Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
26 - 28 October 2020

Virtual Hearing

Name of registrant:	Ellen Fiona Oxenbold
NMC PIN:	15A0757E
Part(s) of the register:	Registered Adult Nurse – Sub-part 1 Adult Nursing – September 2015
Area of registered address:	Staffordshire
Type of case:	Misconduct
Panel members:	Deborah Jones (Chair, lay member) Natasha Duke (Registrant member) Barbara Stuart (Lay member)
Legal Assessor:	Paul Housego
Panel Secretary:	Melissa McLean
Nursing and Midwifery Council:	Represented by Claire Stevenson, Case Presenter
Mrs Oxenbold:	Not present and not represented in her absence
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Suspension Order (12 months)
Interim order:	Interim suspension order (18 months)

Service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Oxenbold was not in attendance, nor was she represented in her absence. The panel was informed that Notice of this Hearing had been sent to Mrs Oxenbold's registered email address on 22 September 2020.

Ms Stevenson, on behalf of the Nursing and Midwifery Council (NMC), informed the panel that the Notice of Hearing provided details of the allegations, the time, dates and the video conferencing details required to join the hearing. The Notice also included information about Mrs Oxenbold's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Ms Stevenson submitted that it had complied with the requirements of Rules 8 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.

The panel noted that under the recent amendments made to the Rules during the Covid-19 emergency period, a Notice of Hearing may be sent to a registrant's registered address by recorded delivery and first class post or to a suitable email address on the register.

In the light of all of the information available, the panel was satisfied that Mrs Oxenbold has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Proceeding in the absence of Mrs Oxenbold

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

Ms Stevenson submitted that Mrs Oxenbold has barely engaged with the NMC. She stated that Mrs Oxenbold has been contacted on numerous occasions with little reply. Ms Stevenson referred the panel to the email correspondence from Mrs Oxenbold dated 27 March 2020, in which she stated:

> *"Please stop sending these emails. Whatever you are sending as attachments do not open."*

Ms Stevenson also referred the panel to email correspondence from Mrs Oxenbold dated 9 July 2020 in which she stated (sic):

> *"As I have attempted several times to try and tell you.*
> *I cannot open these files you send. I will not be attending any hearings.*
> *I have not and will never be re activating my NMC pin. I do not requore any interim orders or extensions.*
>
> *Please do not continue to send documents or list hearing. I am no longer involved with nor intend to ever again nursing practice"*

On 10 July 2020 a case officer at the NMC telephoned Mrs Oxenbold and explained to her how to access the documentation. Mrs Oxenbold confirmed that she could access and see the documentation.

Ms Stevenson also directed the panel's attention to a third email, dated 8 September 2020 in which Mrs Oxenbold stated (sic):

"Thank you for your messages.

I have however, stated in previous and numerous emails to you that I am not and will not be entering nursing. My pin has been lapsed, I do not pay subscriptions to practice, I have not continued with CPD submission and therfore request this whole pharce be closed end of story.

I won't be attending hearings, video phone or otherwise in person.

If you do not remove the case and myself from records I will consider any further contact as harassment and will be contacting my solicitors."

Ms Stevenson informed the panel that the NMC were trying to establish communication with Mrs Oxenbold however she has indicated that she no longer wishes to be contacted by the NMC. Ms Stevenson submitted that in light of the correspondence from Mrs Oxenbold, it would appear that she has voluntarily absented herself. She further submitted that Mrs Oxenbold has not sought an adjournment and therefore there is no reason to believe that an adjournment would secure her attendance on some future occasion.
Ms Stevenson submitted that there is a strong public interest in the expeditious disposal of the case and informed the panel that there are multiple witnesses that are due to be called during the course of this hearing. She further submitted that it is fair, appropriate and proportionate to proceed in the absence of Mrs Oxenbold.

The panel accepted the advice of the legal assessor. He referred the panel to the case of *General Medical Council v Adeogba* [2016] EWCA Civ 162, which indicated that panels should proceed unless there was good reason not to do so. He advised the panel that it had obligations to secure a fair hearing for Mrs Oxenbold as set out in *Held v The General Dental Council* [2015] EWHC 669 (Admin).

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 Oxenbold. In reaching this decision, the panel has considered the submissions of Ms Stevenson, and the advice of the legal assessor. It has had particular regard to the factors set out in the decisions 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 Oxenbold;
- Mrs Oxenbold has informed the NMC that she will not be attending today's hearing and that she no longer wishes to receive correspondence from the NMC.
- There is no reason to suppose that adjourning would secure Mrs Oxenbold's attendance at some future date;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- 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 Oxenbold in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Mrs Oxenbold, she will not be able to challenge the evidence relied upon by the NMC via video link 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 Oxenbold'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 Oxenbold. The panel will draw no adverse inference from Mrs Oxenbold's absence in its findings of fact, accepting the legal assessor's advice relating to *Kuzmin, R (On the Application Of) v General Medical Council* [2019] EWHC 2129 (Admin).

Details of charge

That you, a registered nurse:

1. *On 21 June 2017 whilst responsible for the care of Patient X, failed to adequately manage his care in that you:*
   a. administered 40 units of insulin instead of the prescribed 50 units to Patient X
   b. you failed to adequately check the blood glucose levels of Patient X
   c. failed to follow handover instructions regarding seeking medical review of Patient X prior to the administration of any insulin;

2. *At approximately 11.30, after recording Patient X's temperature as 37.6:*
   a. Incorrectly recorded the MEWS score as 0;
   b. failed to increase the frequency of observations;
   c. did not escalate Patient X's temperature to a senior colleague or medical team;

3. *At approximately 14.30, after recording Patient X's temperature as 39.7:*
   a. Incorrectly recorded the MEWS score as 0;
   b. failed to increase the frequency of observations;
   c. did not escalate Patient X's temperature to a senior colleague or medical team;

AND in light of the above, your fitness to practise is currently impaired as a result of your misconduct.

Facts

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 Stevenson on behalf of the NMC.

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

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:

- Mr 1: Matron at the Trust and the investigating officer for the investigation.
- Ms 2: Senior Staff Nurse in charge on the night shift on 20/21 June 2017.
- Ms 3: Staff nurse on duty on the nightshift on 21/22 June 2017.
- Mr 4: Staff nurse, in charge of the ward on the day shift on 21 June 2017.

Background

The NMC received a referral on 10 April 2018 from University Hospitals Birmingham NHS Foundation Trust ("the Trust") regarding Mrs Oxenbold.

Mrs Oxenbold had been employed by the Trust since 12 September 2016 as a Band 5 Staff Nurse, deployed on Ward 9 ("the Ward") at Good Hope Hospital. Mrs Oxenbold resigned from her substantive post on 16 April 2017 but continued to work on the Ward as a bank nurse until 23 June 2017.

On 21 June 2017, Mrs Oxenbold was working a day shift from 07:00 until 19:30 and was allocated the care of Patient X. Patient X had been transferred from the Intensive Care Unit to the ward the evening before. Patient X had a known medical history of type 2 diabetes and alcohol excess and had been treated for severe sepsis, acute kidney injury and a gastrointestinal bleed. Throughout this time, Patient X was prescribed long acting insulin.

At the start of the shift, Mrs Oxenbold was given a detailed handover by Ms 2, the nurse caring for Patent X on the nightshift of 20 June 2017. She advised Mrs Oxenbold that she was required to monitor Patient X closely, particularly his blood glucose levels. Ms 2 informed Mrs Oxenbold that she was concerned about Patient X's blood glucose level and advised that a medical review was required prior to Patient X receiving any insulin. Mrs Oxenbold was the allocated nurse caring for Patient X.

It is alleged that Mrs Oxenbold administered insulin to Patient X without seeking a medical review. Mrs Oxenbold spoke to the nurse during the day shift of 21 June 2017, Mr 4, however, Ms 2, states that she told Mrs Oxenbold to "*speak to a doctor before giving insulin*". Patient X was prescribed 50 units of insulin however it is alleged that Mrs Oxenbold only gave 40 units. Mr 4, stated that Mrs Oxenbold approached him and explained that there was insufficient stock and so she did not have the full dose. Mr 4 also

stated that he told Mrs Oxenbold that a partial dose of insulin should not be given and that she should ensure the full dose of insulin was given. Mr 4 explains that he told her to come back to him if she had any concerns but no further concerns were raised with him by Mrs Oxenbold during the remainder of the shift. Mrs Oxenbold noted in her written statements, made in connection with the investigation, that she gave a partial dose of 40 units of insulin.

It is alleged that Mrs Oxenbold failed to adequately check the blood glucose levels of Patient X. In Mrs Oxenbold's response dated 29 January 2018, she appears to acknowledge that she did not document the blood glucose recordings accurately and stated that:

> *"I did not document the blood sugar readings as required on the chart am unable to recall whether or not I took them, therefore by this apparent omission, this would be a breach in the Capillary Blood Glucose Policy".*

At 11:30 Mrs Oxenbold documented Patient X's temperature on the ("Modified Early Warning Score") MEWS chart at 37.6 degrees. At this time Mrs Oxenbold recorded the score as 0 and did not increase the frequency of her observations.

At 14:30, Mrs Oxenbold recorded Patient X's temperature on the MEWS chart as 39.7 degrees and again failed to increase the frequency of her observations. At this time Mrs Oxenbold again recorded the MEWS as 0. Mrs Oxenbold also recorded in Patient X's notes that his temperature had been high and that she had administered "*fan therapy*" following which his temperature had reduced to 39.7 degrees, when it had increased from 37.6 degrees.

On both occasions it is alleged that Mrs Oxenbold did not escalate Patient X's raised temperatures to the nurse in charge or the medical team. At approximately 19:00, Mrs Oxenbold handed-over the care of Patient X to Ms 3 (Staff Nurse) and reported to her that Patient X was diabetic and "*his blood sugar was ok*". Her medical notes state that there

were “*no concerns*” regarding Patient X. Mrs Oxenbold had not recorded any blood sugar readings for Patient X during her shift.

Patient X became visibly unwell later that evening and subsequently suffered a non-fatal cardiac arrest. The Trust conducted a serious incident investigation, and the alleged incidents were discovered.

On 29 January 2018 the matter was investigated and referred to the Trust’s disciplinary hearing. A disciplinary hearing was conducted by the Trust on 8 February 2018 and Mrs Oxenbold was dismissed by the disciplinary panel on the basis of gross misconduct.

On 26 October 2018 an interim conditions of practice order for a period of 18 months was made on Mrs Oxenbold’s nursing practice.

Decision and reasons on facts

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 witnesses and made the following conclusions.

The panel considered the evidence of Mr 1 to be credible and consistent. The panel noted that Mr 1 was able to provide helpful answers, it also noted that he was able to say when there was an error within the documentation. Mr 1 was able to provide independent answers and informed the panel of correct procedures, and the consequences of not following these. The panel found Mr 1 to be a clear and logical witness.

The panel considered Ms 2 to be a credible witness. The panel noted that Ms 2 came across as clinically experienced. Her documentary evidence was helpful alongside her oral

evidence. The panel also noted that Ms 2 was confident in answering questions. The panel found Ms 2 to be clear, consistent and reliable.

The panel considered Ms 3 to be a credible witness. It noted that she was clear in her answers and gave a balanced account. Ms 3 came across as clinically experienced and was able to tell the panel what actions should have been taken. The panel found Ms 3 to be clear and consistent.

The panel considered the evidence of Mr 4 to be credible. It noted that Mr 4 was clear about the actions Mrs Oxenbold should have taken. Mr 4's documentary and oral evidence was clear and cogent. The panel found Mr 4 to be clear consistent, reliable and helpful.

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

Charge 1

1. *On 21 June 2017 whilst responsible for the care of Patient X, failed to adequately manage his care in that you:*

The panel found the stem of charge 1 proved in that Mrs Oxenbold was responsible for Patient X. The panel found that Mrs Oxenbold failed to adequately manage his care, as alleged, for the following his reasons.

Charge 1a)

a. administered 40 units of insulin instead of the prescribed 50 units to Patient X

This charge is found proved.

In reaching this decision, the panel took into account the statement from Mrs Oxenbold and the documentary and oral evidence from Mr 1.

The panel took into account the patient records of Patient X dated 21 June 2017 which was created by Mrs Oxenbold, which stated:

> *"Insulin given at 08:00 only 40 units given as no further medication available. Have ordered from pharmacy. No concerns*".

The panel accepted that Mrs Oxenbold herself wrote in Patient X's record that she had only given 40 units of insulin and that there were no concerns regarding Patient X. The panel also took into account Mr 1's witness statement in that he stated:

> "*A partial dose of insulin from a patient's own device should not have been used. The full advice sought from the nurse in charge was not followed*. *In this case, the nurse administered a drug to which the absorption flow would be ineffective to the patient's requirements*".

This was supported in Mr 1's oral evidence, in which he confirmed that a partial dose should not be given. In the event of not being able to obtain a full dose of insulin from either the pharmacy or a nearby ward, further advice should have been sought from a doctor or the nurse in charge. The panel accepted this evidence.

The panel therefore concluded that Mrs Oxenbold administered 40 units of insulin instead of the prescribed 50 units to Patient X and therefore find this charge proved.

Charge 1b)

> *b. you failed to adequately check the blood glucose levels of Patient X*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence of the medical chart of Patient X and the statement by Mrs Oxenbold. It noted that the Blood

Glucose Monitoring Chart for Patient X dated 21 June 2017, shows no entries made during the day shift. The panel took into account that it had been provided with all the Blood Glucose recordings from 21 June 2017 which do not show any recordings during the day shift for Patient X.

The panel noted Mrs Oxenbold's statement in which she stated:

> "*As there were no blood sugar readings on the chart for the day shift 21/06/17 then I am unable to clarify whether I obtained them. My intention was to supervise a student on the ward that day with taking the tea time readings, but unfortunately I was pulled away from the task and had to leave the ward or a period of time to obtain some fluids for another patient at the Drs request. I believe now that this blood sugar reading was never taken."*

The panel took into account that Mrs Oxenbold herself acknowledged that she did not take or document Patient X's blood sugar readings.

The panel accepted that Mrs Oxenbold failed to adequately check the blood glucose levels of Patient X and therefore find this charge proved.

Charge 1c)

> *c. failed to follow handover instructions regarding seeking medical review of Patient X prior to the administration of any insulin;*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Ms 2 and Mr 4. It also took into account the patient records for Patient X and the statement from Mrs Oxenbold.

The panel noted Ms 2's written statements in which she stated:

> "*I informed the registrant [Mrs Oxenbold] that Patient A's [Patient X] blood glucose level had increased but that it still seemed a large dose for the amount of feed administered. I therefore recommended that the registrant seek advice about whether the dosage was appropriate looking at the whole picture of how this patient was presenting*". *I informed the registrant to closely monitor Patient A, specifically their blood glucose levels*".

The panel took into account the handover notes dated 21 June 2017 from Ms 2 which stated that Patient X needed to be monitored. The panel noted that Ms 2's written statement was consistent with her oral evidence, in which the panel accepted as credible and consistent.

The panel bore in mind Mrs Oxenbold's written statement in which she stated:

> "*When I commenced the shift on the 21/06/2017, it was handed over to me that the patient required a medical review as the previous dose of insulin had been omitted due to the patient's low blood sugar the night before. I did speak to a Dr to request a review, and was advised that the patient would be reviewed during the rounds*."

- She further stated:

> "*There is no documentation in the casenotes regarding requesting a medical review prior to his due dose of insulin in the morning, but I was asked to verbally handover by MD*."

The panel took into account the patient records of Patient X dated 21 June 2017 which was created by Mrs Oxenbold in which she stated:

> "*Referred to dietitian for review as pt now taking diet orally without concerns*".

The panel noted there was no reference by Mrs Oxenbold to referring Patient X for urgent medical review or a consultation with a doctor.
The panel also took into account Mr 4's oral evidence in which he stated that he was unable to locate a consultation note from a doctor.

The panel accepted that Mrs Oxenbold failed to follow handover instructions regarding seeking medical review of Patient X prior to the administration of any insulin and therefore find this charge proved.

Charge 2

2. *At approximately 11.30, after recording Patient X's temperature as 37.6:*

The panel found charge 2 proved in its entirety. It noted that from the documentation Mrs Oxenbold did record Patient X's temperature as 37.6 degrees.

Charge 2a)

a. Incorrectly recorded the MEWS score as 0;

This charge is found proved.

In reaching this decision, the panel took into account the patient records of Patient X, the witness statement and oral evidence of Mr 1 and Mrs Oxenbold's written statement.

The panel took account of the temperature entries and noted that Patient X's temperature was recorded as 37.6 degrees. It also noted that Patient X's MEWS score was documented as 0. The panel bore in mind the oral evidence of Mr 1 in which he stated that a temperature of 37.6 degrees should have been a MEWS score of 1 not 0. The panel accepted this evidence. The panel also bore in mind Mrs Oxenbold's written statement in which she stated:

"*I did not carry out all the MEWS readings on the 21/06/17 and may have documented one of the readings wrongly, for which I am sorry."*

The panel accept that Mrs Oxenbold acknowledges that she incorrectly documented the MEWS score.

The panel determined that Mrs Oxenbold did incorrectly record the MEWS score as 0 and therefore find this charge proved.

Charge 2b)

b. failed to increase the frequency of observations;

This charge is found proved.

In reaching this decision, the panel took into account the patient records of Patient X, the evidence of Mr 1, Mr 4 and Mrs Oxenbold's written statement.

The panel noted that from the MEWS chart, Patient X's temperature was not taken between 11:30 and 14:30. The panel also noted that Patient X's temperature had increased from 37.8 to 39.7 degrees.

The panel bore in mind Mr 1's oral evidence in which he stated that if Patient X's temperature was rising, his observations should have increased. It also took into account Mr 1's written statement in which he stated:

"*The registrant should have repeated the MEWS observations at 11:45. This is because, patients should be being monitored within 30 minutes (maximum) to indicate deterioration*."

The panel also took into account the Escalation Pathway guidance when a NEWS (which is the same as MEWS) score is 1-4 or if a patient is causing clinical concern. This states:

- *"Inform nurse in charge;*
- *Increase frequency of observations and document and frequency required;*
- *Consider escalation of care if required;*
- *Document any actions in the patient's notes."*

The panel determined that the criteria was met in these circumstances. It bore in mind Mr 4's oral evidence in which he stated that Mrs Oxenbold did not raise any further concerns with him for the rest of the shift after asking for advice regarding Patient X's blood sugar. He then went on to say that he was at the nurse station all day and would have had frequent interaction with Mrs Oxenbold.

The panel determined that Mrs Oxenbold failed to increase the frequency of observations and therefore find this charge proved.

Charge 2c)

c. did not escalate Patient X's temperature to a senior colleague or medical team;

This charge is found proved.

In reaching this decision, the panel took into account Mrs Oxenbold's written statement, Patient X's patient notes and the oral evidence of Mr 4.

The panel noted that in Mr 4's oral evidence he stated that Mrs Oxenbold did not raise any concerns with him about Patient X for the rest of the day following his earlier interaction. The panel noted from Patient X's patient notes that there is no reference that Mrs Oxenbold raised his condition to a senior member of staff or to the medical team.

The panel bore in mind Mrs Oxenbold's written statement in which she stated:

> "*I did make brief notes about the patient on this system to state patient x general condition during the day and to record there were no concerns clinically regarding his medical state*".

The panel determined that there was no evidence before it to prove that Mrs Oxenbold escalated Patient X's raised temperature to a senior colleague or to the medical team, and therefore find this charge proved.

Charge 3

3. *At approximately 14.30, after recording Patient X's temperature as 39.7:*

The panel found charge 3 proved in its entirety. It noted from the documentation that Patient X's temperature was recorded as 39.7 degrees.

Charge 3a)

a. Incorrectly recorded the MEWS score as 0;

This charge is found proved.

In reaching this decision, the panel took into account Patient X's patient records, Mr 1's documentary evidence and Mrs Oxenbold's written statement.

The panel noted the temperature entries and noted that Patient X's temperature was recorded as 39.7 degrees. It also noted that Patient X's MEWS score was documented as 0. It heard oral evidence from Mr 1 who confirmed that a temperature of 39.7 degrees should have a MEWS score as 2. This was corroborated with his written statement in which he stated:

"*the temperature was recorded as 39.7 and MEWS score was recorded as 0, this should have been 2*".

The panel took into account that Mrs Oxenbold had completed her MEWS competency framework in September 2016, and accepted the written evidence from Mr 1 which stated:

"*The registrant completed her MEWS Competency Framework. Therefore, there is no reason for her to be calculating the score incorrectly and not being aware how to interpret the score."*

Having accepted this evidence, the panel was of the view that Mrs Oxenbold should have correctly recorded Patient X's MEWS score, and did not do so. The panel noted Mrs Oxenbold's written statement in which she stated:

"*The MEWS at 14.30 does look like a temp of 39.7 on the chart, but the overall score I have scored as 0. I do not know why I would have done that".*

The panel accepted that Mrs Oxenbold did incorrectly record the MEWS score as 0 and therefore find this charge proved.

Charge 3b)

b. failed to increase the frequency of observations;

This charge is found proved.

In reaching this decision, the panel took into account patient records of Patient X, the evidence of Mr 1 and Mrs Oxenbold's written statement.

The panel noted that from the MEWS chart, Patient X's temperature was not taken after 14:30. The panel noted that from the Escalation Pathway guidance, Mrs Oxenbold should

have increased the frequency of observations and document the frequency required. It also accepted Mr 1's evidence in that Mrs Oxenbold should have known that observations should have been taken every 15 minutes with a temperature of 39.7 degrees. The panel also accepted Mr 1's written evidence in which he stated:

> "…*patients should be being monitored within 30 minutes (maximum) to indicate deterioration*".

It bore in mind Mrs Oxenbold's statement in which she stated:

> "*I am sorry, I cannot account for omitting to do the patient observations*".

From the evidence before it, the panel determined that Mrs Oxenbold failed to increase the observations of Patient X and therefore finds this charge proved.

Charge 3c)

> *c. did not escalate Patient X's temperature to a senior colleague or medical team*;

This charge is found proved.

In reaching this decision, the panel took into account Mrs Oxenbold's written statement, Patient X's patient notes and the oral evidence of Mr 4.

The panel noted that from Patient X's patient notes, there was no evidence to indicate that his raised temperature had been escalated to a senior colleague or to the medical team.

The panel noted that in Mr 4's oral evidence he stated that Mrs Oxenbold did not raise any concerns with him for the rest of the day following his earlier interaction. The panel noted from Patient X's patient notes that there is no reference that Mrs Oxenbold raised his condition to a senior member of staff or to the medical team. Given Patient X's medical

history and his condition at this time, the panel found that an escalation of monitoring his temperature would have been appropriate. The panel also bore in mind the Escalation Pathway guidance.

The panel noted that Mrs Oxenbold failed to recognise that Patient X's temperature had risen in that she documented on 21 June 2017 on Patient X's records that his temperature had gone down, when in fact it had risen.

The panel bore in mind Mrs Oxenbold's written statement in which she stated:

> "*I did make brief notes about the patient on this system to state patient x general condition during the day and to record there were no concerns clinically regarding his medical state*".

The panel determined that there was no evidence before it to prove that Mrs Oxenbold escalated Patient X's raised temperature to a senior colleague or to the medical team, and therefore find this charge 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 Oxenbold'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 Oxenbold'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 Stevenson spoke to detailed written submissions. Along with the case of *Roylance v General Medical Council*, Ms Stevenson referred the panel to the case of *Calhaem v GMC* [2007] EWHC 2006 (Admin) and Mr Justice Collins in *Nandi v GMC* [2004] EWHC 2317 (Admin).

Ms Stevenson submitted that the facts found proved amount to misconduct. She submitted that the failure to adequately manage the care of a patient is a serious breach of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ("the Code"). Patient X was at risk having arrived on the ward from the Intensive Care Unit ("ITU") and Mrs Oxenbold gave a partial dose of insulin which was against the instructions from the nurse in charge on her shift, Mr 4. Nor were there any records from Mrs Oxenbold that she sought advice from a doctor regarding the insulin dose. Ms Stevenson also stated that Mrs Oxenbold failed to check the blood glucose levels of Patient X adequately or at all. She referred the panel to the Mr 1's witness statement in which he stated:

> *"there was no other measure to detect dropping BGM* [Blood Glucose Monitoring] *and a deterioration of the patient's health had one occurred"*

Ms Stevenson referred the panel to Ms 2's oral evidence. When asked what would be the consequences if Patient X were delayed in receiving a medical review, she responded that there would be serious consequences, that the patient would have a severe hypoglycaemic attack and he would be difficult to revive.

Ms Stevenson submitted that incorrectly recording the MEWS score is a serious breach of the Code. She referred the panel to Mr 1's witness statement in that he explained that the MEWS score is used as a numerical indicator and the score will then trigger a nurse's subsequent actions. In relation to failing to increase the frequency of observations, Ms Stevenson submitted that this is a serious breach of the Code in that Mr 1 stated in evidence that he would have expected Mrs Oxenbold to repeat observations again at 15 minutes' intervals until Patient X's temperature had returned to a normal range, which she did not do.

Ms Stevenson further submitted that failing to escalate Patient X's raised temperature to a senior colleague or to the medical team is a serious breach, as Mr 1 stated in evidence that he would have expected Mrs Oxenbold to escalate the raised temperature by either speaking to the nurse in charge or to the doctor. Mr 1 confirmed that no action was taken by Mrs Oxenbold.

Ms Stevenson submitted that by Mrs Oxenbold's failings, she denied herself the opportunity to highlight a deterioration in Patient X's condition, prevented herself from taking the appropriate action and therefore placed Patient X at an unwarranted risk of harm. Ms Stevenson submitted that Mrs Oxenbold sought to deflect blame towards Mr 4 and partial blame to a student nurse, although there was no evidence of a student nurse being on that shift. She further submitted that Mrs Oxenbold's actions fall far short of what would be expected of a registered nurse and that colleagues would expect that they could rely upon their other colleagues to deliver safe and effective care. Ms Stevenson also submitted that the public would expect that the profession would properly care for friends, relatives and members of the public and to uphold the reputation of the profession.

Ms Stevenson submitted that the following areas of the Code have been breached:

> *"3 Make sure that people's physical, social and psychological needs are assessed and responded to*
> *8 Work cooperatively*
> *10 Keep clear and accurate records relevant to your practice*
> *13 Recognise and work within the limits of your competence*
> *16 Act without delay if you believe that there is a risk to patient safety or public protection*
> *18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations*
> *19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice*
> *20 Uphold the reputation of your profession at all times"*

Submissions on impairment

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

Ms Stevenson submitted that Mrs Oxenbold is unequivocally impaired and that the first three limbs of *Grant* are engaged. She submitted that Mrs Oxenbold made repeated errors across an 11.5 hour shift and sought to deflect blame onto others. Ms Stevenson went onto repeat her misconduct submissions in that by Mrs Oxenbold's failings, she denied herself the opportunity to highlight a deterioration in Patient X's condition, prevented

herself from taking the appropriate action and therefore placed Patient X at an unwarranted risk of harm.

Ms Stevenson submitted that Mrs Oxenbold's behaviour brings the profession into disrepute and has breached fundamental tenets of the profession by failing in numerous areas of the Code of Conduct. She stated that Mrs Oxenbold has not attended this hearing and has hardly engaged with the NMC. She also stated that the NMC are unaware of Mrs Oxenbold's current employment status and whether she has worked as a nurse since the incidents. Ms Stevenson told the panel that Mrs Oxenbold has informed the NMC that she has no intention of returning to nursing. She stated that although Mrs Oxenbold has provided the NMC with two statements where she accepts some degree of inadequate care to Patient X, there is no explanation as to why she acted as she did or how she would act differently in a similar situation in the future.

Ms Stevenson submitted that Mrs Oxenbold has not acknowledged the seriousness of the concerns and therefore the panel can conclude that there is a lack of insight, acceptance or remorse. She further submitted that there is no evidence of remediation or any information to convince this panel that Mrs Oxenbold is not at risk of repeating this behaviour were she to continue to practise.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgements. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin)*, Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Spencer v General Osteopathic Council* [2012] EWHC 3147 (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 Oxenbold's actions did fall significantly short of the standards expected of a registered nurse, and amounted to a breach of the Code. Specifically:

> ***"3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> ***8 Work cooperatively***
> ***10 Keep clear and accurate records relevant to your practice***
> ***13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care***
> ***13.2 make a timely referral to another practitioner when any action, care or treatment is required***
> ***18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations***
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***
> ***20 Uphold the reputation of your profession at all times"***

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 Oxenbold's failure to provide adequate care to Patient X was a serious breach of the Code and amounted to misconduct. The panel noted that Mrs Oxenbold's incorrect recording of Patient X's MEWS score as 0 on both occasions led to a failure to escalate his deteriorating condition to a senior colleague or to the medical team. The panel also took into account that Mrs Oxenbold repeated her failure. It noted that Ms 2 had specifically informed Mrs Oxenbold of her concerns regarding Patient X. The panel bore in mind that Mrs Oxenbold gave a partial dose of insulin to Patient X despite Mr 4 advising against this, and without seeking advice from a doctor. The panel determined that this is serious enough to misconduct. It took into account Ms 2's witness statement in which she stated:

"I informed the registrant that Patient A's blood glucose level had increased but that it still seemed a large dose for the amount offered administered. I therefore recommended that the registrant seek advice about whether the dosage was appropriate looking at the whole picture of how this patient was presenting."

The panel took into account that fact that Mrs Oxenbold failed to increase the frequency of her observations and was of the view that this was serious enough to amount to misconduct. The panel noted Mr 1's witness statement in which he stated:

"The registrant should have repeated the MEWS observations at 11:45. This is because, patients should be monitored within 30 minutes (maximum) to indicate deterioration".

The panel noted that in Mrs Oxenbold's statement she sought to deflect blame onto others and noted that Mrs Oxenbold's failings involved basic aspects of nursing care. Mrs Oxenbold was in charge of Patient X's care and failed to provide adequate care to a vulnerable patient who had just been transferred from the ITU. The panel was of the view that the misconduct had the potential to cause serious harm to a vulnerable patient. Taking all the information into account, the panel concluded that Mrs Oxenbold'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 Oxenbold's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones and registered nurses 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.'*

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; …*

The panel found that limbs (a), (b) and (c) were all engaged in this case. The panel was of the view that administering a partial dose of insulin when being advised not to, failing to correctly record a patient's MEWS score and not escalating a deteriorating patient put Patient X at an unwarranted risk of harm, brought the nursing profession into disrepute and breached fundamental tenets of the profession. The panel also took into account that Mrs Oxenbold sought to deflect blame onto her colleague and a student nurse.

In reaching its decision, the panel considered Mrs Oxenbold's position. The panel was not in possession of any evidence from Mrs Oxenbold herself and therefore was unable to determine Mrs Oxenbold's insight into her misconduct. The panel did not have any information from Mrs Oxenbold regarding how her actions put the patient at a risk of harm, an understanding of why what she did was wrong or how this impacted negatively on the reputation of the nursing profession. The panel noted that although Mrs Oxenbold appeared to acknowledge that she failed in her responsibilities during the local investigation, the panel did not have any further information as to any insight or remorse.

The panel was satisfied that the misconduct in this case is capable of remediation. However the panel noted that it had no information from Mrs Oxenbold as to any steps towards remediation. The panel also took into account that Mrs Oxenbold has informed the NMC that she has no intention of returning to the nursing profession. The panel is of the view that there is a risk of repetition due to the lack of remediation or lack of evidence from Mrs Oxenbold.

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; 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 required. 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 Oxenbold's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Oxenbold'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 Oxenbold's registration has been suspended.

Submissions on sanction

Ms Stevenson spoke to detailed written submissions. She submitted what the NMC consider to be the aggravating and mitigating factors in Mrs Oxenbold's case.

The aggravating factors submitted were:

- No co-operation with the investigation;
- No evidence of remorse, insight or remediation (except for partial acceptances in the Mrs Oxenbold's statements);
- Deflecting blame to colleagues;
- This case is not a one off incident. There was a pattern of misconduct by way of repeated failings and incorrect recordings over an 11.5 hour shift; and,
- Mrs Oxenbold's conduct put Patient X at unwarranted risk of harm.

The mitigating factors submitted were:

- Mrs Oxenbold appears to accept to some degree, in her statements from 2017, that she provided inadequate care to Patient X; and,
- There have been no previous referrals or findings by the NMC regarding Mrs Oxenbold.

Ms Stevenson informed the panel that Mrs Oxenbold is currently subject to an interim conditions of practice order. She told the panel that the NMC have had no evidence as to Mrs Oxenbold's current employment status or whether she has practised nursing since the incidents occurred. Ms Stevenson reminded the panel that in recent correspondence from Mrs Oxenbold, she stated that she will not be returning to the nursing profession.

Ms Stevenson submitted that the appropriate and proportionate sanction in this case is a conditions of practice order for 18 months to 2 years. Ms Stevenson submitted that a conditions of practice order would afford Mrs Oxenbold the opportunity to demonstrate that she can work to the standard expected of a registered professional. She submitted that a longer period of time for the conditions of practice order is sought to allow Mrs Oxenbold the opportunity to alleviate the concerns identified. Ms Stevenson suggested to the panel that the conditions should not allow unsupervised practice until the Mrs Oxenbold has satisfactorily completed retraining in care of diabetic patients.

Decision and reasons on sanction

Having found Mrs Oxenbold'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. 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"). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- No co-operation with the investigation;
- No evidence of remorse, remediation and only limited insight (except for partial acceptances in Mrs Oxenbold's statements);
- No insight into the distress endured by Patient X due to his deteriorating condition;
- Deflecting blame to colleagues;
- There was a pattern of misconduct by way of repeated failings and incorrect recordings over an 11.5 hour shift; and,
- Mrs Oxenbold's conduct put Patient X at unwarranted risk of harm.

The panel also took into account the following mitigating features:

- That Mrs Oxenbold appears to accept to some degree, in her statements from 2017, that she provided inadequate care to Patient X.

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The panel noted that although Mrs Oxenbold has had a short nursing career, there have been no previous referrals or findings by the NMC.

The panel first considered whether to take no action but concluded that this would be inappropriate in this case. The panel had identified a risk of repetition. To take no further action would fail to address the public protection concerns in this case. In addition, it would be inadequate to address the wider public interest considerations arising from the nature and circumstances of the misconduct.

For the same reasons, the panel considered that due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Oxenbold'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 Oxenbold's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Oxenbold's registration would be a sufficient and appropriate response. It noted that this was the sanction which the NMC invited it to consider, although it was not bound by that recommendation. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, and the indicative factors which may indicate that a conditions of practice order is suitable. 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;*
- *Potential and willingness to respond positively to retraining;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel was of the view that although the failings in this case were not attitudinal in nature, it noted from the correspondence from Mrs Oxenbold to the NMC that she may have an attitudinal problem towards the NMC. The panel also noted that Mrs Oxenbold has had little engagement with the NMC and stated that she would see it as "*harassment*" if she receives further contact from the NMC. The panel took into account that to impose a conditions of practice order the registrant would need to be willing to engage in retraining, and she was not. The panel bore in mind Mrs Oxenbold's email correspondence to the NMC dated 27 March 2020 in which she stated:

"*I do not under any circumstances wish to return to practice"*

She further stated in an email to the NMC dated 9 July 2020 which stated:

> *"Please do not continue to send documents or list hearing. I am no longer involved with nor intend to ever again nursing practice"*

In another email dated 8 September 2020 she stated:

> *"I have however, stated in previous and numerous emails to you that I am not and will not be entering nursing …*
> *"If you do not remove the case and myself from records I will consider any further contact as harassment and will be contacting my solicitors."*

The panel took into account that a conditions of practice order is to enable a registrant to practice safely whilst under restriction. The panel noted that Mrs Oxenbold on several occasions has made it clear that she no longer wishes to practise as a nurse. The panel was therefore of the view that there are no practical or workable conditions that could be formulated. In addition, the panel considered that conditions would only be workable in the presence of remorse and insight, and there was an absence of evidence of these.

The panel then went on to consider whether a suspension order would be an appropriate sanction. Again, the panel had regard to the SG, and the indicative factors which may suggest that a suspension order may be appropriate.

The panel considered that, although serious, the misconduct in this case was not at the top of the scale of seriousness. It had already noted that, had there been sufficient evidence of remorse, insight and remediation to minimise the risk of repetition, a conditions of practice order might have been sufficient to mark the seriousness of the misconduct and address the wider public interest considerations in this case. It followed that the panel considered that a period of suspension would be sufficient to address the

public interest considerations. It also considered that a period of suspension would operate to protect the public whilst it was in force.

The panel further bore in mind that there was no evidence of deep-seated attitudinal failings in this case and that the conduct was remediable. It considered that a period of suspension would allow an opportunity for Mrs Oxenbold to reflect on her actions, the concerns identified in this case, the consequences to Patient X, colleagues and the reputation of the profession, and the steps which could be taken to ensure that it was not repeated. In the circumstances set out above, the panel was also satisfied that in this case the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate at this stage. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Oxenbold case to impose a striking-off order.

The panel was therefore of the view that a suspension order would be appropriate, sufficient and proportionate response in this case. It was, at the present time, the only order which would be sufficient to address both the public protection and wider public interest considerations in the light of the absence of evidence of insight, remorse and remediation. 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 might cause Mrs Oxenbold. However if Mrs Oxenbold wishes to engage with the NMC she may apply for an early review of this order.

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 behaviour required of a registered nurse.

The panel determined that a 12 month suspension would give Mrs Oxenbold the opportunity to reflect upon and remedy her failings, to engage with the NMC and to demonstrate to a reviewing panel that she recognises the impact that her actions had on Patient X, colleagues and the profession in general, as well as providing an assurance that the misconduct would not be repeated.

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:

- Engagement with the NMC;
- A reflective piece with specific reference to;
    - The impact Mrs Oxenbold's actions had on Patient X and to her colleagues;
    - The impact her actions had on the reputation of the nursing profession;
    - The standard of nursing that she should have maintained; and
    - The critical importance of taking timely observations of patients.
- Evidence of any work, outside of nursing, particularly in the caring environment.

This will be confirmed to Mrs Oxenbold 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 Oxenbold'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 Stevenson. She submitted that an interim order should be imposed in order to allow for the possibility of an appeal to be brought and determined. She submitted that an interim suspension order for a period of 18 months should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

Decision and reasons on interim order

The panel had regard to the seriousness of the facts found proved and the reasons for its findings on the issues of misconduct, impairment and sanction set out in its substantive determination. 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 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 considered that it was necessary to impose an interim suspension order. It considered that the appropriate duration of the interim suspension order was for a period of 18 months, because of the length of time likely to be required for any appeal, if brought, to be determined or otherwise finally disposed of.

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

That concludes this determination.