Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting

17 September 2020

Virtual Meeting

Name of registrant:	Ellen Joy Byng
NMC PIN:	79Y2000E
Part(s) of the register:	Registered Nurse (Sub Part 2) Learning Disabilities – May 1981
Area of Registered Address:	Worcestershire
Type of Case:	Misconduct
Panel Members:	Debbie Hill (Chair, Lay member) Sally Glen (Registrant member) David Boyd (Lay member)
Legal Assessor:	James Holdsworth
Panel Secretary:	Caroline Pringle
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Suspension order (6 months)
Interim Order:	Interim suspension order (18 months)

Decision on proof of service

The panel considered whether notice of this meeting has been served in accordance with Rules 11A and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ("the Rules").

The panel accepted the advice of the legal assessor. The panel noted that under the amendments made to the Rules during the Covid-19 emergency period, a notice of hearing or meeting can be sent to a registrant's registered address by recorded delivery and first class post or to a suitable email address on the register.

The panel noted that notice of this substantive meeting was sent to Ms Byng by email on 20 August 2020. It was sent to an email address which Ms Byng provided to the NMC in a phone call on 23 July 2020. The notice informed Ms Byng that a panel of the Fitness to Practise Committee would hold a meeting to consider her case on or after 17 September 2020. The notice included the charges which the panel would consider at the meeting, as well as informing Ms Byng that the panel would consider whether her fitness to practise is currently impaired as a result of those charges and, if so, whether a sanction is required. Ms Byng was asked to provide any relevant submissions or documents for the panel by 11 September 2020.

In these circumstances, the panel was satisfied that the notice was sent 28 days in advance of this meeting and had been served in accordance with the Rules. The panel also considered that it was appropriate to consider this matter at a meeting, as Ms Byng has not requested a hearing and indicated on 23 July 2020 that she would not attend a hearing if one were held.

Details of charge

That you, a registered nurse:

1. On or around February 2018 or alternatively on or around 12 April 2018, instructed care staff to reduce the amount of thickener for Resident A:
   1.1. to one scoop instead of two scoops;

1.2. without consulting a GP and/or seeking medical advice;
1.3. without clinical justification;
1.4. without recording your instructions in writing in Resident A's care plan and/or nursing notes and/or risk assessment;
1.5. due to the thickener being used up too quickly and/or for financial reasons;

2. On the 16 and/or 17 April 2018:
2.1. instructed care staff to reintroduce Resident A to an oral diet without:
2.1.1. ensuring that feeding via the PEG was discontinued;
2.1.2. consulting a GP and/or seeking medical advice regarding the PEG regime;
2.1.3. ensuring that a medical assessment was undertaken;
2.1.4. seeking clarification from a GP/medical professional on whether a PEG feed was appropriate;
2.1.5. telling care staff that Resident A was nil-by-mouth;
2.1.6. recording your instructions in writing in Resident A's care plan and/or nursing notes and/or risk assessment;

2.2. Failed to recognise or alternatively on recognising or alternately on being informed that Resident A was nil-by-mouth and/or being fed via PEG without a prescription, failed to:
2.2.1. ensure that feeding via PEG was discontinued;
2.2.2. escalate this to an appropriate medical professional;
2.2.3. sought clarification from a GP/medical professional;
2.2.4. ensure that a medical assessment was undertaken;

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

Background

Ms Byng first joined the NMC register in May 1981. The allegations against Ms Byng arose while she was employed at Saltways Care Home ("the Home"). As of February

2018, Ms Byng had been employed at the Home as a Registered Nurse for a total of 18 years. She had been the acting Deputy Manager for approximately one year.

The Home provided accommodation and nursing care for up to 24 residents. Resident A had been living at the Home since 2004. She had a diagnosis of multiple sclerosis, epilepsy, depression, IBS and glaucoma. Resident A had the capacity to make decisions about her care. Resident A could communicate about her care and eat food orally however she had been assessed as being at high risk of choking as she had difficulty swallowing lumpy hard foods. Resident A had a Percutaneous Endoscopic Gastrostomy ("PEG") regime for hydration and medication.

On 15 April 2018, Colleague A identified Resident A as being at risk of aspiration and a decision was made to feed Resident A via a PEG feed. Resident A's nursing notes were marked 'Nil By Mouth' to reflect this decision. On 18 April 2018 Resident A became ill and, following a GP's assessment, was transferred to hospital. On 23 April 2018 a safeguarding alert was raised following Resident A having previously been given food and fluid orally while simultaneously under a PEG feeding regime. Resident A, while in hospital, deteriorated and died on 29 April 2018. A post mortem recorded her cause of death as (a) aspiration pneumonia in associate with PEG feeding, and (b) multiple sclerosis.

While an inquest into Resident A's death concluded that there was no evidence that any failings of the Home caused or contributed to Resident A's death, a referral was made to the NMC which raised concerns about Ms Byng's practice and judgement in relation to the support and care provided to Resident A at the Home. These concerns form the basis of charges 1 and 2.

Ms Byng left the Home in August 2018 and is currently not working as a nurse. She has provided no formal response to the NMC charges.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel took into account all of the documentary evidence before it. This included:

- A witness statement from Dr 1 – the General Practitioner who visited Resident A on 16 April 2018
- A witness statement from Ms 2 – Support Worker at the Home
- A witness statement from Ms 3 – Support Worker at the Home
- Two witness statements from Ms 4 – Head of Clinical Excellence at Leonard Cheshire, which runs the Home
- Documents from the local investigation at the Home, including the preliminary fact finding report following Resident A's death
- A copy of Resident A's care plan and other documents from her records
- Documents from the Home's disciplinary process in relation to Ms Byng

Ms Byng has made no formal response to the charges. The only information it had from Ms Byng were summaries of two telephone calls, made by NMC staff.

The first of these was dated 20 March 2019 and records that Ms Byng stated that (i) she was too unwell to currently be working as a nurse; (ii) she would never return to the profession; and (iii) she had been following the care plan in good faith and was not responsible for what had happened.

The second telephone note was dated 23 July 2020. During this call, Ms Byng provided further details about her health. She also stated that she had always told the nurses at the Home how to properly administer fluids to patients.

The panel accepted the advice of the legal assessor.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that the

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

The panel considered each charge and made the following findings:

Charge 1.1

1. On or around February 2018 or alternatively on or around 12 April 2018, instructed care staff to reduce the amount of thickener for Resident A:
   1.1. to one scoop instead of two scoops;

This charge is found proved.

In reaching this decision the panel had regard to the evidence of Ms 2, support worker at the Home. She states in her witness statement that around four weeks before Resident A was taken to hospital on 18 April 2018, the Speech and Language Therapy ("SALT") team had put Resident A on a pureed diet. They had also decided that Resident A was to have two scoops of thickener in her fluids. At this point, Resident A was only receiving her medication through her PEG and was still taking food and fluids orally.

The panel also had copies of Resident A's care plan, risk assessment (which had been completed by Ms Byng) and discharge summary from the SALT team, all of which supported the fact that Resident A should have been receiving two scoops of thickener.

In her statement, Ms 2 claims that one or two weeks after Resident A had been assessed by the SALT team, Ms Byng told staff that they were to use one scoop of thickener in Resident A's fluids instead of two. According to Ms 2, Ms Byng said that the Home was running out of thickener and it would last longer if staff only used on scoop.

The witness statement of Ms 3, another support worker at the Home, was consistent with that of Ms 2. She states that she was told directly by Ms Byng to only use one scoop of thickener instead of two because the stock was running out.

The panel could find no evidence to support these events taking place in February 2018. However, taking account of the evidence before it the panel was satisfied that on or around 12 April 2018 Ms Byng instructed care staff to reduce the amount of thickener for Resident A from two scoops to one scoop.

Accordingly, charge 1.1 is found proved.

Charge 1.2

1.2. without consulting a GP and/or seeking medical advice;

This charge is found proved.

Taking account of the evidence before it, which is set out in the panel's decision on charge 1.1, the panel was satisfied that Ms Byng had instructed staff to reduce Resident A's thickener to one scoop to make the stocks last longer. The panel had no evidence that Ms Byng had consulted a GP or sought medical advice from another appropriate healthcare professional, such as a dietician or the SALT team.

The panel was therefore satisfied that on or around 12 April 2018 Ms Byng instructed care staff to reduce the amount of thickener for Resident A without consulting a GP and/or seeking medical advice.

Accordingly charge 1.2 is found proved.

Charge 1.3

1.3. without clinical justification;

This charge is found proved.

Taking account of the evidence before it, which is set out in the panel's decision on charge 1.1, the panel was satisfied that Ms Byng had instructed staff to reduce Resident A's thickener from two scoops to one scoop to make the stocks last longer. It had also found charge 1.2 proved, namely that Ms Byng had done this without consulting a GP or seeking appropriate medical advice. The panel considered that it was evident that attempting to make the stocks of thickener last longer was not a clinical justification for reducing the amount given to Resident A.

The panel was therefore satisfied that on or around 12 April 2018 Ms Byng instructed care staff to reduce the amount of thickener for Resident A without clinical justification.

Accordingly, charge 1.3 is found proved.

Charge 1.4

1.4. without recording your instructions in writing in Resident A's care plan and/or nursing notes and/or risk assessment;

This charge is found proved.

In reaching this decision, the panel had regard to the evidence of Ms 2 and Ms 3, as well as Resident A's records and care plans. Both Ms 2 and Ms 3 give evidence that Ms Byng gave verbal instructions to staff to reduce the number of scoops of thickener. The panel had copies of Resident A's care plans and risk assessments from the relevant time period but could find no evidence within them that Ms Byng recorded her instructions in writing in these records.

The panel was therefore satisfied that on or around 12 April 2018 Ms Byng instructed care staff to reduce the amount of thickener for Resident A without recording her

instructions in writing in Resident A's care plan and/or nursing notes and/or risk assessment. .

Accordingly, charge 1.4 is found proved.

Charge 1.5

1.5. due to the thickener being used up too quickly and/or for financial reasons;

This charge is found proved.

Taking account of the evidence before it, which is set out in the panel's decision on charge 1.1, the panel was satisfied that Ms Byng had instructed staff to reduce Resident A's thickener to one scoop to make the stocks last longer, as the thickener was being used up too quickly.

Accordingly charge 1.5 is found proved.

Charge 2.1.1

2. On the 16 and/or 17 April 2018:

2.1. instructed care staff to reintroduce Resident A to an oral diet without:

2.1.1. ensuring that feeding via the PEG was discontinued;

This charge is found proved.

In reaching this decision the panel had regard to the evidence of Ms 2. According to her statement, on 15 April 2018 the nurse on duty took the decision that Resident A should be nil by mouth ("NBM") as she appeared to be having difficulties swallowing, and should not receive any food or fluids orally. The panel had a copy of Resident A's notes, in which the nurse had recorded that Resident A would be NBM. The panel also had regard to a copy of Resident A's PEG feed regime, detailing when Resident A was fed via the PEG between 16 – 18 April 2018.

Dr 1's evidence confirms that she visited Resident A on 16 April 2018 and agreed that the NBM decision was appropriate in the circumstances.

According to Ms 2, on 17 April 2018, Ms Byng told all of the staff on shift that they should give Resident A a pureed breakfast, with a view to keeping her on food and fluids orally throughout the day if she managed this well. However, Ms 2 states that Ms Byng changed her mind at approximately 11:00 while Ms 2 was giving Resident A a hot drink, and instructed Ms 2 to stop as it appeared that Resident A was struggling.

Ms 2 states that Resident A did not have food or fluid at lunch time and a nurse fed Resident A via her PEG. She also gives evidence that she overheard Ms Byng confirm at approximately 16:30 to another person that Resident A should be given her evening meal but not her drink. Ms 2 states she questioned Ms Byng about this and she confirmed that this instruction was correct.

Ms 2 states that she witnessed Ms 3 giving Resident A her evening meal orally, with Ms Byng giving fluids to Resident A via her PEG. Ms 3's witness statement is consistent with this.

The panel had regard to Ms Byng's statement which she gave during the local investigation. According to this statement, Ms Byng accepts that she was made aware on 15 April 2018 at handover that Resident A was to be given food and fluids via her PEG until her condition had improved. In her local statement, Ms Byng states that she took the decision on 16 April 2018 to give Resident A her breakfast orally as she could not locate any plan to suggest that Resident A could not eat. Ms Byng states that she spoke to the deputy manager when she came on shift and was informed that a plan had been written for Resident A. This was located in the tray on the nurse's desk by the deputy manager. Ms Byng states that when she asked about Resident A's evening meal, she was told that if anything was to be given it should be something soft.

However, the panel considered that Resident A's notes made it clear that Resident A was to be NBM and should only receive food and fluids via her PEG. It was therefore satisfied that on 16/17 April 2018 Ms Byng instructed care staff to reintroduce Resident A to an oral diet without ensuring that feeding via the PEG was discontinued.

Accordingly, charge 2.1.1 is found proved.

Charge 2.1.2

2.1.2. consulting a GP and/or seeking medical advice regarding the PEG regime;

This charge is found proved.

In reaching this decision the panel had regard to the evidence set out in charge 2.1.1 and the evidence of Ms 4, who carried out the local investigation. According to Ms 4's statement, Ms Byng should have recognised that Resident A should not be fed both orally and via the PEG. Ms 4 states that Ms Byng should have recorded any change to diet and nutritional support in respect of her instructions to reintroduce Resident A to being fed orally. Ms 4 states that she would have expected Ms Byng to have contacted the GP surgery for advice and information regarding Resident A and the PEG feed. According to Ms 4, Ms Byng should not have reintroduced Resident A to an oral diet but should have called a GP to discuss reintroducing oral food and ensuring the PEG feed was discontinued. She states that Ms Byng should have recognised that she should not have been feeding Resident A orally and by PEG, and that doing so would put Resident A at risk of harm.

The panel had no evidence that Ms Byng had consulted a GP or sought medical advice regarding Resident A's PEG regime. It was therefore satisfied that on 16/17 April 2018 Ms Byng instructed care staff to reintroduce Resident A to an oral diet without consulting a GP and/or seeking medical advice.

Accordingly, charge 2.1.2 is found proved.

Charge 2.1.3

2.1.3. ensuring that a medical assessment was undertaken;

This charge is found proved.

In reaching this decision the panel had regard to the evidence before it, which is set out in its decisions in relation to charge 2.1.1 and 2.1.2. According to Ms 4's statement, changes should only be made to a PEG regime on the advice of a GP or another appropriate practitioner, such as the SALT team.

The panel had no evidence that Ms Byng had consulted a GP or sought medical advice regarding Resident A's PEG regime, nor that she had requested a medical assessment of Resident A before she took the decision to reintroduce an oral diet.

The panel was therefore satisfied that on 16/17 April 2018 Ms Byng instructed care staff to reintroduce Resident A to an oral diet without ensuring that a medical assessment was undertaken.

Accordingly, charge 2.1.3 is found proved.

Charge 2.1.4

2.1.4. seeking clarification from a GP/medical professional on whether a PEG feed was appropriate;

This charge is found proved.

In reaching this decision the panel had regard to the evidence before it, which is set out in its decisions in relation to charge 2.1.1 and 2.1.2. The panel had no evidence that Ms Byng had sought clarification from a GP or another medical professional, such as the SALT team, on whether a PEG feed was appropriate.

It was therefore satisfied that on 16/17 April 2018 Ms Byng instructed care staff to reintroduce Resident A to an oral diet without seeking clarification from a GP/medical professional on whether a PEG feed was appropriate.

Accordingly, charge 2.1.4 is found proved.

Charge 2.1.5

2.1.5. telling care staff that Resident A was nil-by-mouth;

This charge is found proved.

In reaching this decision, the panel had regard to the evidence of Ms 1 and Ms 2, as set out in charge 2.1.1. According to Ms 1 and Ms 2, Ms Byng instructed them to give Resident A pureed food orally and did not tell them that she was NBM.

The panel was therefore satisfied that on 16/17 April 2018 Ms Byng instructed care staff to reintroduce Resident A to an oral diet without telling them that Resident A was NBM.

Accordingly, charge 2.1.5 is found proved.

Charge 2.1.6

2.1.6. recording your instructions in writing in Resident A's care plan and/or nursing notes and/or risk assessment;

This charge is found proved.

In reaching this decision, the panel had regard to the evidence of Ms 4 as well Resident A's care plan and risk assessments. According to Ms 4, Ms Byng should have recorded any changes to Resident A's diet plan or PEG regime in Resident A's records, with her justifications for doing so.

The panel had regard to Resident A's care plan, notes and risk assessment and could find no evidence that Ms Byng had recorded her instructions to the care staff in these documents.

The panel was therefore satisfied that on 16/17 April 2018 Ms Byng instructed care staff to reintroduce Resident A to an oral diet without recording her instructions in writing in Resident A's care plan and/or nursing notes and/or risk assessment.

Accordingly, charge 2.1.6 is found proved.

Charge 2.2.1

2.2. Failed to recognise or alternatively on recognising or alternately on being informed that Resident A was nil-by-mouth and/or being fed via PEG without a prescription, failed to:

2.2.1. ensure that feeding via PEG was discontinued;

In reaching this decision, the panel had regard to the evidence on Ms 4. According to her witness statement, Ms Byng should have been aware of the dangers of Resident A being fed via a PEG without a prescription and, in response, ensured that the PEG was discontinued, escalated this to the GP or other appropriate practitioner (such as the SALT team), sought clarification from them and arranged for a medical assessment.

However, the panel had no evidence that, when Ms Byng became aware that Resident A was being fed via a PEG without a prescription, that she took any of these steps. The panel was therefore satisfied that on 16/17 April 2018 Ms Byng failed to ensure that the PEG was discontinued.

Accordingly, charge 2.2.1 is found proved.

Charge 2.2.2

2.2.2. escalate this to an appropriate medical professional;

This charge is found proved.

In reaching this decision the panel had regard to the evidence of Ms 4, as set out in charge 2.2.1. The panel had no evidence that, when Ms Byng became aware that Resident A was being fed via a PEG without a prescription, that she escalated this to an appropriate medical professional.

Accordingly, charge 2.2.2 is found proved.

Charge 2.2.3

2.2.3. sought clarification from a GP/medical professional;

This charge is found proved.

In reaching this decision the panel had regard to the evidence of Ms 4, as set out in charge 2.2.1. The panel had no evidence that, when Ms Byng became aware that Resident A was being fed via a PEG without a prescription, that she sought clarification from a GP or an appropriate medical professional.

Accordingly, charge 2.2.3 is found proved.

Charge 2.2.4

2.2.4. ensure that a medical assessment was undertaken;

This charge is found proved.

In reaching this decision the panel had regard to the evidence of Ms 4, as set out in charge 2.2.1. The panel had no evidence that, when Ms Byng became aware that

Resident A was being fed via a PEG without a prescription, that she ensured that a medical assessment was undertaken.

Accordingly, charge 2.2.4 is found proved.

Decision on misconduct

When determining whether the charges found proved amounted to misconduct the panel accepted the advice of the legal assessor and had regard to the terms of *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)* (the Code).

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

The panel was of the view that Ms Byng's actions in respect of charges 1 and 2 did fall significantly short of the standards expected of a registered midwife, and that her actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

4 Act in the best interests of people at all times

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

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

8.6 share information to identify and reduce risk, and

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

.

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it considered that Ms Byng's actions at charges 1 and 2 fell significantly short of the standards expected of a registered nurse. In respect of charge 1, Ms Byng made changes to Resident A's care, as decided by her SALT specialist, with no clinical justification. This could have had serious consequences for Resident A's

well-being. Similarly, her actions at charges 2.1 and 2.2 placed Resident A at serious risk of harm.

In all the circumstances, the panel was satisfied that Ms Byng's actions did fall seriously short of the standards expected of a registered nurse and that charges 1 and 2 amounted to misconduct.

Decision on impairment

The panel next went on to decide if, as a result of this misconduct, Ms Byng's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined it as a registrant's suitability to remain on the register unrestricted. The panel accepted the advice of the legal assessor, which included reference to *CHRE v (1) NMC (2) Grant* [2011] EWHC 927 (Admin).

The panel first considered the test adopted by Mrs Justice Cox in the case of *Grant* at paragraph 76:

> *'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. …'

The panel determined that limbs (a), (b) and (c) of *Grant* were engaged in this case. Ms Byng's actions had, in the past, placed Resident A at unwarranted risk of harm, breached fundamental tenets and brought the profession into disrepute.

The panel then moved on to consider whether Ms Byng was likely to repeat such misconduct in the future. It noted that Ms Byng's misconduct was an isolated incident which related to identifiable areas of her clinical nursing practice, such as PEG feeds, communication, escalation and record-keeping. It considered that this misconduct was capable of remediation through further training and reflection.

However, Ms Byng left the Home in August 2018. The limited information that the panel has from Ms Byng suggests that she has not worked as a nurse since, nor that she intends to in the future. The panel therefore has no evidence of safe practice since the incidents.

Ms Byng has also not provided evidence of any remediation, such as relevant training, online study or reading. The panel had no evidence of any insight from Ms Byng, nor any information about what she would do differently in the future.

The panel concluded that in the absence of any insight, remediation or evidence of safe practice, there remained a risk that Ms Byng would repeat similar misconduct in the future. This could place patients at unwarranted risk of harm. The panel therefore determined that a finding of current impairment was required on public protection grounds.

The panel also 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 profession and upholding the proper professional

standards for members of that profession. The panel determined that Ms Byng's actions had the potential to undermine public confidence and trust in the nursing profession. The panel also considered that the public would expect a regulator to take action in a case where a nurse's misconduct had placed a patient at risk of harm. The panel therefore determined that a finding of current impairment on public interest grounds was also required to maintain proper professional standards and public confidence in the profession.

Having regard to all of the above, the panel was satisfied that Ms Byng's fitness to practise is currently impaired on both public protection and public interest grounds. .

Determination on sanction

The panel considered this case and decided to make a 6 month suspension order, to be reviewed before its expiry.

In reaching this decision, the panel had regard to all the evidence that it had read in this case, as well as the Sanctions Guidance published by the NMC. The panel accepted the advice of the legal assessor and bore 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 noted that the NMC had proposed that a 6 month suspension order would be the appropriate and proportionate sanction. However, the panel reminded itself that the decision on sanction was a matter for the panel, exercising its own independent judgement.

The panel considered that the aggravating factors in this case were:

- a lack of remediation;
- a lack of insight and remorse;
- a lack of engagement with the NMC and the local investigation;
- Ms Byng's misconduct placed a vulnerable patient at risk of harm.

The panel considered that the mitigating factors in this case were:

- the misconduct represents an isolated (albeit serious) clinical issue;
- this is the first item Ms Byng has been referred to the NMC in her 39 year nursing career;
- Ms Byng had worked for the Home for 18 years without concern, prior to this incident.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the risk of repetition identified. Taking no further action would not restrict Ms Byng's practice and would therefore be insufficient to protect the public. The panel also decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered a caution order but decided that this would be inappropriate for the same reasons, as a caution order would not restrict Ms Byng's practice. The panel was also of the view that a caution order would be insufficient to mark the seriousness of Ms Byng's misconduct.

The panel then moved on to consider a conditions of practice order. It noted that Ms Byng's misconduct did relate to an identifiable area of her clinical practice which could be addressed through retraining and support. However, Ms Byng is not currently working as a nurse. She has also stated that she does not intend to return to the profession in the future. She disengaged from the Home's investigation and her engagement with the NMC has been limited. The panel considered that, in the absence of full engagement from Ms Byng and an intention to work as a nurse, it would not be possible to formulate practical or workable conditions. For these reasons, the panel concluded that a conditions of practice order would not be proportionate or appropriate.

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

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

The panel had already decided that a conditions of practice order would not be sufficient to protect the public, given Ms Byng's lack of engagement with these proceedings and her stated intention to leave the profession. A suspension order was therefore required to protect the public from the risk of harm posed by Ms Byng's practice. The panel noted that these incidents represented an isolated occurrence in an otherwise unblemished career of 39 years. The panel was therefore satisfied that this was not a case which involved any harmful deep-seated personality or attitudinal problems. The panel noted that it had no evidence of any insight from Ms Byng, but bore in mind that, in her telephone call of 23 July 2020, she has provided details of various health matters which have impacted upon her ability to engage with the NMC.

The panel was therefore satisfied that a suspension order would be an appropriate and proportionate sanction, which would protect the public and mark the seriousness of Ms Byng's misconduct.

The panel was aware that a striking-off order was an available sanction in this matter. However, it bore in mind that Ms Byng's misconduct was an isolated incident in a lengthy and otherwise unblemished career. It also did not consider her misconduct to be so serious as to be fundamentally incompatible with remaining on the register, and it

could be remediated should Ms Byng choose to do so. For these reasons, the panel determined that making a striking-off order at this stage would be disproportionate.

Taking all of the above into account, the panel determined that a 6 month suspension order was the appropriate and proportionate sanction which would protect the public and uphold the public interest. It considered that 6 months would appropriately reflect the seriousness of Ms Byng's misconduct, maintain public confidence in the profession, and send to the public and the profession a clear message about the standards expected of a registered nurse.

The panel directs that this order should be reviewed before its expiry. At the review, the panel may revoke the order, or it may confirm the order, or it may replace the order with another order. Any future panel may be assisted by:

- Ms Byng's engagement with the NMC and attendance at the next hearing;
- A reflective piece exploring the impact of her actions on Resident A, her colleagues and the reputation of the nursing profession;
- Evidence of remediation e.g. training courses in relation to PEG feeding, communication, escalation and record-keeping;
- Testimonials / references from any paid or unpaid employment;
- Information regarding Ms Byng's future plans to return to the profession.

Determination on interim order

Having determined that a suspension order was the appropriate and proportionate sanction, the panel considered whether to impose an interim order to cover the appeal period.

The panel accepted the advice of the legal assessor.

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

the substantive order in reaching the decision to impose an interim order. To do otherwise would be incompatible with its earlier findings.

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

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

That concludes this determination.