Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday 17 May 2021 – Wednesday 26 May 2021

Virtual Hearing

Name of registrant:	Jaqueline Greenhalgh
NMC PIN:	81K0004E
Part(s) of the register:	Registered Nurse RN1 – 6 July 1999 RN2 – 12 December 1983
Area of registered address:	Lancashire
Type of case:	Misconduct
Panel members:	Robert Barnwell (Chair, Lay member) Louise Poley (Registrant member) Susan Ellerby (Lay member)
Legal Assessor:	Cyrus Katrak
Panel Secretary:	Graeme King
Nursing and Midwifery Council:	Represented by Louis Maskell
Mrs Greenhalgh:	Not present, nor represented
Facts proved by admission:	N/A
Facts proved:	**1, 2, 3, 4 and 5a**
Facts not proved:	**5b, 5c, 5d, 6, 7a, 7b, 8, 9, 10, 11, 12a(i), 12a(ii), 12a(iii) and 12b**
Fitness to practise:	**Impaired**
Sanction:	**Caution order (3 years)**

Details of charges, as amended

That you a Registered Nurse and Ward Manager:

1. On 9 March 2018 gave permission to Colleague A to leave her long day's shift early on 10 March 2018.

2. You knew or ought to have known that the dispensation referred to at 1 would leave the ward short-staffed in number and skill mix.

3. You did not amend the paper rota or the e-roster to reflect the change at (1).

4. You inaccurately verified the unamended long day shift on the e-roster at approximately 11.40 on 16 March 2018.

5. On approximately 12-14 occasions between August 2017 and February 2018, you

   (a) Gave permission to Colleague A to work from home.

   (b) Had no independent means to calculate the number of hours Colleague A actually worked at home

   (c) Notwithstanding (b), verified the number of hours Colleague A claimed to have worked at home without checking

   (d) Did not seek any formal approval for the arrangement from the North Manchester Care Organisation (NMCO) or the Lead Nurse.

6. You provided your password for e-rostering to Colleague A or another.

7. Contrary to the NMCO policy concerning the prevention of Venous Thromboembolism (VTE), you encouraged members of staff to not use anti-embolic Thrombo-Embolic-Deterrent (TED) stockings on the grounds that:

   (a) They did not work

   (b) They were no good.

8. You did not ensure that there were an adequate number of TED stockings on the ward.

9. You advised and/or encouraged a member of staff, Colleague B, to complete the VTE assessment form in a manner which suggested that the patient had TED stockings when in fact he/she did not.

10. You advised and/or encouraged a group of members of staff to tick the box on the VTE form in order to indicate that the patient had refused TED stockings when this was not in fact the case.

11. You advised and/or encouraged members of staff to find a reason for not putting the TED stockings on when that reason was not valid.

12. The advice and/or encouragement set out at clauses 9-11 inclusive was

    (a) Dishonest

        (i) In relation to 9, because you knew that contrary to the form, the patient did not have stockings

        (ii) In relation to 10, because you anticipated that any refusal would not reflect a true refusal by the patient.

(iii) In relation to 11, because you knew that an invalid reason would be sought rather than a valid one.

(b) And/or was dishonestly designed to procure an inappropriate completion of the VTE form by others.

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

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Greenhalgh was not in attendance and that a Notice of Hearing had been sent to her registered email address on 15 April 2021.

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

Mr Maskell, on behalf of the Nursing and Midwifery Council (NMC) submitted that the Notice of Hearing complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules).

The panel accepted the advice of the legal assessor.

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

Decision and reasons on proceeding in the absence of Mrs Greenhalgh

The panel next considered whether it should proceed in the absence of Mrs Greenhalgh. It had regard to Rule 21 and heard the submission of Mr Maskell who invited the panel to continue in the absence of Mrs Greenhalgh.

Mr Maskell referred the panel to an email dated 30 April 2021 from Mrs Greenhalgh to the NMC in which she stated:

> *'Unfortunately I will not be attending the hearing in May.'*

Mr Maskell submitted that Mrs Greenhalgh is clearly aware that this hearing has been scheduled, yet has chosen not to attend or send a representative on her behalf. He advised the panel that Mrs Greenhalgh has not made an application to adjourn and that in these circumstances, the panel could consider that Mrs Greenhalgh had voluntarily absented herself from these proceedings. Mr Maskell also highlighted that there are six witnesses, all of whom are key workers, who have made arrangements to give evidence at this hearing. Mr Maskell submitted that in light of the above, it would be appropriate to proceed in Mrs Greenhalgh's absence

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL.

The panel has decided to proceed in the absence of Mrs Greenhalgh. In reaching this decision, the panel considered the submissions of Mr Maskell and the email from Mrs Greenhalgh to the NMC on 30 April 2021. It had particular regard to the factors set out in the decisions of *Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 as well as to the overall interests of justice and fairness to all parties. It noted that:

- The Notice of Hearing had been served in accordance with the Rules;
- No application for an adjournment has been made by Mrs Greenhalgh;
- Mrs Greenhalgh has indicated that she would not be attending this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Six witnesses are scheduled to attend by video link to give evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that first occurred over 3 years ago and 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.

The panel noted that Mrs Greenhalgh had indicated that she is currently residing in Thailand and it had regard to the current travel restrictions in place due to the Covid-19 pandemic. However, the panel considered that this hearing being held virtually would have allowed Mrs Greenhalgh to attend if she so wished.

There is some disadvantage to Mrs Greenhalgh in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to her registered email address, she will not be able to challenge the evidence relied upon by the NMC 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.

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

Decision and reasons on amending charge 4

At the outset of the hearing, Mr Maskell made an application to amend the wording of charge 4. He submitted that the time and date in the charge were incorrect, however it appears to simply be a typographical error and the amendment will have no material impact on the charge. Mr Maskell applied to amend the charge as follows:

Original charge:

> *'You inaccurately verified the unamended long day shift on the e-roster at approximately 11.36 on 10 March 2018.'*

Amended charge:

> *'You inaccurately verified the unamended long day shift on the e-roster at approximately ~~11.36 on 10 March 2018~~ 11:40 on 16 March 2018.'*

The legal assessor advised the panel that Rule 28 provides that:

> *'(1) at any stage before making its findings of fact, in accordance with [rule 24(5) or (11)] […] the Fitness to Practise Committee, may amend:*

(a) The charge set out in the notice of hearing; or

(b) The facts set out in the charge, on which the allegation is based, unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

(2) before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.'

The panel noted that Mrs Greenhalgh was not in attendance, however it considered that the proposed amendment did not substantially alter the charge that Mrs Greenhalgh is already aware of. It therefore determined that charge 4 could be amended in Mrs Greenhalgh's absence with no unfairness or injustice caused.

Accordingly, the panel amended the wording of charge 4 as per Mr Maskell's application.

Decisions and reasons on applications pursuant to Rule 31

On Day 2 of the hearing, Mr Maskell advised the panel that Witness 7 was unable to join the hearing to provide evidence. He drew the panel's attention to the communication log between Witness 7 and the NMC which laid out, in Mr Maskell's submission, the understandable reasons for Witness 7's non-attendance. Mr Maskell made an application under Rule 31 to admit Witness 7's written statement into evidence. He drew the panel's attention to the factors which a panel is required to consider when admitting hearsay evidence.

Mr Maskell submitted that Witness 7 had planned to attend the hearing until recently and that her statement had been sent to Mrs Greenhalgh, who had not raised any questions or issues with its content. He further submitted that there would be no injustice or unfairness caused to any party by the panel in accepting Witness 7's written statement into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, subject only to the requirements of relevance and fairness, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings and made reference to the relevant case law.

The panel considered the written statement of Witness 7 to be relevant to this hearing and that its content would provide further context to the allegations. It noted that Mrs Greenhalgh had been sent Witness 7's written statement in advance of this hearing and there had been no issues raised with it. The panel also had regard to the understandable reasons given by Witness 7 for her non-attendance. The panel therefore determined that it would cause no unfairness to any party to accept the written statement of Witness 7 into evidence.

In these circumstances, the panel determined that it would accept the written statement of Witness 7 into evidence. The panel did however acknowledge that it would not have the opportunity to challenge any aspect of this statement and therefore determined to attribute the necessary weight to the statement at the time of consideration.

Decision and reasons on facts

In reaching its decisions on the facts in relation to the charges, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Maskell and 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 a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

Background

Mrs Greenhalgh was referred to the NMC by North Manchester General Hospital (the Hospital) where she had been employed since 1984, most recently as a Band 7 Ward Manager on Ward I5 from May 2009 until her dismissal on 2 August 2018. The regulatory concerns relate to false or inaccurate record keeping regarding shifts worked by colleagues and encouraging staff to falsify records. The concerns raised are as follows:

- That Mrs Greenhalgh had allowed a colleague to leave work early on 10 March 2018, which left the ward below safe staffing levels.
- Mrs Greenhalgh instructed or suggested to staff that they should not apply TED stockings to patients, regardless of whether the patients required them.
- Staff were instructed by Mrs Greenhalgh to tick the box on the VTE assessment document that states a patient does not require stockings or had refused them, even if this was not true.
- Mrs Greenhalgh verified staff shifts on the e-roster without checking if they were correct and shared her e-rostering password with another member of staff.

Mrs Greenhalgh was suspended on 5 April 2018 and an internal investigation commenced on 10 April 2018. Following a disciplinary hearing on 2 August 2018, Mrs Greenhalgh was dismissed for gross misconduct.

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 which the NMC had provided.

Having admitted the witness statements into evidence, the panel considered the evidence of the witnesses and made the following conclusions:

Witness 1, Assistant Director of Nursing for Surgery at the Hospital

The panel considered Witness 1 to be a credible and reliable witness. It considered her to be impartial and noted her honesty in advising the panel when she could not recall a particular fact or was unsure about something.

Witness 2, Ward Manager at the Hospital

The panel considered that Witness 2 did her best to assist the panel. It noted that Witness 2 expressed the view that she could have been better supported by senior staff at the Hospital and it noted that she, in her statement, acknowledged the poor relationship between herself and Mrs Greenhalgh.

Witness 3 (Colleague A in the charges), Ward Sister at the Hospital

The panel considered Witness 3 to be a credible and reliable witness. It considered her to be honest in acknowledging areas where her practice in relation to the charges could have been better. The panel considered her to be impartial and noted her honesty in advising the panel when she could not recall a particular fact or was unsure about something.

Witness 4, Ward Sister at the Hospital

The panel considered Witness 4 to be a credible and reliable witness who offered a helpful clinical perspective to the hearing. It considered her to be impartial and noted her honesty in advising the panel when she could not recall a particular fact or was unsure about something.

Witness 5, Ward Sister at the Hospital

The panel considered Witness 5 to be a credible and reliable witness. It considered that she offered clear and straightforward answers. It considered her to be impartial and noted her honesty in advising the panel when she could not recall a particular fact or was unsure about something.

Witness 6, Ward Manager at the Hospital

The panel considered Witness 6 to be a credible and reliable witness, however noted that she was not a direct witness to the charges. It considered that Witness 6 added some contextual background to the charges and that she tried her best to assist the panel.

Witness 7 (Colleague B in the charges), Senior Support Worker at the Hospital, not in attendance

The panel considered that Witness 7 had tried her best to assist the panel and it accepted the reasons why she was unable to attend. However, the panel was unable to challenge this evidence, which was in parts contradictory to other witness evidence. Therefore the panel was unable to place any significant weight on Witness 7's written statement.

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

Charge 1

> On 9 March 2018 gave permission to Colleague A to leave her long day's shift early on 10 March 2018.

This charge is found proved

The panel noted a text message conversation dated 9 March 2018 between Mrs Greenhalgh and Colleague A that stated:

> Colleague A*: 'If everything's ok on ward tomorrow I'm going to finish early and use my last bit of AL. It will leave 2 trained but I'll make sure everything's done. Hope that's ok.'*
>
> Mrs Greenhalgh: *'That's fine xx'*

The panel also considered that Witness 3's evidence corroborated this.

Charge 2

> You knew or ought to have known that the dispensation referred to at 1 would leave the ward short-staffed in number and skill mix.

This charge is found proved

The panel considered that Mrs Greenhalgh had overall responsibility for the rota and should have known that Colleague A leaving her shift early would leave the ward short staffed. It also considered that in Mrs Greenhalgh's statement to the NMC dated 19 September 2019, she confirms that she was aware that Colleague A was the senior band 6 nurse on duty on 10 March 2018. The panel therefore considered that Mrs Greenhalgh should have been aware that allowing a senior nurse to leave the shift early would have staffing consequences.

The panel had regard to Witness 3's evidence in which she stated that, after the text conversation between her and Mrs Greenhalgh, neither had any expectation that one of them would arrange staffing cover.

Charge 3

> You did not amend the paper rota or the e-roster to reflect the change at (1).

This charge is found proved

The panel considered that Mrs Greenhalgh does not dispute this charge. It had regard to a copy of the paper rota and a print out from the Hospital's e-roster, neither of which reflect Colleague A having left early on 10 March 2018.The panel noted Mrs Greenhalgh's statement to the NMC dated 19 September 2019 in which she stated that she:

'…inputted her [Colleague A] wrong hours'.

Charge 4

You inaccurately verified the unamended long day shift on the e-roster at approximately 11.40 on 16 March 2018.

This charge is found proved

The panel considered that Mrs Greenhalgh does not dispute this charge. It had regard to a print out from the Hospital's e-roster that does not reflect Colleague A having left early on 10 March 2018, and that the incorrect hours were verified by Mrs Greenhalgh. The panel noted Mrs Greenhalgh's statement to the NMC dated 19 September 2019 in which she stated that she:

'…inputted her [Colleague A] wrong hours'.

Charge 5a

On approximately 12-14 occasions between August 2017 and February 2018, you:

a) Gave permission to Colleague A to work from home.

This charge is found proved

The panel had regard to a Notes of Witness Meeting dated 8 May 2018 from the Hospital and noted that Mrs Greenhalgh had accepted that she permitted Colleague A to work from home. It also had regard to Witness 3's evidence in which she stated that she worked from home '*a couple of times a month between around August 2017 and February 201*8'.

Charge 5b

On approximately 12-14 occasions between August 2017 and February 2018, you:

b) Had no independent means to calculate the number of hours Colleague A actually worked at home

This charge is found NOT proved

The panel considered that Mrs Greenhalgh would have, through her own experience, been aware of how long Colleague A would have needed to complete the off-duty rota. The panel had nothing before it to suggest that Colleague A had not completed the work, and therefore considered that Mrs Greenhalgh would have known how long this had taken by virtue of having previously had the responsibility for completing the off-duty rota.

Charge 5c

On approximately 12-14 occasions between August 2017 and February 2018, you:

c) Notwithstanding (b), verified the number of hours Colleague A claimed to have worked at home without checking

This charge is found NOT proved

The panel considered that Mrs Greenhalgh was able to verify Colleague A's hours from her own experience of completing the off-duty rota and considered that completion of Colleague A's work would have been a sufficient check. In the absence of any evidence to suggest the off-duty rota was not completed, the panel considered that Mrs Greenhalgh would have known how long Colleague A should have taken to complete this task.

Charge 5d

On approximately 12-14 occasions between August 2017 and February 2018, you:

d) Did not seek any formal approval for the arrangement from the North Manchester Care Organisation (NMCO) or the Lead Nurse.

This charge is found NOT proved

The panel had no information before it to demonstrate what the NMCO working from home policy was, therefore it had nothing to identify what format of formal approval Mrs Greenhalgh should have sought. It also had regard to the Notes of Witness Meeting dated 8 May 2018 from the Hospital in which Mrs Greenhalgh stated:

'I never kept it a secret. I've told people but never made it official.'

In response to being asked who she told*: 'The matrons.'*

Charge 6

You provided your password for e-rostering to Colleague A or another.

This charge is found NOT proved

The panel had regard to Witness 3's evidence in which she stated that Mrs Greenhalgh had never shared any password with her. She further stated that she, other senior staff and the ward PA had their own passwords, therefore would not need to use anyone else's. Although Mrs Greenhalgh made reference to a password being shared in the Notes of Witness Meeting dated 8 May 2018 from the Hospital, it was not clear which password, if any, was shared. The panel had no information before it to demonstrate that Mrs Greenhalgh had shared her e-rostering password with any other person.

Charge 7a

> Contrary to the NMCO policy concerning the prevention VTE, you encouraged members of staff to not use anti-embolic TED stockings on the grounds that:
>
> a) They did not work

This charge is found NOT proved

The panel considered that Witnesses 3, 4 and 5 are all Registered Nurses and that all provided corroborative evidence to say that TED stockings were used appropriately. It considered that Mrs Greenhalgh had specific clinical concerns over the use of TED stockings, however the panel had no information before it to suggest that her personal opinion about TED stockings influenced her professional practice.

Charge 7b

> Contrary to the NMCO policy concerning the prevention of VTE, you encouraged members of staff to not use anti-embolic TED stockings on the grounds that:

b) They were no good.

This charge is found NOT proved

The panel considered that Witnesses 3, 4 and 5 are all Registered Nurses and that all provided corroborative evidence to say that TED stockings were used appropriately. It considered that Mrs Greenhalgh had specific clinical concerns over the use of TED stockings, however the panel had no information before it to suggest that her personal opinion about TED stockings influenced her professional practice.

Charge 8

You did not ensure that there were an adequate number of TED stockings on the ward.

This charge is found NOT proved

The panel had regard to Witness 6's evidence in that there were only 3 pairs of TED stockings in stock when she took over the ward from Mrs Greenhalgh. However, the panel had no information before it to demonstrate that this was inadequate or was due to Mrs Greenhalgh's actions. The panel noted that Witness 3 stated that they often had to borrow TED stockings from other wards and it considered that in all probability, stocks were likely low at times. However, the panel had no information before it, or consistent evidence, to clarify exactly how stock shortages should have been dealt with. It also did not have sight of any stock levels/charts to confirm the stock levels, nor did it have sufficient evidence to find that any shortage at that time was due to Mrs Greenhalgh's actions.

Charge 9

You advised and/or encouraged a member of staff, Colleague B, to complete the VTE assessment form in a manner which suggested that the patient had TED stockings when in fact he/she did not.

This charge is found NOT proved

The panel had regard to the written statement from Witness 7 in which she stated:

'The Registrant [Mrs Greenhalgh] informed me that I should just tick the box that said the patient had the stockings, even though they had not.'

However, the panel was unable to cross-examine Witness 7 as she was not in attendance at the hearing. In contrast, the panel had regard to the evidence of Witnesses 3, 4 and 5, all of whom are Registered Nurses and stated that they never heard, directly or indirectly, Mrs Greenhalgh telling a member of staff to falsify a VTE assessment form. The panel did not have sight of any evidence to suggest that any patient required stockings and was not provided with them.

Charge 10

You advised and/or encouraged a group of members of staff to tick the box on the VTE form in order to indicate that the patient had refused TED stockings when this was not in fact the case.

This charge is found NOT proved

The panel had regard to the written statement from Witness 7 in which she stated:

‘*The Registrant [Mrs Greenhalgh] informed me that I should just tick the box that said the patient had the stockings, even though they had not.’*

However, the panel was unable to cross-examine Witness 7 as she was not in attendance at the hearing. In contrast, the panel had regard to the evidence of Witnesses 3, 4 and 5, all of whom are Registered Nurses and stated that they never heard, directly or indirectly, Mrs Greenhalgh telling a member of staff to falsify a VTE assessment form. The panel did not have sight of any evidence to suggest that any patient required stockings and was not provided with them.

Charge 11

You advised and/or encouraged members of staff to find a reason for not putting the TED stockings on when that reason was not valid.

This charge is found NOT proved

The panel did not have sight of any evidence to demonstrate that Mrs Greenhalgh advised and/or encouraged staff to find a reason to not use TED stockings. The panel had regard to the evidence of Witnesses 3, 4 and 5, all of whom are Registered Nurses and stated that if stockings were not used, it was for a valid clinical reason in accordance with the Hospital’s policy.

Charge 12a(i)

The advice and/or encouragement set out at clauses 9-11 inclusive was:

a) Dishonest

(i) In relation to 9, because you knew that contrary to the form, the patient did not have stockings

This charge is found NOT proved

Having found charges 9-11 not proved, the panel found this charge not proved.

Charge 12a(ii)

The advice and/or encouragement set out at clauses 9-11 inclusive was:

a) Dishonest

(ii) In relation to 10, because you anticipated that any refusal would not reflect true refusal by the patient.

This charge is found NOT proved

Having found charges 9-11 not proved, the panel found this charge not proved.

Charge 12a(iii)

The advice and/or encouragement set out at clauses 9-11 inclusive was:

a) Dishonest

(iii) In relation to 11, because you knew that an invalid reason would be sought rather than a valid one.

This charge is found NOT proved

Having found charges 9-11 not proved, the panel found this charge not proved.

Charge 12b

The advice and/or encouragement set out at clauses 9-11 inclusive was:

b) And/or was dishonestly designed to procure an inappropriate completion of the VTE form by others.

This charge is found NOT proved

Having found charges 9-11 not proved, the panel found this charge not 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 Greenhalgh'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, 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 Greenhalgh'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.'*

Mr Maskell invited the panel to find that Mrs Greenhalgh's misconduct was serious and fell below what would have been expected of a reasonable and competent nurse. Further, Mrs Greenhalgh's actions demonstrated a departure from the professional standards required of a registered nurse. Mr Maskell submitted that Mrs Greenhalgh was a Ward Manager and had a responsibility to ensure policies were followed and that staffing levels were as safe as could be. He drew the panel's attention to the 'Pennine Acute Hospital's NHS Trust (the Trust) Policy for the Escalation of Nursing & Midwifery Staffing Shortfalls and Booking of Temporary Staffing' which states that the Ward Manger is responsible and accountable for ensuring safe staffing and managing the rotas safely and effectively. Mr Maskell further submitted that Mrs Greenhalgh allowing staff requests by text message, as per charge 1, was also in contravention of Trust policy, namely its 'Nursing & Midwifery Rostering Procedure'. Mr Maskell submitted that it would appear that Mrs Greenhalgh put convenience for colleagues before the best interests of patients which, he submitted, amounts to misconduct.

Mr Maskell drew the panel's attention to the specific areas of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) which, in his submissions, Mrs Greenhalgh had breached.

Submissions on impairment

Mr Maskell 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. He referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011]* EWHC 927 (Admin) and invited it to consider whether Mrs Greenhalgh had put patients at an unwarranted risk of harm, whether she had breached fundamental tenets of the nursing profession, and whether she had brought the nursing profession into disrepute through her actions.

Mr Maskell submitted that the panel will also need to consider whether Mrs Greenhalgh has demonstrated any insight into her conduct and decide whether she fully appreciates the extent of her shortcomings.

Mr Maskell submitted that Mrs Greenhalgh's actions put others at an unwarranted risk of harm. Further, she was responsible for ensuring safe staffing on the ward, however this was not always done. Mr Maskell further submitted that given the busy nature of ward, it would appear that Mrs Greenhalgh did not always put the interests of the patients first and as a result, they were put at an unwarranted risk of harm.

Mr Maskell submitted that Mrs Greenhalgh's actions brought the profession into disrepute and contravened the expectation that a registered nurse should behave professionally. Further, it would appear that Mrs Greenhalgh expected staff to use their own judgment with regards to safe staffing, despite this being her responsibility. Mr Maskell further

submitted that Mrs Greenhalgh had a duty to communicate with staff, however charge 4 demonstrated a lack of communication.

Mr Maskell submitted that Mrs Greenhalgh had breached fundamental tenets of the profession as a consequence of her having breached the Code.

Mr Maskell submitted that confidence in the NMC as a regulator would be undermined if impairment was not found in the case of a Ward Manager who had allowed unsafe staffing levels and failed to appropriately communicate with staff.

Mr Maskell referred the panel to the case of *Cohen v General Medical Council [2008]* EWHC 581 (Admin) and invited the panel to determine whether Mrs Greenhalgh's conduct is capable of remediation, whether it has been remedied, and whether her actions are likely to be repeated in future.

Mr Maskell submitted that Mrs Greenhalgh has not engaged with the NMC in relation to this hearing and that she has not provided any information about her current employment. He submitted that nothing is known about Mrs Greenhalgh's current practice and/or actions taken to address the regulatory concerns.

In having regard to all the above, Mr Maskell invited the panel to find that Mrs Greenhalgh's fitness to practise is currently impaired by way of her misconduct on the grounds of public protection and public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments including *Roylance*, *Grant* and *Cohen*.

Decision and reasons on misconduct

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

The panel was of the view that Mrs Greenhalgh's actions, specifically in relation to charges 1 and 2, did fall significantly short of the standards expected of a registered nurse, and it considered them to amount to several breaches 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

8 - Work co-operatively

To achieve this, you must:

8.2 - Maintain effective communication with colleagues

8.5 - Work with colleagues to preserve the safety of those receiving care

11 - Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.2 - Make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

25 - Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 - Identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'

The panel recognised that breaches of the Code do not automatically result in a finding of misconduct. It went on to consider the charges, by determining whether Mrs Greenhalgh's actions were sufficiently serious so as to amount to misconduct.

The panel determined that Mrs Greenhalgh's actions in relation to charges 1 and 2 amounted to serious misconduct. The panel did not consider charges 3, 4 and 5a to constitute serious misconduct.

In determining that charges 1 and 2 constituted serious misconduct, the panel considered that, while Colleague A should have ensured the ward was appropriately staffed before leaving her shift early, this was ultimately Mrs Greenhalgh's responsibility. It had regard to the Trust's staffing policy which clearly states that the Ward Manager is:

'Responsible for ensuring ward rotas are managed safely and effectively.'

The panel considered that disregarding the Trust's staffing policy constitutes serious misconduct. It also considered that Mrs Greenhalgh's actions in allowing Colleague A to leave early resulted in the ward having a nurse to patient ratio of 1:14 when it should have been 1:8; the panel considered this to be inappropriate.

The panel therefore determined that Mrs Greenhalgh's actions in charges 1 and 2 fell short of the conduct and standards expected of a registered nurse and amounted to serious misconduct.

The panel considered that charges 3 and 4 were isolated incidents and noted that by the time Mrs Greenhalgh was able to verify the shift some 6 days later, the paper roster had been changed by various people. It had no evidence before it to suggest Mrs Greenhalgh regularly verified inaccurate shifts.

The panel considered that charge 5a appeared to be accepted practice within the ward and that Colleague A working from home did not appear to have any ill effect on patients or colleagues. It noted Witness 2's evidence in which she confirmed that she was indeed working from home, namely completing the off-duty roster.

Decision and reasons on impairment

The panel next went on to decide if, as a result of Mrs Greenhalgh's misconduct in relation to charges 1 and 2, her fitness to practise is currently impaired.

Registered nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust registered nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *…'*

The panel considered limbs a, b and c to be engaged in this case. It noted that the charges of dishonesty were not proved.

The panel considered that Mrs Greenhalgh had responsibility for the staffing of the ward and, on 10 March 2018, that ward was understaffed. While it noted that no patient harm had been reported, the panel considered that Mrs Greenhalgh's actions did place patients at an unwarranted risk of harm by virtue of her not appropriately staffing the ward.

The panel also considered that Mrs Greenhalgh had brought the profession into disrepute by way of her disregarding accepted policy and her job description.

In considering whether Mrs Greenhalgh has remediated the concerns identified, the panel had regard to the case of *Cohen*.

The panel considered that Mrs Greenhalgh's misconduct is eminently remediable as it appears to be a one-off incident that occurred in a frequently understaffed ward. However, the panel had nothing before it to demonstrate any remediation or insight from Mrs Greenhalgh. Further, it had no information about her current employment status and no evidence of any steps she had taken to ensure that her misconduct is not repeated.

In light of all the above, the panel had insufficient evidence before it to determine that Mrs Greenhalgh's practice is not currently impaired. It could not be satisfied that Mrs Greenhalgh does not currently pose a risk to patient safety, nor that the risk of repetition had reduced. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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 considered that a well-informed member of the public would be alarmed if they were aware that a ward manager had authorised a member of staff to leave her shift early, knowing that this would leave busy ward inadequately staffed. It concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. The panel therefore determined that a finding of impairment on public interest grounds was also required.

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

Sanction

The panel has decided to impose a caution order for a period of three years. The effect of this order is that Mrs Greenhalgh's name on the NMC register will show that she is subject to a caution order and anyone who enquires about her registration will be informed of this order.

Submissions on sanction

Mr Maskell submitted that the sanction imposed by the panel should be no more than is necessary and it should balance the public protection and public interest elements of the case alongside Mrs Greenhalgh's interests in considering this.

Mr Maskell submitted that a suspension order would be the appropriate order in this case. He further submitted that Mrs Greenhalgh was in a senior position at the time and had not acted in accordance with her job description. Further, her serious mismanagement of the rota presented a risk of harm to patients on the ward. Mr Maskell submitted that Mrs Greenhalgh had not engaged with the NMC in regards to this hearing which the panel could deem as an aggravating factor. He invited the panel to consider that Mrs Greenhalgh's apparent willingness to put colleague convenience above patient safety presented an attitudinal concern that could not be easily remedied by conditions of practice.

Decision and reasons on sanction

The panel accepted the advice of the legal assessor.

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

As regards aggravating factors, the panel considered the following as relevant:

- Mrs Greenhalgh was an experienced nurse, in a managerial position at the time of the incident
- While the panel noted that Mrs Greenhalgh had relied on an experienced nurse not to leave the shift unless adequately staffed, it was ultimately Mrs Greenhalgh's responsibility to ensure safe staffing
- While the panel did not consider there to be deep seated attitudinal concerns, it noted that Mrs Greenhalgh granted permission for Colleague A to leave her shift early without question in a 'laissez-faire' manner
- There was the potential for harm to be caused due to the inadequate staffing of the ward

As regards mitigating factors, the panel considered the following as relevant:

- Mrs Greenhalgh, while not in attendance at this hearing, remains somewhat engaged with the NMC
- Several witnesses gave evidence to the effect that the ward was frequently understaffed and that there were six vacancies at the time of charges 1 and 2
- Mrs Greenhalgh had served as Ward Manager at the Hospital since 2009 with no other concerns raised
- Mrs Greenhalgh qualified as a nurse over 30 years ago and has never faced regulatory proceedings before
- Witness evidence would suggest that Mrs Greenhalgh is a good nurse whose clinical practice is not under question
- There was no actual harm caused as a result of Mrs Greenhalgh's misconduct

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the misconduct found. Taking no further action would not mark the

public protection issues in this case. Further, it would not address the public interest concerns identified.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel was of the view that Mrs Greenhalgh's misconduct was unacceptable and must not happen again, but also that it was at the lower end of the spectrum of impaired fitness to practise. Whilst the panel found that Mrs Greenhalgh's fitness to practise was impaired on public protection grounds, it considered that this stemmed from a one-off lapse in judgement. It noted that there was no evidence before it to suggest that Mrs Greenhalgh's fitness to practise is, or had been, an ongoing concern. It had regard to several witnesses referring to Mrs Greenhalgh as a good and competent nurse and noted that this is the first time that she has faced regulatory action in a career spanning over 30 years.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. The panel noted that the misconduct found is relates to one aspect of Mrs Greenhalgh's managerial practice. This misconduct can be addressed by a caution order and no useful purpose would be served by a conditions of practice order.

The panel determined that a caution order would adequately protect the public. For the next three years, Mrs Greenhalgh's employer - or any prospective employer - will be on notice that her fitness to practise had been found to be impaired and that she is subject to a caution order. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of three years would be the appropriate and proportionate response. This order would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered nurse.

At the end of the three year period, the note on Mrs Greenhalgh's entry in the register will be removed. However, the NMC will keep a record of the panel's finding that her fitness to practise had been found to be impaired. If the NMC receives a further allegation that Mrs Greenhalgh's fitness to practise is impaired, the record of this panel's finding and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to Mrs Greenhalgh in writing.

That concludes this determination.