**Nursing and Midwifery Council**
**Fitness to Practise Committee**

**Substantive Hearing**
**17 March 2020**
**14 – 17 September 2020**
**26 – 29 October 2020**

Nursing and Midwifery Council
114-116 George Street, Edinburgh, EH2 4LH
Virtual Hearing

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|---|---|---|
| **Name of registrant:** | Helen Mulhearn | |
| **NMC PIN:** | 91G0114E | |
| **Part(s) of the register:** | Registered Nurse – Sub Part 1<br>Adult Nursing (22 September 1994) | |
| **Area of registered address:** | Renfrewshire | |
| **Type of case:** | Misconduct | |
| **Panel members:** | Noreen Kent<br>Sharon Peat<br>Jocelyn Griffith | (Chair, Registrant member)<br>(Registrant member)<br>(Lay member) |
| **Legal Assessor:** | Michael Bell | |
| **Panel Secretary:** | Oliver Stephens<br>Xenia Menzl | (17 March 2020)<br>(14 – 17 September,<br>26 – 29 October) |
| **Nursing and Midwifery Council:** | Represented by<br>Alastair Kennedy<br>Tracey Brown<br><br>Case Presenter | <br>(17 March 2020)<br>(14 – 17 September 2020<br>26 – 29 October 2020), |
| **Mrs Mulhearn:** | Not present and not represented in absence | |
| **Facts proved by admission:** | 1 a), b), c), d), e), f), g), 2, 3, 4, 5 a), c), d), | |
| **Facts proved:** | 5 b), 6, 7, | |

| | |
|---|---|
| **Facts not proved:** | 8 |
| **Fitness to practise:** | **Impaired** |
| **Sanction:** | **Suspension Order (12 Months)** |
| **Interim order:** | **Interim Suspension Order (18 Months)** |

**Decision and reasons on service of Notice of Hearing on 17 March 2020**

The panel was informed at the start of this hearing that Mrs Mulhearn was not in attendance and that the Notice of Hearing letter had been sent to Mrs Mulhearn's registered address by recorded delivery and by first class post on 4 February 2020.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mrs Mulhearn's registered address on 5 February 2020. It was signed for against the printed name of 'MULHEARN'.

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

Mr Kennedy, on behalf of the Nursing and Midwifery Council (NMC), submitted that it 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 Mulhearn has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

**Decision and reasons on proceeding in the absence of Mrs Mulhearn on 17 March 2020**

The panel next considered whether it should proceed in the absence of Mrs Mulhearn. It had regard to Rule 21 and heard the submissions of Mr Kennedy who invited the panel to

continue in the absence of Mrs Mulhearn. He submitted that Mrs Mulhearn had voluntarily absented herself.

Mr Kennedy referred the panel to the proof of posting bundle provided by the NMC which included the form '*Your response to the notice of hearing*'. He pointed the panel to the part of the document asking '*Do you plan to come to the hearing*' and submitted that Mrs Mulhearn has ticked the box '*No'*; further Mrs Mulhearn ticked '*Yes'* to the question '*If you are not coming to the hearing, do you want the hearing to go ahead without you?';* and lastly Mrs Mulhearn ticked '*No'* relating to the question '*do you want to ask for a postponement to a change of date'*. Mr Kennedy highlighted the fact that Mrs Mulhearn has also written '*I have applied for voluntary removal from the Register and no longer want to practise as a nurse*', however, he explained that this application was refused by the Registrar.

The panel accepted the advice of the legal assessor.

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 *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Mulhearn. In reaching this decision, the panel has considered the submissions of Mr Kennedy, Mrs Mulhearn's response to the notice of hearing, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and 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 Mulhearn;

- Mrs Mulhearn has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A witness has attended today to give live evidence,
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Some of the charges relate to events that occurred in 2012;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Mulhearn in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her registered address. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Mulhearn's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

**Details of charge**

That you, whilst employed as a Band 5 Registered Nurse by Glasgow City Community Health Partnership between 11 November 2012 and March 2018:

1) In relation to patient X on 12 November 2012:

    a) Administered Oramorph instead of Morphine Sulphate (MST)
    **[found proved by admission]**
    b) Failed to record the medication error in (a) above **[found proved by admission]**
    c) Failed to report the medication error in (a) immediately
    **[found proved by admission]**
    d) Requested colleague S not to disclose the medication error in (a) above
    **[found proved by admission]**
    e) Administered medication, namely Zopiclone which had not been prescribed
    **[found proved by admission]**
    f) Failed to record the medication error in (e) above **[found proved by admission]**
    g) Failed to report the medication error in (e) immediately
    **[found proved by admission]**

2) In relation to an unknown patient "A" on 5 April 2014 administered 28 iu (International Units) of Humulin insulin instead of 16 iu of Humulin insulin.
**[found proved by admission]**

3) In relation to a patient Y on 3 October 2017 administered 18 iu of Humulin insulin instead of 16 iu Humulin insulin. **[found proved by admission]**

4) Did not complete the Supportive Improvement Plan/Action Plan dated 12 January 2018
**[found proved by admission]**

5) Failed to complete records accurately in that you:

   a) Used the wrong drop down box in patient records on dates specified in Schedule 1 indicating there was a home visit when there was no actual visit at the time specified in the record; **[found proved by admission]**
   b) Stated that a home visit had taken place when there was no home visits for patients on dates specified in the record as set out in Schedule 2; **[found proved]**
   c) Used the words “see previous notes” instead of entering details of attendances in records for patients and dates set out in Schedule 3; **[found proved by admission]**
   d) Used or copied entries made by others from various records for patients and dates as specified in Schedule 4; **[found proved by admission]**

6) Your conduct in charges 1(b) and/or (c) was dishonest in that you knew you had a duty to record and/or report the medication error you had made and intended by your actions to conceal the said error. **[found proved]**

7) Your conduct in charge 1(d) was contrary to your duty of candour in that you knew colleague S had a duty to record and/or report the medication error you had made and intended by your actions to persuade her not to do so. **[found proved]**

8) Your conduct in charge 5(d) was dishonest in that you intended to create a misleading impression that the entries were an accurate record of interactions you had with patients expressed in your own words. **[not proved]**

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

**Schedule as amended**

**Schedule 1**

Patient C on 15/01/18

Patient ***D*** on 15/01/18

Patient ***F*** on 12/01/18

**Schedule 2**

Patient ***B*** on 09/01/18

**Schedule 3**

Patient ***B*** on 09/01/18

Patient ***D*** on 12/01/18

Patient B on 12/01/18

Patient C on 12/01/18

**Schedule 4**

Patient ***B*** on 30/01/18

Patient G on 09/02/18

Patient H on 09/02/18

Patient I on 09/02/18

Patient J on 09/02/18

**Adjournment of the Hearing due to Covid-19**

After the charges were read out by the Panel Secretary the panel retired to read the papers.

In the intervening period the Panel Secretary received an email from the NMC indicating that panels should conclude hearings (on 17 March 2020) one way or another given the situation in the UK with Covid-19. Panel members were asked to adjourn proceedings and for Panel Members to look at provisional dates to resume the hearing in due course. Furthermore, the email invited the panel to speak to the NMC Case Presenter to ascertain the situation in regard to interim orders or the need for them. The Chair then confirmed with Mr Kennedy that an interim order in this case was already in place and the NMC did not seek to change that order.

The panel adjourned the hearing and gave the Panel Secretary dates of availability in order to reschedule the hearing in due course.

**Decision and reasons on service of Notice of Hearing on 14 September 2020**

The panel was informed at the start of this hearing that Mrs Mulhearn was not in attendance and that the Notice of Hearing letter had been sent to Mrs Mulhearn's registered address by recorded delivery and by first class post on 18 August 2020.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mrs Mulhearn's registered address on 19 August 2020. It was signed for against the printed name of 'MULHEARN'.

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

Ms Brown, on behalf of the Nursing and Midwifery Council (NMC), submitted that it 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 Mulhearn has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

**Decision and reasons on proceeding in the absence of Mrs Mulhearn on 14 September 2020**

The panel next considered whether it should proceed in the absence of Mrs Mulhearn. It had regard to Rule 21 and heard the submissions of Ms Brown who invited the panel to continue in the absence of Mrs Mulhearn.

Ms Brown reminded the panel that Mrs Mulhearn has not attended the hearing in March and submitted that she again is not in attendance today. She submitted that Mrs Mulhearn has made no request to adjourn the hearing and that there has been nothing to suggest that an adjournment would secure Mrs Mulhearn's attendance. Ms Brown referred the panel to a telephone note made by the NMC Case Officer, dated 11 September 2020, in which Mrs Mulhearn gave no information to confirm a request for adjournment or her attendance. Ms Brown submitted that this is in accordance with Mrs Mulhearn's initial response to the original notice of hearing in which she states that she does not plan to come to the hearing and that she is content for the hearing to go ahead in her absence.

Ms Brown therefore submitted that Mrs Mulhearn has voluntarily absented herself.

Ms Brown reminded the panel that Mrs Mulhearn has indicated that she wanted voluntary removal and submitted that this would indicate that it would be in Mrs Mulhearn's own interest that a final conclusion should be reached in this matter and invited the panel to proceed in her absence.

The panel accepted the advice of the legal assessor.

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 *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Mulhearn. In reaching this decision, the panel has considered the submissions of Ms Brown, Mrs Mulhearn's response to the notice of hearing, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and 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 Mulhearn;
- Mrs Mulhearn has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A witness has attended today to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Some of the charges relate to events that occurred in 2012;

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Mulhearn in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Mulhearn's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

**Decision and reasons on service of Notice of Hearing on 27 October 2020**

The panel was informed at the start of this hearing that Mrs Mulhearn was not in attendance and that the Notice of Hearing letter had been sent to Mrs Mulhearn's registered address by recorded delivery and by first class post on 14 October.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mrs Mulhearn's registered address on 15 October 2020. It was signed for against the printed name of 'JELEN MULHEAN'.

The panel took into account that the Notice of Hearing provided details of the allegations, the time and date of the hearing and the fact that it would be a virtual hearing, held

remotely. The Notice contained, amongst other things, information about Mrs Mulhearn's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence. It also contained a link for Mrs Mulhearn to participate in the hearing.

Ms Brown, on behalf of the Nursing and Midwifery Council (NMC), submitted that it 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 Mulhearn has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

**Decision and reasons on proceeding in the absence of Mrs Mulhearn on 27 October 2020**

The panel next considered whether it should proceed in the absence of Mrs Mulhearn. It had regard to Rule 21 and heard the submissions of Ms Brown who invited the panel to continue in the absence of Mrs Mulhearn.

Ms Brown reminded the panel that Mrs Mulhearn has not attended the hearing in March or in September and submitted that she again is not in attendance today. She submitted that Mrs Mulhearn has made no request to adjourn the hearing. She referred the panel to Mrs Mulhearn's initial response to the original notice of hearing in which she states that she does not plan to come to the hearing and that she is content for the hearing to go ahead in her absence. Ms Brown submitted that there has been nothing to suggest that an adjournment would secure Mrs Mulhearn's attendance. Ms Brown referred the panel to a telephone note made by the NMC Case Officer, dated 21 October 2020 which recorded an incoming call from Mrs Mulhearn. The note states:

*'I'm returning your call*

*I got the transcripts. I've read some but I havent* [sic] *been through it all*
*I got your other letter that it's on 26, 27, 29,29*
*I'm not attending the virtual meeting, the hearing*
*Do you want my response?*
*I'll send it through my husbsnd's* [sic] *email my emai* [sic] *is not sorted yet.*
*Just a few things I want to mention but I'll put it an email'*

Ms Brown therefore submitted that Mrs Mulhearn has voluntarily absented herself

The panel accepted the advice of the legal assessor.

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 *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Mulhearn. In reaching this decision, the panel has considered the submissions of Ms Brown, Mrs Mulhearn's response to the notice of hearing, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and 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 Mulhearn;
- Mrs Mulhearn has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- This is in conjunction with Mrs Mulhearn's response on the previous occasions of the hearing
- Ms Mulhearn has sent an email with responses clarifying her position to the panel

- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Some of the charges relate to events that occurred in 2012;
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Mulhearn in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her registered address. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Mulhearn's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

**Decision and reasons on application to amend the schedule pursuant to Rule 28 (a)**

The panel heard an application made by Ms Brown, on behalf of the NMC, to amend the wording of the schedules in regard to charge 5.

Ms Brown submitted that this was on the ground that the schedules relating to charge 5 should reflect the witness statement of the witness who will be called before this panel. She submitted that the witness statement was made before the redactions were made to anonymise the patients' names to which the schedules refer to.

Ms Brown referred the panel to Exhibit 4 which laid out the proposed amendments.

Original Schedule 1:

Patient C on 15/01/18

Patient E on 15/01/18

Patient L on 12/01/18

Proposed amended Schedule 1:

Patient E on 15/01/18

Patient ~~E~~ ***D*** on 15.01.18

Patient ~~L~~ ***F*** on 15.01.18

Original Schedule 2 from

Patient A on 09/01/18

Patient D on 15/01/18

Patient K on 11/02/18

Proposed amended Schedule 2

Patient ~~A~~ ***B*** on 09/01/18

~~Patient D on 15/01/18~~

~~Patient K on 11/02/18~~

Original Schedule 3

Patient A on 09/01/18

Patient A on 12/01/18

Patient B on 12/01/18

Patient C on 12/01/18

Proposed amended Schedule 3

Patient ~~A~~ ***B*** on 09/01/18

Patient ~~A~~ ***D*** on 12/01/18

Patient B on 12/01/18

Patient C on 12/01/18

Original Schedule 4

Patient A on 30/01/18

Patient F on 09/02/18

Patient G on 09/02/18

Patient H on 09/02/18

Patient I on 09/02/18

Patient J on 09/02/18

Proposed amended Schedule 4:

Patient ~~A~~ ***B*** on 30/01/18

~~Patient F on 09/02/18~~

Patient G on 09/02/18

Patient H on 09/02/18

Patient I on 09/02/18

Patient J on 09/02/18

Ms Brown informed the panel that the proposed amendments were sent to Mrs Mulhearn on 11 September 2020 and that the matter was discussed with her on the telephone on the same day.

Ms Brown submitted that Mrs Mulhearn has seen the unredacted statements of the witness as well as the unredacted patient records and has admitted the charges to which the schedule relates. She submitted that the application to amend is the result of an administrative error that occurred when the redactions were taking place. Ms Brown submitted that there is no injustice to Mrs Mulhearn as she is fully aware of exactly which patients and which details of charges were laid against her.

Ms Brown submitted that amending the schedule would also be fair towards Mrs Mulhearn as it removes certain patients and dates from the schedule and corrects inaccuracies without making a material change to the relative charges.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

**Decision and reasons on application to hear the witness, Colleague 1, to be held in private**

During her submission regarding an application to hear the witness Colleague 1 via video-link, Ms Brown made a request that the application be held in private on the basis that explaining the circumstances as to why Colleague 1 could not attend personally would

include references to her health. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Having heard that there will be reference to Colleague 1's health, the panel determined to hold the application to hear the witness Colleague 1 via video-link in private.

**Decision and reasons on application to admit video-link evidence.**

The panel heard an application made by Ms Brown under Rule 31 to allow Colleague 1 to give their evidence over video link. Ms Brown informed the panel that Colleague 1 was contacted on 14 September 2020 as it was understood that the panel had not had an opportunity to read the papers in full at the time of the last hearing date, 17 March 2020. She explained that it was noted that the number of papers was substantial and it was understood that may have taken the panel some time to read. Additionally, she submitted that there were further preliminary matters required to be dealt with. Ms Brown informed the panel that Colleague 1 was contacted to advise that she might not be required until later in the day so as not to inconvenience her. She submitted that in the course of that contact it transpired that Colleague 1 has been [PRIVATE].

Ms Brown submitted that it should be considered that, taking Colleague 1's [PRIVATE] into consideration, her evidence may be more appropriately taken by way of video evidence. She submitted that the NMC have been running hearings by way of video-link conference during the last few months. She submitted that due to the fact that Colleague 1 was to arrive late today and her evidence may not be completed today she may be required to travel again the following day which would be two days of travelling. She submitted that this may pose considerable risk on her.

In the preparation of this hearing, the NMC had indicated to Mrs Mulhearn in the Case Management Form (CMF) that it was the NMC's intention for Colleague 1 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Colleague 1, Mrs Mulhearn made the decision not to attend this hearing. On this basis Ms Brown advanced the argument that there was no lack of fairness to Mrs Mulhearn in allowing Colleague 1 to give evidence over the video-link.

The panel gave the application in regard to Colleague 1 serious consideration. The panel noted that Colleague 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 signed by her.

The panel considered whether Mrs Mulhearn would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Colleague 1 to that of video-link evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to Colleague 1 to give evidence remotely via video-link, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

**Application to admit further evidence under Article 31 (1)**

Ms Brown submitted that during the panel's questioning of Colleague 1 further documents regarding Mrs Mulhearn's improvement plan in 2018 came to light. She submitted that Colleague 1 was able to produce this additional documentation which she had personally written up with regard to that improvement plan.

Ms Brown submitted that in the preparation of this hearing, the NMC had indicated to Mrs Mulhearn in the Case Management Form (CMF) that it was the NMC's intention for Colleague 1 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Colleague 1, Mrs Mulhearn made the decision not to attend this

hearing. Ms Brown submitted that Mrs Mulhearn has voluntarily absented herself and waived her right to appear. On this basis Ms Brown advanced the argument that there was no lack of fairness to Mrs Mulhearn. She further submitted that it is in the public interest not to delay this case any further and contacting Mrs Mulhearn regarding these additional papers may result in considerable delay.

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

The panel noted that Mrs Mulhearn has on several occasions stated that she would like this case to be over. It determined that as Mrs Mulhearn has seen the additional documents previous to these proceedings, as shown in the signature on one of these documents there is no unfairness to her. The panel therefore allowed the additional documentation into evidence.

**Background**

The charges arose whilst Mrs Mulhearn was employed as a registered nurse by Glasgow City Health and Social Care Partnership (“the Partnership”).Mrs Mulhearn was employed as a band 5 district nurse with the Partnership from November 2008 until she resigned in June 2018.

It is alleged that Mrs Mulhearn made a medication error on 12 November 2012. As a result the Partnership concluded disciplinary proceedings against Mrs Mulhearn. The disciplinary hearing resulted in a first and final warning and she was placed on a formal Stage One Capability Plan for a period of four months.

In 2014, it is alleged that Mrs Mulhearn made a further medication administration error, this time relating to insulin administration, and was placed on a further formal Capability Plan which was successfully completed in 2015. At that time there was no suggestion, as had been in the 2012 case, about any failure to record, report or escalate Mrs Mulhearn’s error.

It is alleged that Mrs Mulhearn made a further insulin administration error on 3 October 2017 and was again placed on a formal capability plan in January 2018. It is also alleged that, when this plan was reviewed with Mrs Mulhearn in February 2018, concerns were raised regarding her record keeping. It is alleged that she had cut and pasted entries for several patient records from other nurses' notes and it is further alleged that Mrs Mulhearn recorded home visits as having taken place when she had not in fact made such visits.

It is alleged that Mrs Mulhearn did not engage with the improvement plan and did not complete several tasks in relation to reflective practice despite assurance that she would complete these reflective accounts. Mrs Mulhearn resigned on 5 June 2018.

**Facts**

At the outset of the hearing on 17 March 2020, the panel heard from Mr Kennedy, who informed the panel that Mrs Mulhearn made admissions to all charges save for charge 5 b) in the response to the notice of hearing. He submitted that Mrs Mulhearn admits the matters in Schedule 2 but under '*Explanation*' explains that she had ticked the wrong box. Mr Kennedy then explained that he had concerns regarding Mrs Mulhearn's admissions to Charges 6, 7 and 8 which relate to dishonest and lack of candour. He submitted that the concerns arose due to the circumstances in which the response to the notice of hearing was completed. Mr Kennedy informed the panel that until this document was produced Mrs Mulhearn's position was that she had not been dishonest. However, Mr Kennedy informed the panel that Mrs Mulhearn made an application for voluntary removal. He explained that voluntary removal in these circumstances will not be granted unless all charges against a registrant are admitted. Mr Kennedy therefore invited the panel to not consider charges 6, 7 and 8 as admitted by Mrs Mulhearn. He invited the panel to find charge 1, charge 2, charge 3 and charge 4 proved in its entirety by way of admission as well as charge 5 a), c), and d).

The panel therefore finds charges 1, 2, 3 and 4 in their entirety proved as well as charge 5 a), c) and d), by way of Mrs Mulhearns's admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Brown on behalf of the NMC and by the documents submitted by Mrs Mulhearn.

The panel has drawn no adverse inference from the non-attendance of Mrs Mulhearn.

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

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

- Colleague 1: Band 6 District Nurse at Glasgow City Health and Social Care Partnership

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

The panel considered the evidence of the witness and made the following conclusions:

The panel considered the evidence of Colleague 1 to be professional and credible. Colleague 1 told the panel what she knew and admitted when she did not know something. Colleague 1 was helpful when she explained the internal systems. The panel found her a reliable and credible witness and fair to Mrs Mulhearn. The panel found her evidence to be consistent and balanced.

**Submission on Facts**

Ms Brown submitted that there is sufficient evidence before the panel to find each remaining charge proved.

Ms Brown submitted that in relation to charge 5 b) Mrs Mulhearn did fail to complete records accurately in recording that home visits had taken place when there were no home visits for patients on the 9 January 2018. She submitted that Colleague 1 gave evidence confirming Ms Mulhearn's poor record keeping supported by the improvement plan and relevant patient records. She submitted that Colleague 1 confirmed that Mrs Mulhean had been in the clinic all day on the 9 January 2018 as she had returned from sick leave on that day. Ms Brown submitted that this had been confirmed by records and by the fact that on that day a meeting at the management house was scheduled at which Mrs Mulhearn would be informed of the care and support improvement plan being implemented. Furthermore, she submitted that the entry on 9 January 2018 shows that no mileage was claimed which supports that Mrs Mulhearn was in the office. Mrs Brown submitted that Colleague 1 explained that the dates of entries in the system were pre-populated and that the entry could not have been an error associated with an entry relating to a different day. She therefore invited the panel to find this charge proved.

Ms Brown then addressed charge 6. She submitted that Mrs Mulhearn was aware of the medication error she made but did not record that she had administered Oramorph rather than MST to the patient in the notes. She submitted that Mrs Mulhearn falsely recorded that she had administered MST to the patient and then asked the Healthcare Assistant (HCA) not to report the incident as she wanted to deal with it herself. However, Ms Brown submitted that Mrs Mulhearn did not report the incident to any other medical staff at the time, nor the out-of-hours service or her line manager. She submitted that Mrs Mulhearn also did not inform the family of the error. Ms Brown submitted that Mrs Mulhearn had written an entry into the patient's medication record which she was aware was false. She submitted that if it had been a genuine error why would Mrs Mulhearn not have acted immediately to record and report the error. Ms Brown reminded the panel that the HCA

raised concerns about the situation. She submitted that with her actions Mrs Mulhearn was intending to mislead. She therefore invited the panel to find charge 6 proved.

Ms Brown submitted that in relation to charge 7, Mrs Mulhearns conduct in charge 1 d) was contrary to her duty of candour in that she knew that Colleague S had a duty to record and/or report the medication error she had made yet persuaded her not to do so. She submitted that after the medication error was made Mrs Mulhearn asked Colleague S not to report the incident on several occasions of which evidence can be found in the disciplinary report dated 27 February 2013. She submitted that Colleague S contacted Mrs Mulhearn on 14 November 2012 to voice her concerns about the failure to report the incident to which Mrs Mulhearn replied that the incident had since been reported and that the matter does not need to be discussed with anyone else. However, Ms Brown submitted that the report about the incident was not made until the 14 November 2012. She submitted that Mrs Mulhearn admitted that she had asked Colleague S not to report the incident and that therefore the associated dishonesty in charge 7 should be proved as well. She submitted that if Mrs Mulhearn was unaware of her and her colleague's duty to report then there would have been no need to ask Colleague S to not report the issue. Ms Brown submitted that Mrs Mulhearn did so with the intention to mislead and that persuading her colleague not to record or report the medication error was in breach of her duty of candour. She therefore invited the panel to find charge 7 proved.

Ms Brown submitted that the panel heard from Colleague 1 in relation to charge 8. She submitted that Colleague 1 was concerned that Mrs Mulhearn was copying notes made by other staff nurses and that the entries were not made in her own words. She submitted that Colleague 1 confirmed that although there was no specific policy in place staff nurses regularly received record keeping training where they were advised that notes should be written in their own words. Ms Brown further submitted that the Nursing and Midwifery Council Code specifies that records must be completed accurately and without falsification which was also referred to in Mrs Mulhearn's improvement plan. She submitted that Colleague 1 stated that in her view any copying and pasting is falsifying records and that it is an incorrect and dangerous practice as it is not giving a true picture of the patient visits.

She submitted that Colleague 1 stated that copying and pasting notes is not a straightforward process and would have not saved Mrs Mulhearn any time. Ms Brown submitted that Mrs Mulhearn has admitted that she was duplicating entries from other colleagues' visits and invited the panel to find this charge proved.

Following the panel retiring to consider the remaining charges and prior to it handing down its determination thereon, Mrs Mulhearn sent an email to the NMC dated, 26 October 2020, stating that she had read the transcripts of the prior days of this hearing and setting out her position regarding '*use of the CNIS'* and the issue of cutting and pasting. Mrs Mulhearn's further emails were put before the panel and were considered by it in reaching its conclusions on facts.

**Finding of Facts**

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

**Charge 5 b)**

5) Failed to complete records accurately in that you:
   b) Stated that a home visit had taken place when there was no home visits for patients on dates specified in the record as set out in Schedule 2;

**This charge is found proved.**

In reaching this decision, the panel took into account the patient visit record for Patient A dated 9 January 2018 and the witness statement by Colleague 1.

The panel noted that the record states in handwriting that '*Home visit recorded, however HM was in clinic all day'*. It noted that the entry showed the date of 9 January 2018 and that a visit took place for 60 minutes. The panel noted that the patient notes state '*see*

*previous notes*'. The panel took into account the witness statement of Colleague 1 which states:

> '*Helen was on sick leave from 9 October 2017 and was cleared to return to work on 8 January 2018, and looking back at the rota I can confirm her first day back in the Clinic was 9 January 2018. As this was her first day back, she would've spent the morning going over her emails and getting caught up with work whilst accompanying a Band 6 member of staff, that person being myself*'

The panel further noted that no mileage was claimed for that day by Mrs Mulhearn and that she admitted that she had ticked the wrong box.

The panel considered the evidence of Colleague 1 and the improvement plan documentation provided to it. It was concluded that Mrs Mulhearn would have known that she had an obligation to fill all records in accurately.

The panel accepted that the evidence of Colleague 1 confirmed that Mrs Mulhean had been in the clinic all day on the 9 January 2018. The panel further noted that the entry on 9 January 2018 shows that Mrs Mulhearn had claimed no mileage for this date and that the dates of entries in the system were pre-populated and that the entry could not have been an error associated with an entry relating to a different day. The panel determined that there were no home visits for patients on the date specified in the record as set out in Schedule 2. The panel further determined that by making an entry that such visits had occurred Mrs Mulhearn had failed to complete records accurately.

The panel was therefore satisfied that it is more likely than not that Mrs Mulhearn failed to complete records accurately in that she stated that a home visit had taken place when there were no home visits for patients on dates specified in the record as set out in Schedule 2.

The panel therefore find this charge proved.

**Charge 6**

6) Your conduct in charges 1(b) and/or (c) was dishonest in that you knew you had a duty to record and/or report the medication error you had made and intended by your actions to conceal the said error.

**This charge is found proved.**

In reaching this decision, the panel took into account the 2008 NMC code, the Standards for medicines management – NMC 2007 (Withdrawn 2019) and the record of the disciplinary hearing, dated 27 February 2013. The panel adopted the test for dishonesty as set out in *Ivey v Gentings* [2017] *UKSC 67*.

The panel first established if Mrs Mulhearn had a duty to record or report a medication error.

The panel noted that the Standards for medicines management – NMC 2007 (Withdrawn 2019) states:

> *'Standard 24: Management of adverse effects. As a registrant, if you make an error you must take any action to prevent any potential harm to the patient and report as soon as possible to the prescriber, your line manager or employer (according to local policy) and document your actions. Midwives should also inform their named supervisor of midwives.'*

The panel therefore concluded that Mrs Mulhearn had a duty to record and report the medication error immediately. The panel noted that the disciplinary hearing notes stated that Mrs Mulhearn did not report the medication error until two days later, namely the 14 November 2012. The panel further noted that the disciplinary report states Mrs Mulhearn only verbally reported the error to a colleague, however, never reported the error formally through Datix.

The panel noted that Mrs Mulhearn states that she attempted to report the error by the next morning by phoning the Govan Health Centre and alerting the Band 6 caseload holder but that no one was available.

However, the panel also noted that Mrs Mulhearn repeatedly asked Colleague S not to report the error on several occasions. The panel noted that Mrs Mulhearn did not inform the family of the error, that there is no evidence that Mrs Mulhearn recorded the error on the patient visit form nor did she complete a Datix entry.

The panel concluded that Mrs Mulhearn had tried to minimise the error. The panel was of the view that Mrs Mulhearn in this case put her own interest first instead of the patient's. It noted that the pharmacist stated that not reporting the error put the patient at a risk of harm. The panel was of the view that Mrs Muhearn's actions in this situation lead to the conclusion that she had tried to mitigate the outcome for herself by not being open and transparent about the error. This is supported by the lack of recording and asking Colleague S not to report the incident. The panel was of the view that this was a fundamental concern in regard to Mrs Mulhearn's nursing practice. It concluded that the impact of the error on the patient was not foremost in Mrs Mulhearn's mind and that she made significant attempts to conceal it. The panel therefore determined that the intention behind Mrs Mulhearn's actions and omissions was to conceal her error.

The panel further concluded that an ordinary decent person would find that Mrs Mulhearns inherent mind-set in that situation was not to be honest, ergo it was dishonest.

The panel was therefore satisfied that Mrs Mulhearn's actions in charges 1(b) and (c) were dishonest in that she knew she had a duty to record and report the medication error, however, had made and intended by her actions to conceal the said error.

**Charge 7**

7) Your conduct in charge 1(d) was contrary to your duty of candour in that you knew colleague S had a duty to record and/or report the medication error you had made and intended by your actions to persuade her not to do so.

**This charge is found proved.**

In reaching this decision, the panel took into account of the 2008 NMC Code and the statement by Colleague S.

The panel noted that everyone working in the NHS has a duty to speak up and act when seeing wrongdoing and concluded that this should be known by Mrs Mulhearn. It considered that ultimately that duty sits with the nurse, however, it noted that Colleague S had a duty to ensure that an error is reported if she sees that the person responsible has not reported it. This is confirmed by the statement of another colleague who states:

> '*I discussed with colleague S that when a registered nurse makes an error they have to report this has happened and complete a Datix form.* […]
> *We then discussed that both of us were aware we had to disclose this form a professional code of conduct. I informed Colleague S that I would contact* [PD Nurse] *to discuss the incident once she had spoken to Helen and to confirm that a Datix had been submitted.*'

The panel determined that Mrs Mulhearn knew Colleague S had a duty to record and/or report the medication error that she herself had made.

The panel determined that on several occasions Mrs Mulhearn asked Colleague S to be complicit in the concealment of her error and not to report it. It further noted that Colleague S felt uncomfortable and pressured by what was being asked of her. This is again confirmed in the above noted statement which states:

'*Colleague S sounded upset and stated she had no way of knowing if this was actually reported.* […] *she felt awful to report one of her colleagues but she was aware she was accountable and this was the right thing to do in these circumstances.*'

The panel reminded itself of its findings in charge 6 and that it had found that Mrs Mulhearn tried to conceal her error. It therefore concluded that it is more likely than not that the conduct in charge 1(d) was contrary to Mrs Mulhearn's duty of candour in that she knew colleague S had a duty to record and/or report the medication error and that she had made and intended by her actions to persuade her not to do so.

This charge is therefore found proved.

**Charge 8**

8) Your conduct in charge 5(d) was dishonest in that you intended to create a misleading impression that the entries were an accurate record of interactions you had with patients expressed in your own words.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account Colleague 1's witness statement and oral evidence as well as the patient records.

The panel noted that there was no policy in place stating that copying and pasting of patient records was not allowed. It further noted that Colleague 1 gave evidence that copying and pasting of patient's care plans was common practice but not actual nursing notes. The panel noted that although Mrs Mulhearn copied and pasted other colleagues entries there were entries where she had adapted what she had copied and pasted where necessary. The panel was of the view that although this is not best practice, by modifying the copied entries, Mrs Mulhearn was personalising the entries, making them her own.

The panel noted that there is no indication that the recorded entries do not accurately reflect the patient visit. The panel further noted that Mrs Mulhearn states that this was common practice amongst the nurses and that she further stated that:

> *'It was never mentioned during my PDN training.*
> *If it is available as part of the CNIS system I did not see a problem in using it. In fact, I saw it as a means to improve my time management, which was often criticised.'*

The panel concluded that although the paperwork did suffer under this practice there is no indication that Mrs Mulhearn did not deliver the care stated in the patient's visit. The panel was of the view that Mrs Mulhearn adopted the common practice of copying and pasting care plans and applied it to nursing records, modifying the entries to make them her own. The panel determined that in acting in this manner Mrs Mulhearn had not sought to mislead.

The panel was therefore not satisfied that Mrs Mulhearn's conduct in charge 5(d) was dishonest in that she intended to create a misleading impression that the entries were an accurate record of interactions she had with patients expressed in her own words

This charge is therefore not found proved.

**Fitness to practise**

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mrs Mulhearn'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.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Mulhearn's fitness to practise is currently impaired as a result of that misconduct.

**Submissions on misconduct**

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Brown invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms 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) in making its decision.

Ms Brown identified the specific, relevant standards where Mrs Mulhearn's actions amounted to misconduct. She pointed out the specific parts of the 2008 and 2015 code that Mrs Mulhearn has breached, namely:

In the 2015 Code:

- prioritising people;
- practising effectively;
- preserving safety; and
- promoting professionalism and trust.

In the 2008 Code:

- working effectively as part of a team;
- managing risk;
- keep clear and accurate records
- dealing with problems; and
- upholding the reputation of your profession.

Ms Brown submitted that the duty of candour is a duty on a nurse to be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm. She further submitted that nurses must be open and honest with their colleagues, employers and relevant organisations and must not stop someone from raising concerns.

Ms Brown submitted that dishonesty is regarded as one of the most serious categories of misconduct and that honesty, integrity and trustworthiness are an integral part of nursing practice.

Ms Brown invited the panel to find that the failures in the charges found proved amount to misconduct. She submitted that the facts found in the earlier investigations and disciplinary proceedings provide prima facie evidence towards proving misconduct and that this evidence has not been challenged. She submitted that dishonestly failing to

record and report a medication error with the intention of concealing that error amounts to behaviour that falls far short of what is expected of a nurse. She referred the panel to the very serious implications that could have occurred as a result of the medicine administration failures admitted in charge 1, which were identified and commented on by a pharmacist. She submitted that Mrs Mulhearn has not properly cared for this patient.

Ms Brown submitted that similarly the medication errors found proved in charges 2 and 3 fall far below what would be expected of a nurse. Furthermore, she submitted that the failures in completing records accurately, and completing records in relation to a patient that she had not seen, also amount to behaviour that falls far short of what is expected of a registered nurse.

**Submissions on impairment**

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

Ms Brown submitted that in this case all four limbs of *Grant* are engaged. She submitted that Ms Mulhearn has put a number of patients at unwarranted risk of harm by making medication errors, patients being put in danger by Mrs Mulhearn giving medication that was not prescribed, and in failing to adequately read prescriptions resulting in incorrect medicines and incorrect doses of medicines being given. Furthermore, she submitted that Ms Mulhearn failed to accurately complete records.

Ms Brown submitted that Mrs Mulhearn brought the nursing profession into disrepute by failing to demonstrate the standards expected of a registered nurse. She submitted that the public would be concerned to hear that a nurse who made a medication error did not

then immediately seek assistance and put a patient at risk. It would also be concerned that a nurse practising for that length of time has repeatedly made medication errors. She submitted that the public would be concerned that an experienced nurse failed to keep an accurate record of her interactions with patients and thereby failed to provide a detailed pathway of care, putting patient needs at risk. She submitted that Mrs Mulhearn has breached one of the fundamental tenets of the profession by not making the care of her patients her first priority.

Ms Brown referred the panel to the case of *Cohen v GMC [2008] EWHC 581 (Admin)* which sets out guidance on remediation. She submitted that in this case there are allegations relating to two historical time periods. She submitted that Mrs Mulhearn has completed capability plans following those events and therefore it is a matter for the panel to determine whether Mrs Mulhearn has already remediated her conduct in relation to those charges and referred the panel to the case of *Meadow v GMC* [2007] *EWCA Civ 1390*.

Ms Brown submitted that Mrs Mulhearn's conduct is not easily remediable and that although she has previously undergone extensive periods of supervision, failures in care have been repeated. She submitted that there is no evidence before the panel to show that Mrs Mulhearn has remediated her conduct. She reminded the panel that although Mrs Mulhearn has completed two capability programmes she resigned before completing the improvement plan. Mrs Brown submitted that Mrs Mulhearn resigned from her post with the Partnership in June 2018, is not currently employed in a nursing capacity and has not worked as a registered nurse since resigning from the NHS. Furthermore, she submitted that Mrs Mulhearn has indicated repeatedly that she no longer wishes to practice as a registered nurse and has completed a voluntary removal form. Ms Brown submitted that Mrs Mulhearn has now had a significant period out of practice and taking that into account in combination with the lack of remediation there is a high risk of repetition.

Ms Brown submitted that Mrs Mulhearn has engaged with the NMC investigation and provided a detailed response to the regulatory concerns, she has accepted the medication

errors and poor record keeping. However, Ms Brown submitted that until February 2020 Mrs Mulhearn did not accept that she had acted dishonestly after the incident in 2012, stated that she would not record home visits if they had not taken place, placing the blame on the Community Nursing Information System, and that the medication errors were caused by exhaustion and stress at work. She submitted that the communication from Mrs Mulhearn dated, 26 October 2020, contained further explanatory and exculpatory comments regarding her actions.

Ms Brown submitted that in order to protect the public, to uphold the confidence in the profession as a whole, and to uphold the standards of conduct and behaviour expected of a nurse a finding of impairment is required. She therefore invited the panel to find that Mrs Mulhearn is currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

**Decision and reasons on misconduct**

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

The panel was of the view that Mrs Mulhearn's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Mulhearn's actions amounted to breaches of the Code. Specifically:

In the 2008 Code:

***The people in your care must be able to trust you with their health and wellbeing***

*To justify that trust, you must:*

- *make the care of people your first concern* […]
- *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.*

*As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions.*

***Share information with your colleagues***

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

***Manage risk***

*32 You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.*

***Keep clear and accurate records***

*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.*

*43 You must complete records as soon as possible after an event has occurred.*

***Deal with problems***

*54 You must act immediately to put matters right if someone in your care has suffered harm for any reason.*

*55 You must explain fully and promptly to the person affected what has happened and the likely effects.*

***Uphold the reputation of your profession***

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

In the 2015 Code:

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

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

***6 Always practise in line with the best available evidence***

*To achieve this, you must:*

*6.2 maintain the knowledge and skills you need for safe and effective practice*

***8 Work co-operatively***

*To achieve this, you must:*

*8.2 maintain effective communication with colleagues*

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

***9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues***

*To achieve this, you must:*

*9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*

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

*This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*

*To achieve this, you must:*

*10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

***13 Recognise and work within the limits of your competence***

*To achieve this, you must, as appropriate:*

*13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*

*13.5 complete the necessary training before carrying out a new role*

***14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place***

*To achieve this, you must:*

*14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*

***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***

*To achieve this, you must:*

*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 Uphold the reputation of your profession at all times***

*To achieve this, you must:*

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

***22 Fulfil all registration requirements***

*To achieve this, you must:*

*22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Mulhearn repeatedly fell short of the standard required of a registered nurse. The panel noted that Mrs Mulhearn repeatedly made errors and that despite continued support from her employer and comprehensive support plans Mrs Mulhearn eventually disengaged and walked out of a meeting put in place to discuss her improvement plan. The panel determined that in her actions Mrs Mulhearn has not put patients first, not taking responsibility for her failures and actions. The panel found that Mrs Mulhearn repeatedly found excuses diverting responsibility and blaming circumstances for her repeated failings.

The panel therefore found that Mrs Mulhearns's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

The panel next went on to decide if as a result of the misconduct, Mrs Mulhearn's 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. Patients and their families must be able to trust nurses with their lives and

the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

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

The panel was of the view that all four parts of Grant were engaged in this case in relation to the past. It found that patients were put at risk and there was the potential of physical harm as a result of Mrs Mulhearn's misconduct. The panel found that Mrs Mulhearn's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Further, the panel was of the view that Mrs Mulhearn has, despite being supported through various capability plans, continued to breach the fundamental tenets of the nursing profession and due to the lack of remediation is liable to do so in the future. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty serious.

The panel considered whether Mrs Mulhearn's practice is impaired with regard to her lack of candour and dishonesty that occurred when she tried to cover up her medication mistake in 2012. The panel was of the view that there is evidence that Mrs Mulhearn has learned from her failings and remediated her actions in this particular regard. It noted that Mrs Mulhearn has in later medication errors not intended to mislead or cover up and had reported her mistakes. The panel was therefore of the view that with regard to Mrs Mulhearn's lack of candour and dishonesty a finding of impairment is not necessary to protect the public.

However, the panel was of the view that a finding of impairment with regard to Mrs Mulhearn's lack of candour and dishonesty was necessary with regard to the public interest. The panel was of the view that a decent member of the public would be horrified to learn that a nurse tried to mitigate her actions by not reporting and recording a medication error and trying to convince a colleague to be complicit in her actions.

The panel then moved on to consider if Mrs Mulhearn's fitness to practise is impaired with regard to her clinical failings.

Regarding insight, the panel considered that Mrs Mulhearn repeatedly found excuses diverting responsibility and ownership for her actions and blaming circumstances, poor training, poor support, stress and work pressures. The panel noted that Mrs Mulhearn criticised the extra work asked of her due to the improvement and capability plans, stating that she had to write essays while [PRIVATE]. It determined that these reflections and the repetition of her failings show that she has not learned from her mistakes nor has she taken her reflections forward and shown that she has understood the seriousness of her actions. The panel was of the view that Mrs Mulhearn has not shown any insight into the potential impact her actions had on patients, shown any remorse or a level of understanding of her failings. The panel therefore concluded that Mrs Mulhearn has little insight into her failings.

The panel was satisfied that the misconduct in this case is capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Mulhearn has remedied her practice. The panel noted that Mrs Mulhearn has still not taken responsibility for her actions although she has successfully completed capability plans twice in the past, which included completing reflections on her practice. The panel was of the view that Mrs Mulhearn, by resigning prior to completing her latest improvement plan, has not shown that she successfully reflected on her actions. There is no evidence, therefore, that any learning has occurred. The panel determined that any learning would have resulted in a change of behaviour, however, there is evidence that even after completing capability plans, Mrs Mulhearn repeated her record keeping failings and drug errors. The panel was of the view that due to the lack of insight and reflection Mrs Mulhearn has not acknowledged her limitations and did not learn from her failings. The panel determined that Mrs Mulhearn has failed to demonstrate relevant insight into the full nature of her acts and omission nor the potential consequences for patients, patients' families, colleagues and public confidence in the profession. The panel was of the view that without acknowledging her limitations Mrs Mulhearn is not able to fully remediate her practice.

The panel concluded that there is a risk of repetition based on her lack of insight and lack of remediation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required to maintain the confidence of the public and the NMC as a regulator. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Mulhearn's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Mulhearn's fitness to practise is currently impaired.

**Sanction**

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

**Submissions on sanction**

Ms Brown reminded the panel of the NMC Sanctions Guidance (SG) and that any sanction imposed must be proportionate, balancing the interests of the public against those of Mrs Mulhearn.

Ms Brown submitted that the aggravating factors in this case are:

- There have been a number of incidences;
- Despite extensive and intensive support put in place by her employer Mrs Mulhearn still had difficulties in relation to basic nursing tasks;
- Mrs Mulhearn has not yet completed her capability plan after last incident;
- The dishonesty was in a clinical context relating to medication, inaccurate records and candour;
- Mrs Mulhearn had sought to cover up the first incident by asking a HCA not to disclose the error;
- Colleague 1 stated that Mrs Mulhearn required prompting with medication and had to be reminded on procedures, including working out doses of insulin;
- Mrs Mulhearn has used other colleagues' entries on the records she completed by cutting and pasting entries; and
- Mrs Mulhearn has not shown remorse.

Ms Brown submitted that the mitigating factors in this case are:

- There does not appear to have been actual patient harm;
- The medication errors occurred following a significant gap in time between each error and may not indicate a lack of competence in respect of medication administration;
- Mrs Mulhearn successfully completed a competency programme after the first two errors;
- Mrs Mulhearn's third medicine error in October 2017 appears to be the least serious and as a result of this error, she was supervised. It was observed that no further errors were made although it is to be noted that she had been supervised;
- Mrs Mulhearn has provided copies of her reflections following the first three incidents and appears to accept her failings; and
- Mrs Mulhearn has indicated that she no longer wishes to practise as a registered nurse, having qualified in 1994, and has completed a voluntary removal form.

Mrs Brown submitted that the dishonesty found in this case may be considered to be at the lower end of the spectrum. However, she submitted that Mrs Mulhearn's dishonesty and lack of candour could be considered a serious departure from the standards expected of a nurse. Alternatively, she submitted that the panel may feel that the dishonesty in this case may be considered borderline enough to consider a striking off order.

Ms Brown submitted that the panel having found current impairment, it is the NMC's position that it would seek the imposition of a suspension order for a period of 12 months. Ms Brown therefore invited the panel to impose such an order.

The panel accepted the advice of the legal assessor which included reference to the SG.

**Decision and reasons on sanction**

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

The panel took into account the following aggravating features:

- Previous disciplinary findings;
- Lack of insight into failings;
- No remediation of the latest concerns, despite two successfully completed capability plans;
- Pattern of misconduct over a period of time, including several failures in fundamental nursing care; and
- Medication errors which put patients at a serious risk of suffering harm.

The panel also took into account the following mitigating features:

- Partial admissions to the charges; and
- Periods of absence from continual practice.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Mulhearn's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the*

*spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Mulhearn's misconduct included a repeated number of failings, with little insight, over a length of time and that it was not at the lower end of the spectrum. It therefore concluded that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions; and*
- *The conditions will protect patients during the period they are in force.*

The panel noted that although the areas of concern in Mrs Mulhearn's practice were remediable, Mrs Mulhearn's basic nursing skills like time management, medication administration and record keeping were lacking. It noted that Mrs Mulhearn showed that she has been willing in the past to respond positively to retraining and support. However, it also noted that Mrs Mulhearn was not willing to discuss her failings during the last improvement plan and perceived it as a personal attack. Furthermore, the panel noted that Mrs Mulhearn has indicated that she wishes to be removed from the register and applied for voluntary removal. The panel is therefore of the view that there are no practical or workable conditions that could be formulated and monitored, given the lack of insight and the close monitoring Mrs Mulhearn would need together with her disengagement.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *A suspension order is sufficient to protect patients, public confidence in nurses and midwives, or professional standards*

The panel was of the view that the failings found proved were not incompatible with being on the register. It noted that it had previously found that Mrs Mulhearn has learned from her experience of acting dishonestly and its consequences in 2012. The panel determined that Mrs Mulhearn's dishonesty, albeit that it put her interests above those of the patient, was not repeated and could be considered to be at the lower end of the spectrum.

The panel noted that it had found that the remaining failings were in regard to Mrs Mulhearn's clinical practice and that this was remediable through reflection, further insight, taking ownership and responsibility for her actions, further education, and training. The panel noted that Mrs Mulhearn had been positive about previous capability plans and had completed them successfully. It was of the view that if Mrs Mulhearn gains further insight into her failings and the potential consequences for patients, patients' families, colleagues and public confidence in the profession, she would be more likely to engage with a supportive capability program and address the existing regulatory concerns.

It did go on to thoroughly consider whether a striking-off order would be proportionate and appropriate in this case. However, for the reasons stated above the panel was of the view that a striking-off order at this stage of the process would be disproportionate and punitive. It noted that Mrs Mulhearn walked out of an improvement plan meeting but considered this to be an act of frustration rather than a deep seated attitudinal problem, as Mrs Mulhearn

previously worked well with the capability plans put in place. It also noted that Colleague 1 spoke well of Mrs Mulhearn's character during her oral evidence. It was of the view that the failings found proved were remediable if Mrs Mulhearn reflected on them, gained insight and decided to broaden her knowledge through additional training. Taking account of all the information before it, the panel concluded that a striking off order would be disproportionate at this time. However, it was mindful that should Mrs Mulhearn not engage in this process the next reviewing panel will have this sanction available to it.

Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Mulhearn's case to impose a striking-off order at this stage of the proceedings.

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

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the case and give Mrs Mulhearn sufficient time to reflect on her failings, develop further insight, and identify her learning needs in order to practice safely and effectively as a registered nurse. It also marks the public interest with regard to the seriousness of the case and the dishonesty found proved.

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

Any future panel reviewing this case would be assisted by:

- A broad ranging reflection piece using a recognised model, e.g. Gibbs, addressing the areas of concern identified in this determination;
- References from any employers including paid or unpaid work within or outwith a healthcare setting;
- Evidence of any relevant education, learning or updating Mrs Mulhearn has undertaken regarding current nursing practices;
- Continued engagement with the process, and attendance at a future review hearing, in person, via video-link or telephone.

This will be confirmed to Mrs Mulhearn in writing.

**Interim order**

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Mulhearn's own interest until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

**Submissions on interim order**

The panel took account of the submissions made by Ms Brown. She submitted in light of the panel's determination the NMC invites it to impose an interim suspension order for 18 months.

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

**Decision and reasons on interim order**

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months for the same reasons as set out previously in the determination.

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

That concludes this determination.