Mrs Williams knew that she was required to have indemnity insurance (as
per the Code), whilst working for the Home in the capacity of a self-employed worker. The panel concluded that Mrs Williams also knew that she did not have indemnity insurance whilst she was working at the Home.

Submission on misconduct and impairment

NMC submissions

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 Mrs Williams', Registrant A's, and Registrant C's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

On behalf of the NMC, Mr Kennedy invited the panel to take the view that Mrs Williams', Registrant A's, and Registrant C's actions amount to a breach of *The code: Standards of conduct, performance and ethics for nurses and midwives 2008* (the 2008 Code) and *The Code: Professional standards of practice and behaviour for nurses and midwives 2015* (the 2015 Code). (The charges in this case span a period which covers both of the codes, the 2015 Code applied after 31 March 2015). He then directed the panel to specific paragraphs and identified where, in the NMC's view, Registrant A's, Mrs Williams' and Registrant C's actions amounted to breaches of the 2008 Code and the 2015 Code. Mr Kennedy further submitted that these breaches and Mrs Williams', Registrant A's and Registrant C's actions amounted to serious misconduct.

Mr Kennedy referred the panel to the case of *Roylance v GMC (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...'*

He then 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. Mr Kennedy referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).*

Mr Kennedy submitted that Registrant A's failings amount to misconduct. He submitted that her failings relate to basic areas of nursing practice, namely, medication administration, record keeping, communication and escalation. Further, Mr Kennedy submitted that Registrant A's failings occurred over a considerable period of time and are serious, particularly in that some of her failings contributed to the death of a patient.

Due to Registrant A's non-engagement with the NMC, an enquiry had been made to establish whether she is currently working as a registered nurse. On 30 August 2019 the NMC sent an email to Registrant A's last known employer, Gibraltar Nursing Home, to enquire as to whether she was still working for them.

Mr Kennedy informed the panel that the NMC had received an email from the HR department at Gibraltar Nursing Home dated 1 October 2019 which stated the following in response to the NMC's email on 30 August 2019:

1. *Does Registrant A still work with you? If yes please state when she commenced her employment. If no please confirm when she left and why?* ***Yes she still works for Gibraltar Nursing Home. Start date: 29/05/2017***

2. *What was or is Registrant A's role?* ***She works as a Registered Nurse.***

3. *Please provide your comments on Registrant A's clinical practice.* ***When she came to work with us she was very honest about her NMC referral from her previous role. She makes unbelievable connections with the residents that live at the home and can lead the care team effectively. She started on shadowed medication and now completes this herself. Her clinical performance is up there she just lacks confidence.***

4. *Please also advise if there are or has been any concerns regarding Registrant A's Practice/disciplinary issues?* ***Any medication errors have been picked up***

and sorted through Audits. She does not make repetitive mistakes and does not make any more errors than other registrants working at the home. No disciplinary issues.

Mr Kennedy submitted that it was difficult to gauge insight, remediation or remorse from the information available. The information from her employer is insufficient to assess her level of insight or the risk of repetition of her misconduct. Mr Kennedy invited the panel to conclude that Registrant A's fitness to practise is currently impaired on public protection and public interest grounds.

In respect of Mrs Williams, Mr Kennedy informed the panel that, prior to this referral, the NMC had received a separate referral in relation to her practice. The charges related to abuse towards patients and dishonesty, and a substantive hearing took place in relation to these matters in December 2015. Mr Kennedy drew the panel's attention to a letter dated 12 December 2016 which set out the decision of a substantive order reviewing panel:

'The panel decided to revoke the current suspension order with immediate effect in accordance with Article 30(2) and 30(4) (e).

This is the second review of a suspension order originally imposed by a panel of the Conduct and Competence Committee on 8 December 2015 for 9 months. A reviewing panel on 2 September 2016 imposed a 3 month suspension order. The current order is due to expire on 7 January 2017.'

Mr Kennedy submitted that Mrs Williams' failings amount to misconduct. He submitted that her failings relate to medication administration, communication, labelling, record keeping, escalation and professional practice. Mr Kennedy submitted that Mrs Williams' failure to ensure that she gave the right dose of warfarin was serious. Further, Mrs Williams withheld warfarin despite knowing that it was needed to prevent clotting. Mr Kennedy submitted that Mrs Williams' failures in sending the wrong forms with blood

samples, failure to follow up in relation to samples which had been sent and failure to escalate issues contributed to the death of a patient.

Mr Kennedy further submitted that it was a requirement to have professional indemnity insurance and Mrs Williams' failure to ensure this was in place amounted to misconduct.

Mr Kennedy submitted that Mrs Williams has not shown any evidence of remediation as she no longer works as a nurse. Mr Kennedy also submitted that, although Mrs Williams should be aware of the meaning of insight, having demonstrated this at her previous NMC hearing, she has demonstrated very little insight in this case. She has continued to deflect blame, and he submitted that there is no evidence to show that she understands the ways in which she has breached the trust placed in her by others. Mr Kennedy submitted that she has not recognised the wider effect of her actions on the nursing profession and has demonstrated attitudinal problems. Accordingly, Mr Kennedy invited the panel to conclude that Mrs Williams' practice is impaired on public protection and public interest grounds.

In relation to Registrant C, Mr Kennedy submitted that the charges arose from his position as home manager and show failures in relation to communication, delegation of duties to others, supervision of others and patient care. Registrant C did not have a clear oversight of what was happening in the Home in relation to the administration of Warfarin to 2 patients and in relation to weight loss and fluid intake for another. Registrant C was in a senior role at the Home and ultimately, he was responsible for all that happened. Mr Kennedy submitted that the charges in relation to Patient 1 are particularly serious as Registrant C's behaviour contributed to her death. Mr Kennedy submitted that all of the charges against Registrant C amount to misconduct.

Mr Kennedy acknowledged that the risk of repetition of Registrant C's clinical failings had diminished, as he had been working as a nurse without incident for the past three years. Registrant C has also undertaken training and provided reflective accounts and references. Mr Kennedy submitted that Mrs Jones' conduct was remediable, and that it

has been remediated to a great extent, but there remain doubts in relation to the risk of repetition due to Registrant C's susceptibility to pressure from Mr 2.

Mr Kennedy submitted that Registrant C had fallen so far below the standards expected of a registered nurse that the public would expect the NMC to take some form of action. A sanction can only be applied if current impairment is found. He therefore concluded that a finding of current impairment is necessary is on public interest grounds.

Further evidence from the registrants

Registrant C provided a further bundle of documents which included the following:

- Training certificates;
- A reference from his current employer;
- References from a friend and from colleagues;
- Reflective statements.

Registrant C also gave further evidence under affirmation and called Ms 12 as a witness.

Mrs Williams gave further evidence under affirmation and provided the following documents:

- A reflective statement;
- A reference from the Managing Director of Connective Care Education dated 3 October 2019.
- A reference from Mrs Williams' course tutor.

Mrs Williams also made an application to call Ms 5 as a witness via telephone.

Decision and reasons on application pursuant to Rule 31 (telephone evidence)

On day 24, the panel heard an application made by Mrs Williams pursuant to Rule 31, for Ms 5 to give evidence by telephone. She told the panel that Ms 5, as set out in her earlier application was unable to take time off work, but she would be available to give evidence by telephone at 14:30.

Mr Kennedy did not oppose this application.

Ms Collins did not oppose this application.

The panel accepted the advice of the legal assessor.

The panel considered that it is fair to hear from Ms 5 by telephone in the circumstances. Once it had heard from the witnesses, the panel would determine what weight to attach to this evidence.

Ms 5's evidence

Ms 5 referred to her earlier statement adduced by Mrs Williams at the facts stage.

In her evidence she told the panel that Mrs Williams was one of the best nurses at the Home and she always tried her best to ensure that the residents were cared for.

Mrs Williams' evidence

In her evidence Mrs Williams referred the panel to her written reflective statement. She told the panel that she has been unable to attend any training courses in relation to anti coagulants and warfarin therapy because she needed an active NMC PIN.

Mrs Williams told the panel that she is no longer working as a registered nurse and that she is currently undertaking training in education. Mrs Williams told the panel that she did not undertake this training as a result of these proceedings, and that she has been trying to get into education for the past seven years.

Mrs Williams expressed remorse for her failings and drew the panel's attention to the reference from her manager, in particular, about her good character.

In response to the panel's determination on facts, Mrs Williams said that she is now proficient in IT and that she is happy to provide copies of all of her bills which are not in her name.

During cross examination, Mrs Williams accepted that due to the amount of time since she last practised as a nurse, she would need to undertake a Return to Practice course if she decided to return to nursing. Mrs Williams told the panel that she has not kept her nursing skills up to date, but she doesn't think that she would have any problems with returning to practice, other than a lack of confidence.

In response to questions from the panel, Mrs Williams accepted that she is currently impaired and that she would need some form of supervision or undertake a back to work programme.

Evidence of Ms 12

Ms 12 is the registered manager at Ty Pentwyn care home (Home 2) and is a registered nurse. She told the panel that she has been Registrant C's manager since January 2016. She employed him after he was recommended by Mr 2 as being a suitable candidate for the position as a registered nurse. Ms 12 told the panel that it was entirely her decision to offer Registrant C the post and Mr 2 had no involvement with this decision. She said that Registrant C possessed a kind and caring nature, essential to working in a care home.

Ms 12 told the panel that when Registrant C commenced employment at Home 2, due to the issues at the Home, he lacked confidence in his abilities as a nurse. Ms 12 said that Registrant C has always kept her informed about the NMC proceedings. Following the imposition of an interim conditions of practice order by the NMC, Ms 12 said she fully supported Registrant C. Ms 12 worked closely with Registrant C, creating a Personal Development Plan (PDP) and providing supervision.

Ms 12 said that she was impressed by Registrant C's attitude in that he proactively sought training in respect of anti-coagulation medication and diabetes management. Ms 12 carried out regular supervisions with Registrant C and noted that his confidence began to gradually increase. With the increase in Registrant C's confidence, Ms 12 started to increase his workload and allocate more residents for him to manage. In addition to this, Registrant C was responsible for the supervision of care staff.

Ms 12 told the panel that she has no concerns about Registrant C's clinical competence. She said that the Home 2 does not currently have any residents requiring warfarin therapy. Ms 12 said that if residents requiring warfarin therapy were accepted by Home 2, that she would arrange update training for all staff. Ms 12 told the panel that she carries out monthly audits on care plans and she has no concerns about Registrant C's practice in this regard. Following a recent inspection, Registrant C's care plans were found to be exemplary. Ms 12 said that she would be happy to write a reference attesting to Registrant C's skills as a nurse.

When asked about Registrant C's friendship with Mr 2, and whether she was aware of this relationship impacting his abilities as a nurse, Ms 12 said that she was not aware of any issues and has no concerns about this.

Registrant C's evidence

In his evidence Registrant C told the panel that he accepted that the charges found proved amounted to misconduct.

Registrant C told the panel that since the Home closed, he has been working at Home 2 as a registered nurse. Registrant C informed the panel that this was the sister care home of the Home and owned by Mr 2. After the closure of the Home, Registrant C said that he contacted the manager of Home 2 who agreed to interview him for the post as a registered nurse. Registrant C said that Mr 2 had no involvement with the recruitment process.

Registrant C told the panel that had successfully completed a Personal Development Plan in compliance with an interim conditions of practice order. He also told the panel that he has successfully completed specific training in anti-coagulation medication, developing as a worker, stress management and safeguarding vulnerable adults, as well as other relevant training in order to keep his nursing skills up to date.

Registrant C referred the panel to a number of references and testimonials from his colleagues who attest to his good character and clinical competence. Registrant C also provided two recent written reflections and gave examples of how he has demonstrated good practice and overcome difficult situations in order to prioritise patient care.

Registrant C accepted that his practice was impaired at the time the charges arose and expressed remorse for the impact on the residents at the Home, his colleagues and the profession as a whole. Registrant C told the panel that he has worked since these charges without incident and had a long unblemished career prior to these proceedings. Further, Registrant C assured the panel that he has no intention of working as a care home manager in the future.

Ms Collins' submissions

Ms Collins submitted that the vast majority of the charges found proved are serious and do amount to misconduct, as accepted by Registrant C in his evidence.

Ms Collins submitted that Registrant C has fully engaged with local investigations and these NMC proceedings. She submitted that Registrant C has considerable insight into his failings and he has demonstrated deep-felt remorse for his actions and omissions and the impact on the residents, their families, his colleagues and the profession as a whole. Registrant C has not sought to deflect blame and accepted full responsibility.

Ms Collins submitted that Registrant C has fully addressed the areas of clinical concern. Registrant C has completed relevant training, kept his nursing skills up to date and worked at Home 2, under supervision, since these charges arose without incident.

With regard to Registrant C's friendship with Mr 2, Ms Collins submitted that there is no financial or other tie which prevents him from acting independently as a nurse. Registrant C was employed at Home 2 because Ms 12 could see his potential as a nurse and because he met her expectations during his probationary period.

Ms Collins invited the panel to find that Registrant C is no longer impaired on the ground of public protection. He has fully reflected on his misconduct and provided evidence of remediation.

With regard to public interest, Ms Collins submitted that it has been almost four years since the charges arose, Mrs Jones has made full and in depth admissions during the local investigations and to the NMC. Registrant C has been working as a nurse since January 2016 and been able to demonstrate that he can practise safely as a nurse.

Ms Collins addressed the panel on the charge relating to contribution to a patient's death. She submitted that if a nurse has fully remediated clinical failings, but a finding of impairment is made on public interest grounds because of an outcome, this may be contrary to encouraging nurses to be open and honest when things go wrong.

Notwithstanding the seriousness of these matters, Ms Collins submitted that through no fault of Registrant C, the NMC investigation has taken almost four years and he has demonstrated that he is fit to practise. She submitted that the public do not seek retribution, they seek confirmation that a nurse is safe to practise. Ms Collins invited the panel to find that Registrant C is not currently impaired on the ground of public interest.

Panel decision on misconduct

The panel has accepted the advice of the legal assessor which included reference to a number of authorities which are relevant, these included: *Roylance*; *Grant, Cohen v GMC [2008] EWHC 581 (Admin)* and *Yeong v GMC [2009] EWHC 1923 (Admin).*

The panel assessed the evidence of Ms 5 and Ms 12.

The panel was mindful that the majority of Ms 5's evidence was relevant to the facts stage of the proceedings that has already been determined. Further, much of Ms 5's evidence related to third party evidence. The panel noted that Ms 5 was able to provide evidence about Mrs Williams' practice but it noted that Ms 5, herself, was not a registered nurse. The panel determined that Ms 5's evidence, given the above, was of limited assistance.

The panel was of the view that Ms 12 was a credible, reliable and honest witness. She was able to provide a relevant and detailed account of Registrant C's current practice as a registered nurse. Ms 12 was also able to assist the panel with matters relating to Mr 2.

The panel followed 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, Mrs Williams', Registrant A's and Registrant C's fitness to practise is currently impaired as a result of that misconduct.

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of the 2008 Code and the 2015 Code.

The panel, in reaching its decision, was mindful of the overarching objectives of the NMC; it 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 Mrs William's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to breaches of the 2008 Code and the 2015 Code. Specifically:

The 2008 Code:

Introduction

• work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community
• provide a high standard of practice and care at all times
• be open and honest, act with integrity and uphold the reputation of your profession.

21 You must keep your colleagues informed when you are sharing the care of others.

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

28 You must make a referral to another practitioner when it is in the best interests of someone in your care.

35 You must deliver care based on the best available evidence or best practice.

42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.

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

62 You must have in force an indemnity arrangement which provides appropriate cover for any practice you undertake as a nurse or midwife in the United Kingdom.

The 2015 Code:

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

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

6.1 make sure that any information or advice given is evidence based including information relating to using any health and care products or services

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice

13.2 make a timely referral to another practitioner when any action, care or treatment is required

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

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

The panel appreciated that breaches of the Codes do not automatically result in a finding of misconduct. However, the panel was of the view that the charges found proved against Mrs Williams, individually (with the exception of charge 7) and cumulatively amounted to serious misconduct.

The panel found that Mrs Williams' misconduct related to fundamental nursing skills and persisted over a significant period of time. In addition to this, in the panel's assessment, there were pervasive attitudinal concerns arising out of the pattern of behaviour during

these proceedings and evident from the substantive hearing that concluded in December 2015.

The panel found that Mrs Williams' actions and omissions were serious and in breach of the fundamental tenets of the profession.

The panel was of the view that any registered nurse should have been aware of the reason for administering warfarin, particularly where a patient had undergone an artificial valve replacement. Mrs Williams had a professional responsibility to ensure that regular blood samples were taken and sent to the Clinic for residents who needed warfarin therapy. She also had a duty to ensure that the residents in her care who needed warfarin therapy were receiving the correct dosage in accordance with a current INR.

Mrs Williams repeatedly failed to administer the correct dosage of warfarin. The panel was of the view that Mrs Williams was aware of the risks associated with stopping warfarin therapy but complied with Registrant A's instruction to withhold warfarin and failed to challenge that instruction. Mrs Williams failed to follow up on INR results or appropriately escalate her concerns when she had been taking INR blood samples but not received an INR dosage instruction.

Mrs Williams made a note in the diary, stating that withholding drugs is a 'POVA', but she failed to follow this up when no action was taken by others. The panel considered that Mrs Williams' lack of professional curiosity and failure to escalate her concerns amounted to misconduct.

With regard to record keeping, the panel noted that the primary communication between the nurses was written entries in the diary, handover and patient notes. The panel was of the view that Mrs Williams' failure in keeping clear and accurate records amounted to serious misconduct because of the impact that this had on patient care.

The panel determined that Mrs Williams' actions and omissions in contributing to the death of a patient amounted to serious misconduct.

The panel was of the view that Mrs Williams' actions fell short of the standards to be expected of a registered nurse. Fellow registered nurses and the public are likely to consider Mrs Williams' actions and omissions deplorable. Accordingly, the panel determined that Mrs Williams' actions and omissions amounted to misconduct.

Decision on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To 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 judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) 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.

Mrs Justice Cox went on to say in Paragraph 76:

> I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.
>
> > 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 finds that limbs a, b and c are engaged in Mrs Williams' case.

In relation to insight, the panel had regard to Mrs Williams' reflective statement and her oral evidence. The panel considered that Mrs Williams sought to blame others for the failings at the Home and has not demonstrated any meaningful insight or remorse into her actions, omissions and responsibilities. In her evidence, under cross examination, Mrs Williams did not acknowledge any breach of the trust that had been placed in her. She continued to deflect blame and did not recognise her failings. It was only in response to the panel's questions that Mrs Williams appeared to recognise that she was currently impaired. The panel considered that Mrs Williams' self-serving approach and intention to deflect blame to her colleagues are inconsistent with insight. Accordingly, the panel determined that Mrs Williams has demonstrated limited insight.

With regard to remorse, the panel considered that Mrs Williams appeared to demonstrate some remorse but she has failed to address the full impact of her misconduct on all of the residents at the Home, her colleagues and the profession as a whole.

The panel had regard to the previous determination and noted that these charges arose before that substantive hearing. The panel noted with concern that the misconduct proved in this referral demonstrated that when viewed in the context of the earlier referral, there was, cumulatively, an extensive pattern of repeated misconduct between March 2014 and July 2015. The panel considered that this was indicative of an attitudinal problem on the part of Mrs Williams. At the second review of the substantive order (of suspension), Mrs Williams was considered to have developed significant insight. However, this panel is concerned that she has been unable to recognise the need for, or to demonstrate comparable insight into her misconduct which is the subject of the present referral.

The panel also noted Mrs Williams' lack of insight in relation to the need for indemnity insurance. Further, Mrs Williams' presentation during these proceedings has been selective and evasive when faced with challenging questions.

Accordingly, the panel determined that while Mrs Williams' clinical failings are potentially remediable, it noted that attitudinal issues are, by their very nature, difficult to remediate.

Mrs Williams is not currently working as a nurse and has not practised as a nurse for more than three years. The panel had no evidence that Mrs Williams has remediated any of her clinical failings. Further, the panel was of the view that there was no evidence of remediation with regard to the attitudinal concerns Mrs Williams has demonstrated. The panel considered that these attitudinal concerns have been persistent through Mrs Williams' conduct in these proceedings.

The panel concluded that, given the lack of insight, remorse and remediation, and what appears to have been a more extensive pattern of misconduct over a lengthy period, there is a significant risk of repetition of the misconduct. The panel therefore concluded that Mrs Williams does present a risk to members of the public. Accordingly, the panel determined that Mrs Williams is currently impaired on the ground of public protection.

The panel took account of the nature of Mrs Williams' misconduct, and the seriousness of the charges, in particular her contribution to the death of Patient 1. In the judgement of the panel, public confidence in the profession and the regulator would be undermined if a finding of impairment was not made in light of the matters found proved.

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, public confidence in the profession and the regulator would be undermined if a finding of impairment was not made in light of the matters found proved.

Having regard to all of the above, the panel determined that Mrs Williams' fitness to practise is currently impaired on public protection and public interest grounds.

Determination on sanction

Having determined that Mrs Williams' fitness to practise is impaired, the panel has considered what sanction, if any, it should impose. The panel has considered this case carefully and has decided to make a striking-off order. The effect of this order is that the NMC register will show that Mrs Williams' name has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence in this case including the evidence and submissions of Mrs Williams, the evidence presented by the NMC and Mr Kennedy's submissions.

In his submissions, Mr Kennedy informed the panel that the NMC sanction bid was that of a striking off order.

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 Sanctions Guidance (SG) published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgment.

Before making its decision on the appropriate sanction, the panel established the aggravating and mitigating features in Mrs Williams' case.

The panel considered the aggravating features to be:

- Mrs Williams' insight into her failings was limited;

- No evidence of remediation or remorse;
- A pattern of behaviour that was indicative of a deep seated attitudinal issue;
- Mrs Williams' failures were wide ranging, fundamental in nature and persisted over a significant period of time;
- Mrs Williams' actions and omissions caused actual patient harm and in relation to Patient 1, contributed to her death;
- Mrs Williams' conduct placed other residents at risk of harm.

The panel considered the mitigating features to be:

- Difficult personal circumstances at the time the charges arose;
- Mrs Williams' was at the Home during a time of significant disruption and change;
- In relation to warfarin therapy, there were systematic failures, namely, the anticoagulation clinic and the GPs failure to follow up when blood samples were missing/inadequate;
- In relation to warfarin therapy, there were systematic failures, namely, the anticoagulation clinic's and the GPs' failure to follow up when blood samples were missing/inadequate;
- Mrs Williams worked at the Home intermittently.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the charges found proved in this case. 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, the panel took into account the SG, 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 bore in mind that it had found at the impairment stage that there was a continuing risk of repetition due to Mrs Williams' lack of insight and remediation. The panel therefore was

clear that Mrs Williams' impairment was not at the lower end of the spectrum. A caution order would be manifestly inappropriate in view of the seriousness of the misconduct found and also in view of the panel's finding on impairment. A caution order would not maintain public confidence in the profession or in the regulator. Therefore, the panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Williams' registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. It had regard to the SG and the following factors:

> *'Conditions may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):*
>
> - *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*
> - *the nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision*
> - *patients will not be put in danger either directly or indirectly as a result of conditional registration*
> - *the conditions will protect patients during the period they are in force*
> - *it is possible to formulate conditions and to make provision as to how conditions will be monitored.'*

The panel concluded that a conditions of practice order would not be appropriate in the circumstances of Mrs Williams' case. Mrs Williams is not currently working as a registered nurse and has not done so since the charges arose. She has informed the panel that she has no intention of returning to clinical nursing but she needs her PIN to remain active in support of her qualification in education. The panel noted that whilst

some of the misconduct found gave rise to identifiable areas of Mrs Williams' practice which were capable of retraining, this was eclipsed by the seriousness of Mrs Williams' attitudinal concerns which she presents. In theory, conditions of practice could be formulated to address the clinical failures. However, the panel found that in Mrs Williams' case there are serious attitudinal problems, which the panel do not consider could be addressed by a conditions of practice order. Therefore, the panel considered that conditions of practice would be wholly insufficient to protect the public or mark the seriousness of the misconduct in this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel took into account the SG, in particular:

> *'This sanction may be appropriate where the misconduct is not fundamentally incompatible with continuing to be a registered nurse or midwife in that the public interest can be satisfied by a less severe outcome than permanent removal from the register. This is more likely to be the case when some or all of the following factors are apparent (this list is not exhaustive):*
>
> - *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 considered that Mrs Williams' misconduct had placed patients at significant risk of harm. It bore in mind its findings that there is a high risk of the misconduct being repeated due to Mrs Williams' lack of insight and remediation. This would place patients at unwarranted risk of harm. The panel determined that Mrs Williams' misconduct was a significant departure from the standards expected of a registered nurse. The panel considered that Mrs Williams' conduct was not a single instance but was an extensive pattern of repeated misconduct over a considerable period of time, which in the panel's view, was demonstrative of deep-seated attitudinal problems.

The panel went on to consider a striking-off order, the panel took note of the following paragraphs of the SG:

'This sanction is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional, which may involve any of the following factors.

- *A serious departure from the relevant professional standards as set out in key standards, guidance and advice.*
- *Doing harm to others or behaving in such a way that could foreseeably result in harm to others, particularly patients or other people the nurse or midwife comes into contact with in a professional capacity. Harm is relevant to this question whether it was caused deliberately, recklessly, negligently or through incompetence, particularly where there is a continuing risk to patients. Harm may include physical, emotional and financial harm. The seriousness of the harm should always be considered.*
- *Abuse of position, abuse of trust, or violation of the rights of patients, particularly in relation to vulnerable patients.*
- *…*
- *…*
- *…*
- *Persistent lack of insight into seriousness of actions or consequences…'*

The panel determined that Mrs Williams' conduct in respect of the charges found proved were significant departures from the standards expected of a registered nurse. The panel was of the view that Mrs Williams' failure to ensure she had indemnity insurance was exacerbated by a previous finding of dishonesty. Further, the panel determined that Mrs Williams' persistent lack of insight demonstrated a lack of integrity, attempts to deflect blame, and pejorative comments about her colleagues all demonstrated a deep seated attitudinal problem. The panel determined that this pattern of behaviour and lack of insight made it incompatible for Mrs Williams to remain on the NMC register. The

panel determined that Mrs Williams' conduct was so serious that to allow her to continue practising as a nurse would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel was clear that a suspension order would not be a sufficient, appropriate or proportionate sanction to either protect the public or satisfy the public interest. In the panel's judgement, public confidence in the profession and the NMC as a regulator would be undermined by the imposition of a suspension order.

Balancing all of these factors and after taking into account all of the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. It is the only order sufficient to protect the public and meet the public interest in declaring and upholding the proper standards in the nursing profession and to meet the public interest in maintaining public confidence in the nursing profession and the NMC as its regulator.

Accordingly, the panel directs that Mrs Williams' name be removed from the NMC register.

Determination on Interim Order

Mr Kennedy reminded the panel that the substantive order will not take effect until after the 28 day appeal period. The panel has considered the submissions made by Mr Kennedy that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the

seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. To do otherwise would be incompatible 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 the suspension order 28 days after Mrs Williams is sent the decision of this hearing in writing.

That concludes this determination.