Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
13 – 15 September 2021, 27 September – 1 October 2021, 7 – 20 April 2022

Nursing and Midwifery Council,
93 George Street, Edinburgh, EH2 3ES &
10 George Street, Edinburgh, EH2 2PF

Name of registrant:	Miss Carol Young
NMC PIN:	85K0345S
Part(s) of the register:	Registered Nurse Mental Health Nursing (12 January 1989) Lecturer / Practice Educator (23 June 2006)
Area of registered address:	Anglesey
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, Lay member) Laura Wallbank (Registrant member) Tanya Tordoff (Registrant member)
Legal Assessor:	Maria Clarke (13 September - 1 October 2021) Peter Jennings (7 - 19 April 2022) Simon Walsh (20 April 2022)
Hearings Coordinator:	Leigham Malcolm (13 September 2021 - 14 April 2022) Graeme King (19 - 20 April 2022)
Nursing and Midwifery Council:	Represented by Ms Julian Norman, NMC Case Presenter
Miss Young:	Present and represented by Mr Christopher Geering, instructed by Clyde & Co
Facts proved by admission:	1b, 4b & 4dii

No case to answer:	1d
Facts proved:	1a, 1c, 2a, 2b & 3
Facts not proved:	4c, 4di & 4diii
Fitness to practise:	Impaired
Sanction:	Caution order (5 years)
Interim order:	N/A

Details of charge, as amended

That you, a registered nurse whilst employed as a community practitioner nurse for NHS Ayrshire and Arran:

1) Failed to provide appropriate care to Patient A, in that you:

a) Did not conduct any home visits for Patient A between 5 February 2016 and 10 November 2016. **(Proved)**

b) Did not record any home visits for Patient A between 5 February 2016 and 10 November 2016. **(Proved)**

c) Did not conduct a review/risk assessment after being informed on 30 August 2016 that Patient A had stopped taking lithium. **(Proved)**

d) Between 2 December 2014 and 3 February 2016 you did not document/record any home visits for Patient A. **(No case to answer)**

2) In January 2017 at the Adverse Event Review Panel in relation to Patient A you stated incorrectly that you had:

a) Conducted a visit for Patient A in June 2016. **(Proved)**

b) Conducted a visit for Patient A in September 2016. **(Proved)**

3) Your actions in charge 2 a) & b) above were dishonest as you knew you had not visited Patient A as stated, but were seeking to represent that you had. **(Proved)**

4) Failed to provide appropriate care to Patient Y, in that you:

a) **(Not considered due to Rule 28 ruling – see page 15)**

b) Did not book a follow up appointment for Patient Y after cancelling the appointment on 12 December 2016. **(Proved)**

c) Did not notify NHS Ayrshire and Arran that Patient Y was an at-risk patient requiring follow up. **(Not proved)**

d) Did not adequately document/record in Patient Y's records:

i) Referral information **(Not proved)**
ii) Initial Assessment **(Proved)**
iii) Clinical Records **(Not proved)**

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

Preliminary question in connection with an application concerning Ms 2's oral evidence

Ms Norman, on behalf of the Nursing and Midwifery Council (NMC) informed the panel that she would be making an application that Ms 2 should have a photograph of Patient A on the desk with her while she gave her evidence. Failing that, Ms 2 would like the panel to see a photograph of Patient A.

However Ms Norman first had a preliminary application, which was that Ms 2 should be present during the argument and the panel's decision on the substantive application. Mr Geering, on your behalf, opposed this preliminary application on the ground that the panel

should follow the usual practice, which was that argument relating to a witness' evidence is heard in the absence of the witness.

Ms Norman and Mr Geering agreed that the NMC's request was unusual and the legal assessor advised that, generally speaking, it would not be appropriate for a witness to be present in these circumstances.

In reaching its decision the panel bore in mind that Rule 22(6) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (the Rules) provides that no witness as to fact may observe the proceedings until she has given evidence. It is uncontroversial that Ms 2 is a witness of fact.

Having considered the preliminary question carefully, the panel was not persuaded that it should make an exception to the principle of Rule 22(6). Indeed, the panel was of the view that if Ms 2 were to hear the arguments of the Ms Norman and Mr Geering on the substantive application, that may influence the evidence she then gives in respect of the actual fitness to practise hearing.

Accordingly, the panel determined that it was not appropriate for Ms 2 to be present to hear the substantive application concerning her evidence.

Application concerning Ms 2's oral evidence

Ms Norman told the panel that although the photograph was not evidence, it would serve as a memorial to Patient A and it would comfort Ms 2 whilst she gave her oral evidence for the photograph to be on the desk with her.

Ms Norman secondly requested that, should the panel be minded not to allow the photograph to be placed on the desk, then Ms 2 would like the panel to see the

photograph. She then had a third application which was that, if the panel did not adopt either of these two courses, its decision should be communicated to the witness Ms 2.

Ms Norman did not suggest that the photograph was evidence; she submitted that the application was in the nature of witness support, although she fell short of contending that it was an application for special measures. She acknowledged that the requests were unusual but submitted that in the context of the case they were reasonable. She explained that underlying the application was a feeling on Ms 2's part that references to her mother as Patient A, rather than by her name, were '*dehumanising'* and that she wanted the panel to know that her mother '*had a face'.*

Mr Geering submitted that the photograph was not evidence and should not be placed on the table. He submitted that the process must be dispassionate and objective. He opposed the picture being shown at all, submitting that the hearing was not an inquest or a memorial and that to allow emotion into the process would undermine its integrity.

The panel accepted the advice of the legal assessor who stated that, ultimately, it was a matter for the panel.

In reaching its decision on the applications the panel kept in mind that its function is to determine the professional disciplinary charges which the NMC has brought against you. The hearing is not an inquest and the charges contain no allegation that you caused or contributed to Patient A's death. The primary purpose of NMC proceedings is the protection of the public, including patients, and the panel is well aware that patients are human beings. The redaction of Patient A's name in the documents is in accordance with the standard practice at NMC hearings and is in the interests of confidentiality.

The panel accepted the submissions of both parties that the photograph was not itself evidence. For the panel to see the photograph would not be relevant to any of the

decisions which it is necessary for the panel to make and the photograph is not admissible evidence under Rule 31.

It is established practice, at these hearings and in courts of law, that a witness may refer to a document such as a contemporaneous note of events in order to refresh his or her memory. The photograph is not an aide-memoire of that sort. Although at one stage Ms Norman said that it is implicit in the request that having the photograph may improve the quality of Ms 2's evidence, it has not been suggested that having the photograph with her would assist Ms 2's recollection of events.

While it is of course understood that Ms 2 will have been affected by the events concerning her mother, the application is not put on the basis that she is a vulnerable witness requiring special measures under Rule 23, and it is not clear that Ms 2 would come under any of the categories in that rule. The power to take special measures is in any event discretionary.

The panel appreciated that the photograph would serve as a memorial to Patient A and may provide comfort to Ms 2 whilst she gives her oral evidence. However, although the application is being made at Ms 2's request, the panel also bore in mind that to be looking at the photograph while she is giving evidence could be a cause of distress rather than of comfort.

The panel was also mindful of the potential effects, both real and perceived, of allowing the photograph to be placed on the table or shown to the panel. An informed member of the public might be of the view that there was a risk that the panel had allowed the evidence, and the panel's own judgment, to be affected by emotive, rather than objective, considerations.

After careful deliberation, the panel determined not to allow the request for the photograph to be placed on the table or shown to the panel. In coming to this decision the panel had

regard to the need to maintain public confidence in the profession and in the fairness and objectivity of the regulatory process. Ultimately, the panel had serious concerns around any real or perceived influence that the photograph may have on its decision making, as well as possible effects on people in the hearing room. To ensure that the objectivity of its decision making could not be called into question, and to protect the integrity of the hearing process, the panel decided not to allow Ms Norman's request.

The panel did however accede to Ms Norman's third application. The panel determined that, before she began her evidence, the chairman would inform Ms 2 of the panel's decision and give her a brief explanation of its reasons.

Decision and reasons on application to admit NHS Scotland guidance around adverse incidents into evidence

Prior to the close of the NMC's case, the panel heard an application made by Ms Norman under Rule 31 to allow into evidence a document detailing NHS Scotland's guidance around adverse incidents. She submitted that the document would assist the panel with the investigation and interview processes for adverse incidents.

Mr Geering opposed the application and submitted that the documents were undated and not relevant. He further submitted that none of the NMC's witnesses had stated that they used the guidance and at this late stage it would be unfair to admit it.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. These included that Rule 31 provides that, so far as it is '*fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel noted that the guidance referred to by Ms Norman was undated and the witnesses had given no evidence which shed any light on its date. The panel had no

information as to whether the guidance was in force at the time of the incidents nor any evidence that it had been used by any of the NMC's witnesses to guide their local investigations.

Given that there was no evidence of the date of the guidance or whether it was in force at the time of the investigation, the panel was not satisfied that the evidence was relevant nor that its admission into evidence would be fair. In these circumstances the panel refused the application.

Subsequently to the panel's decision, Ms Norman and Mr Geering informed the panel that the date of the document had been clarified and that it was accepted that it pre-dated the events of 2017. Mr Geering accordingly withdrew his objection to the admission of the document.

The panel therefore received the NHS Scotland guidance in evidence. The panel has of course formed no view as to what weight it will attach to the document.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Norman to amend the wording of charge 1d. This application was connected with an application by Mr Geering that there was no case to answer on that charge, but the panel will deal first with the question of amendment. The proposed amendment was to insert the words 'or conduct' into the charge, as set out below:

1) Failed to provide appropriate care to Patient A, in that you:

> *d) Between 2 December 2014 and 3 February 2016 you did not document/record* ***or conduct*** *any home visits for Patient A.*

It was submitted by Ms Norman that the proposed amendment would provide clarity and better reflect the evidence adduced in this case. She submitted that failure to carry out visits between December 2014 and February 2016 was implicit in the charge and that you had yourself dealt with that issue because you said there was an agreement that visits were not necessary.

The panel heard submissions from Mr Geering who opposed the amendment. He pointed to the lateness of the application and the fact that the NMC had not, for example, sought to obtain diaries for the relevant period.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

Charge 1a alleges that you did not conduct home visits between February and November 2016 and charge 1b alleges that you did not record them. Charge 1d by contrast alleges, in relation to a different time period, only that you did not document/record home visits. There is no allegation in charge 1d that you did not carry out visits.

Under Rule 28 the panel has a discretion to amend the facts set out in the charge, unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

The panel noted that the original charges, set out above, had been before you for a number of years, and that you had prepared and responded to those original charges. The panel did not accept that it was implicit in the present wording that home visits were not carried out, and that the proposed amendment only clarified this. The panel considered that the amendment applied for by Ms Norman would effectively introduce a fresh allegation which altered charge 1d significantly.

While the panel has power to amend the facts in the charge at any time before it makes its findings of fact, the late stage at which this application is made, at the end of the NMC's evidence, is a factor to be taken into account in considering fairness.

The panel is not persuaded that it would be fair to you to have to give instructions to your representative and prepare your response to an amendment on what is in substance a new charge. In the panel's judgment such an amendment to the charge at this late stage in proceedings, and subsequent to the NMC closing its case, cannot be made without injustice. That is sufficient to dispose of the application, as the requirements of Rule 28 are not met. Further, even if it had simply been a matter of discretion, balancing the public interest with your interest in a fair hearing, the panel would not have allowed the amendment to charge 1d.

Decision and reasons on application of no case to answer

The panel then considered an application from Mr Geering, made under Rule 24(7), submitting that you had no case to answer in respect of charge 1d.

Mr Geering submitted that the allegation in charge 1d is based upon the word '*failed*' and implies a duty to document visits to Patient A, and that that duty had been breached because visits to Patient A were not documented. He submitted that there was no evidence before the panel that any visits were carried out, and that it was not possible to document visits that never occurred.

Mr Geering referred the panel to the case of *R v Galbraith* [1981] 1 WLR 1039 and submitted that there was no evidence before the panel to support charge 1d and therefore you had no case to answer in response to it.

Ms Norman opposed the application. However, in substance she relied on the same submission that any failure to carry out visits to Patient A was implicit within the charge.

This would have the result that, regardless of whether no visits occurred or whether they occurred but were not recorded, there would be evidence amounting to a case to answer.

The panel took account of the submissions made and accepted the advice of the legal assessor. In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

As it has set out in its reasons in relation to the proposed amendment, the panel has determined that a failure to carry out home visits is not implicit in charge 1d, which alleges only that they were not recorded. The panel did not have sight of any evidence, nor did it hear any evidence, that you had conducted home visits to Patient A during the period in charge 1d. It therefore follows that there would not be any documentation of those visits and not making a false record cannot amount to a failure to provide appropriate care.

The panel is accordingly not satisfied that there is any evidence on an essential element of charge 1d. In the event that it might be argued that there could be some inference, for example because of the passage of time, that one or more visits must have occurred, in the panel's judgment that inference would be so tenuous that a panel, mindful of the law and the burden and standard of proof, could not properly find the charge proved.

Accordingly, Mr Geering's submission of no case to answer is upheld.

The hearing went part heard on 1 October 2021 due to lack of time. Proceedings came to a close subsequent to the NMC closing its case and prior to the panel

The hearing resumed on 7 April 2022.

Background

The charges arose whilst you were employed as a registered nurse for NHS Ayrshire and Arran Trust (the Trust) with whom you commenced employment in 2009 as a Mental Health Nurse. In 2013 you became involved in the provision of care for Patient A. You visited Patient A on 4 February 2016. In November 2016 Patient A took her own life. You were suspended by the Trust on 6 February 2017 and **[private].** The family of Patient A made a referral to the NMC in relation to your nursing practice on 5 December 2017. You are currently employed by Bryn Seiont Newydd Nursing Home.

The referral received by the NMC raised issues around:

- Care planning.
- Risk assessment.
- Level of visits / contact.
- Lack of adequate response to concerns raised in summer 2016 about the patient's compliance with her medication.

Issues were raised around the dates you visited Patient A as well as the evidence you provided during the Adverse Event Review about those dates. The last documented contact between you and Patient A was that on 4 February 2016.

During the Adverse Event Review meeting in January 2017, it is alleged that you told the meeting that you visited Patient A in June 2016 and September 2016. It is alleged that this was not accurate. You told this hearing that you did not visit Patient A in June 2016, and did not say you had; the witnesses had misunderstood. You maintain that you did visit Patient A in September 2016.

An audit of your patient records was also carried out and it was established that a patient had been referred for a Community Psychiatric Nurse (CPN) assessment with you. Patient Y's appointment was cancelled and no follow up arrangements were made nor was anything recorded anywhere in any of the patient notes.

Witnesses

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

- Daughter A
- Daughter B
- Daughter C
- Ms 1, Senior Manager at North Ayrshire Health and Social Care Partnership
- Mr 2, General Manager at North Ayrshire Health and Social Care Partnership
- Ms 3, Clinical Nurse Manager at North Ayrshire Health and Social Care Partnership
- Dr 4, Consultant Psychiatrist at NHS North Ayrshire
- Mr 5, Nurse Consultant for Digital Services and Mental Health Services at North Ayrshire Health and Social Care Partnership

It heard oral evidence from the following witnesses called on your behalf:

- Ms 6, formerly Home Manager of Montrose House
- Ms 7, Head of Nursing Deputy Manager at Bryn Seiont Newydd Nursing Home
- Ms 8, Home Manager

The panel also heard evidence from you under affirmation.

Decision and reasons on amendment of charge

Prior to the panel retiring to make its decision on facts, the legal assessor invited the observations of the parties concerning the wording of charge 4, as this was merely factual and did not speak to the quality of care provided to Patient Y.

The panel heard submissions from Ms Norman and Mr Geering. Ms Norman agreed that the panel ought to determine whether or not Patient Y should have been considered to be 'at risk', and proposed amending charge 4c by adding, '*did not identify that Patient Y should be considered at risk'.*

Mr Geering supported amending the stem of charge 4 so that it mirrored the working of charge 1.

The panel accepted the advice of the legal assessor and had regard to Rule 28. The panel was of the view that an amendment to charge 4 was in the interest of justice. The panel, having heard from Ms Norman and Mr Geering, was satisfied that there would be no prejudice to you and no injustice would be caused to either party by amending charge 4 in the following terms:

4) ***Failed to provide appropriate care to Patient Y, in that you:***

a) …

b) ***Did not book a follow up appointment for Patient Y after cancelling the appointment on 12 December 2016.***

c) Did not notify NHS Ayrshire and Arran that Patient Y was an at-risk patient requiring follow up.

d) Did not adequately document/record in Patient Y's records;

i) Referral information

ii) Initial Assessment

iii) Clinical Records

Decision and reasons on facts

During the course of proceedings, Mr Geering advised the panel that you admitted to charges 1b, 4b & 4dii. The panel therefore finds charges 1b, 4b & 4dii proved by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case, including the testimonial evidence called on your behalf, together with the submissions made by Ms Norman and Mr Geering.

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

Charge 1

1) Failed to provide appropriate care to Patient A, in that you:

Charge 1a

a) Did not conduct any home visits for Patient A between 5 February 2016 and 10 November 2016;

This charge is found proved.

In reaching this decision, the panel took account of all of the evidence before it. This included the job description for your role at the time of CPN Charge Nurse, as well as the oral evidence of Daughter A and Ms 1, and of yourself. It also had regard to Patient A's medical notes and an email from Patient A's General Practitioner (GP) to you dated 30 August 2016. It bore in mind that you have not been the subject of any previous regulatory findings and took account of the positive testimonial evidence attesting to your nursing standards and honesty.

You accepted in your oral evidence that Patient A was under your care. Patient A's care also fell within your job role under the job description for CPN Charge Nurse. The panel therefore determined that the provision of care to Patient A was your responsibility. The email from Patient A's GP to you on 30 August 2016 states:

'Dear Carol,

I spoke with Patient A and she told me she has stopped lithium. She said she discussed it with [Dr 9] in last clinic but nothing is mentioned in clinic letters. Is this correct? She has been feeling ok. If so I'll take off repeats etc.…'

(Dr 9 is Patient A's consultant psychiatrist.)

Your response read:

‘I’ve checked her face notes, Patient A was recommended on lithium February this year. She was last seen by [Dr 9] in May but no mention of any medication changes then…’

Patient A had previously come off lithium and been put back onto it so this was the second time she had stopped taking lithium; her consultant was apparently unaware of it.

You told the panel that following that email exchange you visited Patient A in September without making an appointment to do so, as you though she might avoid speaking to you if she knew you were coming. You said that Patient A was in her front garden, with her dog. You did not get out of your car and Patient A came over to you. There was a conversation lasting five or six minutes. Patient A did not want you to come into the house. You confirmed with her that she would attend her next appointment with the consultant and you formed a view as to her presentation.

Daughter A, in her oral evidence, told the panel that, in the course of a telephone conversation with her following Patient A’s death, you told her that you last visited Patient A in February 2016. Your evidence was that this was not what you said. Daughter C was in the room with Daughter A at the time. The panel has however attached no weight to Daughter C’s account of the conversation, as she only heard one side of the conversation and would not be able to shed light on whether Daughter A may have misunderstood what you were saying.

Ms 1 also told the panel, in her oral and written evidence, that you reported to her, in the week following Patient A’s death, that your last visit to Patient A had been in February 2016.

Patient A’s medical notes contained no record of any visits between 5 February 2016 and 10 November 2016, nor are there any notes within your diary.

The panel bore in mind that there were failures at the Trust regarding the changeover of computer systems and that you were unable to create certain kinds of entry on the Care Partner system. There were difficulties within the team on Arran and your return **[private]** had been poorly managed. It also bore in mind what you said in your oral evidence around not documenting visits you had made and that you accepted that at the time your practice was below standard. The panel however accepted your evidence that you were able to make free-text entries on Care Partner patient activity records. You gave an example of such a free-text entry earlier in 2016 where you made a brief note of a review and risk assessment and the panel had sight of entries made by you relating to the visit to Patient A in February 2016 and again the entry relating to the telephone conversation with Daughter A on 15 November 2016.

In the circumstances arising from the exchange of emails from the GP on 30 August, the panel considered that, if you had visited Patient A in September as you told the panel, that visit would have been crucial to the provision of her care. In the panel's view, had that visit taken place, you would have documented it somewhere. There was no reason why you could not have documented it in a free-text entry, similar to the one to which you referred in evidence.

On balance, the panel preferred the evidence of Daughter A and Ms 1 to your evidence. It accepted that you told Daughter A and Ms 1 that your last visit to Patient A was in February 2016 and it finds that that was correct.

The panel accordingly determined that you did not conduct any home visits for Patient A between 5 February 2016 and 10 November 2016.

Charge 1c

> c) Did not conduct a review/risk assessment after being informed on 30 August 2016 that Patient A had stopped taking lithium

This charge is found proved.

The panel is satisfied that an appropriate standard of care would have involved a visit and a review and risk assessment following the email from the GP on 30 August 2016. You did not dispute this.

Given that the panel has found that you did not visit Patient A following the email on 30 August 2016, it is satisfied that you did not conduct a review or risk assessment.

The panel was of the view that, even if it had accepted your evidence that you did conduct a visit, the review/risk assessment which you describe, but did not document, would not in these circumstances have been of a kind that constituted appropriate care. The panel therefore found charge 1c proved.

Charge 2

2) In January 2017 at the Adverse Event Review Panel in relation to Patient A you stated incorrectly that you had:

Charge 2a

a) Conducted a visit for Patient A in June 2016

This charge is found proved.

In reaching this decision, the panel took account, among other matters, of the Adverse Event Review Report dated 10 January 2017. It bore in mind that the report was

completed by Ms 3 and Ds 4, a Clinical Nurse Manager and a Consultant Psychiatrist. Ms 3 and Dr 4 were not involved in Patient A's care.

The panel also took account of your oral evidence, in which you stated that the interview on which the report is based was conducted unprofessionally. You told the panel that you were not provided with a copy of the report or given an opportunity to propose amendments. Ms 3 and Dr 4 clarified to the panel that it was customary practice for the Adverse Event Review Report Group to destroy their notes once the report had been completed. Whilst there are some difficulties around the notes, the panel heard evidence that the notes were for the authors of the report and subsequently destroyed. Both authors of this report were clear in oral and written evidence that the report was a true reflection of the meeting that took place, though summarised and not written in a chronological order. The Adverse Event Review Report states that you informed Ms 3 and Dr 4 that you visited Patient A in June and September 2016.

It is accepted by you that you did not visit Patient A in June 2016 and the panel has previously found that you did not visit Patient A in September 2016.

Your evidence to this hearing was that you did not tell the Adverse Event Review Meeting that you saw Patient A in June; you told it that you saw her in September, which you say is correct. It follows that if you did state that you saw Patient A in June that statement was incorrect.

While what was said at that meeting forms part of the NMC's case against you, the panel has accepted that the Adverse Event Review was intended as a learning review and not as part of a disciplinary procedure. You were interviewed at the same time as Dr 9, Patient A's consultant. The panel also accepts that the Trust's procedures may not have been followed correctly, and that the report itself lends some weight to your point that Dr 9 seems to have regarded himself as speaking on behalf of the mental health team and that he did most of the talking.

The panel noted that the report sets out (correctly) that you saw Patient A on 4 February 2016. Later in the same paragraph it records that you reported having seen the patient in June. Having then dealt with the stage at which Patient A appears to have stopped taking lithium, it then records that you reported seeing the patient in September.

Later in the report it sets out what you told the meeting occurred when you saw Patient A in June, with some detail about matters such as the patient looking after her grandchildren and her other activities, as well as references to weight gain and eating and sleeping. In a separate paragraph, the report sets out that you were asked about Patient A's presentation in September and you reported that she was okay.

While the report discusses whether it may have been in June or July that the patient stopped taking lithium, there is no event in June such as a clinic appointment which might be confused with a visit from you.

The panel has very carefully considered whether Ms 3 and Dr 4 may have misunderstood what you were telling them. It has reached the conclusion that they did not. The panel preferred the evidence of Ms 3 and Dr 4, whom it considered to have no reasons to present anything other than what occurred, to your evidence.

Charge 2b

b) Conducted a visit for Patient A in September 2016

This charge is found proved.

You admit that you told the Adverse Event Review meeting that you visited Patient A in September 2016. For the reasons set out in relation to charge 1a, the panel has found that this was incorrect. Accordingly, the panel found charge 2b proved.

Charge 3

> 3) Your actions in charge 2 a) & b) above were dishonest as you knew you had not visited Patient A as stated, but were seeking to represent that you had.

This charge is found proved.

For the reasons set out in relation to charges 2a and 2b, the panel has found that you told the Adverse Event Review meeting that you visited Patient A in June and again in September 2016 and that both of these statements were incorrect.

The panel bore in mind that in deciding whether you were dishonest, it must first consider your state of mind. In reaching its decision, the panel took into account all of the evidence before it. The panel bore in mind that you had recently returned to work **[private]**. It also bore in mind the issues you had been experiencing in the workplace.

However, you have not suggested that you were confused during the Adverse Event Review meeting and that you made incorrect statements inadvertently. You have asserted to the present hearing that you did not say that you saw the patient in June 2016 and that it was true that you saw her in September. The panel has determined that you knew that you did not visit Patient A in those months. The panel finds that you were aware that your failure to see the patient over a period of many months was open to criticism and you were seeking to represent to the Adverse Event Review meeting that you had seen her twice that summer.

The next question for the panel is whether, given that state of mind, your actions were dishonest by the standards of ordinary decent people. The panel is satisfied on the balance of probabilities that they were.

Charge 4

4) Failed to provide appropriate care to Patient Y, in that you:

Charge 4c

c) Did not notify NHS Ayrshire and Arran that Patient Y was an at-risk patient requiring follow up.

This charge is found NOT proved.

The evidence was that at the time you were asked to see Patient Y she was not yet one of your patients. Patient Y's GP spoke to you and asked you to see her. You saw Patient Y promptly when asked, made a further appointment for her, and referred her for appropriate social work care. You asked the GP to make a formal referral through the SCI Gateway system and she did so. That referral became part of a new record for Patient Y. By the time that occurred you had already seen the patient.

The SCI Gateway referral was described by the GP as routine, as opposed to urgent, and stated among other matters that Patient Y would not contemplate suicide because of her religious beliefs.

While Patient Y had some physical health problems, the matter which seems to have principally concerned the GP was that she was having difficulty looking after her husband, who had his own medical problems.

The NMC has not identified who at the Trust should have been notified by you, and has left it to the panel to decide whether Patient A was an ‘at risk’ patient.

The panel noted that the risk assessment policy sets out specific risk factors to be considered. All mental health patients are at risk to some degree, and for this charge to have any meaning, the risk present must have been in some way more that would be the case with patients falling within the usual range of referrals. In the panel’s judgment there is no information before it suggesting that Patient Y was vulnerable to any specific risk, such as self-harm or abuse, requiring escalation to some senior level of the Trust, as distinct from referral to appropriate services, which was what you did. Indeed, the evidence before the panel suggests the contrary.

The panel was not satisfied, on the evidence before it that you failed to provide appropriate care in not notifying the Trust that Patient Y was an at-risk patient requiring follow up.

Charge 4d

d) Did not adequately document/record in Patient Y’s records;

Charge 4d(i)

i) Referral information

This charge is found NOT proved.

The panel took account of Patient Y’s records in which there were no entries made by you.

You told the panel that you were unable to make entries because you did not have access to SCI Gateway, the referral process, and were unable to create a patient record on Care Partner: you could only make entries in an existing record. The NMC's case is that you visited the patient and you ought to have recorded the care provided.

The panel accepted your evidence that you were not yourself able to initiate a patient record on Care Partner. You asked the GP to make a formal referral through SCI Gateway which she did, and the referral information was incorporated into the new record by another member of staff some five months later.

The panel was not therefore persuaded that you failed to provide appropriate care by not documenting the referral information in the record yourself.

Charge 4d(iii)

iii) Clinical Records

This charge is found NOT proved.

In relation to charge 4diii the panel noted that the SCI Gateway referral was part of Patient Y's records. That you did not make an adequate record of the initial assessment is the subject of 4d(ii), which you have admitted. The NMC has not presented any evidence to the panel regarding what other clinical records would have existed at this stage to be documented in the patient's records. Indeed it is unclear to the panel what is intended by the complaint that you should have documented the clinical records in Patient Y's records.

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 your 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 amounted to misconduct. Secondly, and only if the facts found proved amounted to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Norman invited the panel to take the view that the facts found proved amount to misconduct and summarised the key issues as follows:

a) a failure by you to carry out appropriate visits with Patient A between February and November 2016, including a failure to review when you found Patient A had stopped her lithium abruptly;
b) dishonestly attempting to mislead the Adverse Event Review Panel into believing that those visits had been conducted when they had not; and
c) inaction in respect of Patient Y, by failing to make any record of the appointment you had with Patient Y or booking any further appointment.

Ms Norman drew the panel's attention to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (The Code). Ms Norman highlighted the specific points of The Code where the NMC contends that your actions amounted to misconduct and invited the panel to find that your conduct fell short of the standards expected among nurses and that such a falling short was serious.

Mr Geering accepted that the failings identified at charges 1a, 1b, 1c, 2a, 2b and 3 constitute misconduct but submitted that the failings identified at charges 4b and 4d(ii) do not. He invited the panel to consider each charge distinctly and drew the panel's attention to the case of *Schodlok v GMC* [2015] EWCA Civ 669 and *Nandi v GMC* [2004] EWHC 2317 (Admin).

Mr Geering submitted that your failure to book an appointment for Patient Y is not of itself misconduct. He submitted that Patient Y was not classed as vulnerable nor is there any evidence before the panel to suggest that Patient Y was at risk of suicide. Further, you did contact the GP after your appointment with Patient Y and, in an attempt to obtain the care Patient Y needed, you also arranged for a social services referral. Mr Geering submitted that the follow up appointment between you and Patient Y was to see how her engagement with social services was going – not because Patient Y presented an acute risk and needed particular further care. He acknowledged that it was not acceptable to fail to book a follow up appointment but submitted that, in the circumstances, it was not sufficiently serious to go to fitness to practise.

Mr Geering submitted that the failure identified at charge 4d(ii) does not constitute misconduct as there is significant mitigation. He submitted that Patient Y's GP did not send through a SCI Gateway referral. Mr Geering accepted that, in theory, you could have opened such a record yourself but submitted that you had no training in doing so, and this was not the way the team operated. He reminded the panel of the evidence of Ms 5 who also had no understanding that she could open a new patient record. Mr Geering submitted that the Trust has not provided any record of you being given training on Care

Partner, of when any training was offered in Arran, or even of who the super user was who was supposed to train you. Mr Geering submitted that, even if you had opened a record, in any event, you did not have the patient's details – not least the CHI – to open such a record.

Mr Geering submitted that the NMC evidence suggests that management of SCI Gateway was the responsibility of the Trust's administrative staff and that there is no evidence to suggest that this happened in this instance. Mr Geering accepted that in the intervening time period, Patient Y fell off your radar, and that this was your fault and responsibility, but submitted that you faced systematic issues arising from (i) poor training, (ii) a GP who twice did not understand how to refer cases properly, (iii) administrative support who did not escalate information.

Mr Geering submitted that it would be wholly unjust to say responsibility fell on you alone, and to such an extent that a fellow nurse would describe your failure as deplorable.

Submissions on impairment

Ms Norman 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. She made reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Norman submitted that your insight was far from complete during your evidence. She noted that you accept that your record keeping was inadequate, but invited the panel to consider whether this was an admission made with true insight, or whether it was made through self-interest in order to support your dishonest account of having visited Patient A September 2016 when you had not. Ms Norman submitted that you have maintained an

account which you knew was dishonest throughout the proceedings, which has led to Patient A's daughters having to give evidence.

Ms Norman submitted that the following matters arise with regard to impairment:

a) Lack of insight, which means that there is a real risk of repetition;
b) Attitudinal failings, which can be difficult to remediate, and this is particularly so in respect of dishonesty;
c) Breadth of charges found proved: this is not a case in which there is a narrow or singular point of failure but rather a spectrum of failings, each of which presents a risk to the public if repeated;
d) Repetition between patients: at a time when Patient A had just died, and you were aware that your inaction was to be raised as an issue, you again failed to take any action in respect of Patient Y;
e) Risk to the reputation of the profession, again particularly so in respect of dishonesty.

Ms Norman invited the panel to find that your fitness to practise is currently impaired.

Mr Geering accepted that your fitness to practise should be found to be impaired, but on public interest grounds only. He submitted that there is no basis for saying you present a risk to the public and that such an assessment comes down to a risk of repetition. Mr Geering submitted that in light of your history, retraining, and subsequent employment, there is no risk of repetition.

Mr Geering submitted that the misconduct in question is isolated essentially to one patient during 2016 and that this is not a case of multiple failing across your caseload, or a broad range of clinical misjudgments, or repeated acts of dishonesty or lack of integrity. He submitted that any assessment of risk has to balance the misconduct identified against the evidence of your career more widely. Mr Geering advised the panel that you have been a

nurse for 35 years and, before moving to Arran, had worked on the wards. Further, you have worked autonomously in the past as a community mental health nurse, have worked as a care home manager and have lectured at a university. Mr Geering submitted that in that time, you garnered nothing but praise and he drew the panel's attention to your remediation bundle which contains positive testimonials. He submitted that you have never before failed a patient in your care, or fallen from the standards of integrity and honesty that you set yourself.

Mr Geering submitted **[private]**. He submitted that your return to work in 2015 was poorly managed, which was indicative of the wide difficulties you faced while working on Arran. Mr Geering reminded the panel of various evidence that spoke to the IT and IT training provided by the Trust as being inadequate. He reminded the panel that your manager at the time was not NMC registered and that you faced a demanding caseload and a lack of administrative support.

[Private]

Mr Geering submitted that there is no basis for finding that you lack insight or that you present a risk of repetition for the following reasons:

a) You accepted you failed Patient A and that your care fell short of the standards of practice your patients should have expected.

b) You have shown an understanding of the seriousness of the allegations and the impact these will have on public confidence. You devised and followed a sustained period of retraining to show that – whether these allegations were true or false – these concerns do not represent your current practice.

c) Your training is not limited simply to lip service, or an on line certificate. Rather you have summarised your learning in your reflections, and sought to apply those lessons in a practical sense to your own work.

d) You have reflected on the nature and impact of this dishonesty and have shown an appreciation of the impact the panel's findings will have on public trust and on the profession.

e) You have read widely on this subject which reinforces that you understand the significance of the panel's findings.

f) You have cooperated with your regulator fully and consistently throughout these proceedings. You understand and respect this process, and respect the decision made against you.

g) You have conceded that a finding of impairment is appropriate.

The panel accepted the advice of the legal assessor who endorsed the case references made by both advocates.

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. It noted that you accept that your conduct in relation to Patient A amounted to misconduct but considered that a finding of misconduct is a decision for the panel.

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of The Code. It was of the view that your actions breached the following tenets of The Code:

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

20 - Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 - Keep to and uphold the standards and values set out in The Code
20.2 - Act with honesty and integrity'

The panel appreciated that breaches of The Code do not automatically result in a finding of misconduct. It took account of all the evidence before it and the circumstances of the case as a whole and determined that your actions did amount to misconduct.

The panel determined that your actions in charges 1a and 1c (as you did not make the visits, charge 1b no longer features) fell short of the standards expected of a registered nurse. It was of the view that your misconduct was serious and would be considered deplorable by members of the profession and the public. It considered that not to visit a high risk patient for eight months, when you were aware of the patient's history and were aware that there was an agreement for three-monthly visits in place, was a significant

departure from the standards expected. Further, the panel considered that not to conduct a review or risk assessment upon becoming aware that Patient A had stopped taking lithium exacerbated the seriousness of the misconduct in this case.

The panel also determined that your actions in charges 2a and 2b constituted serious misconduct. It considered that to state that you had conducted a visit to a high risk patient when in fact you had not, amounted to numerous breaches of fundamental nursing standards such as honesty, integrity and candour.

The panel determined that your actions in charge 3 also constituted serious misconduct. It considered that dishonesty will always be considered a serious departure from the standards expected and it was satisfied that any member of the profession, or public, would consider your actions to be deplorable.

The panel determined that, while your actions at charges 4b and 4d(ii) fell below the standards expected, it did not consider them to constitute serious misconduct. It had no evidence before it to suggest that Patient Y was high-risk and therefore it placed no weight on the NMC's argument that the seriousness of this conduct was exacerbated in view of your actions in relation to Patient A. The panel had no evidence to suggest that your actions at charge 4b were anything other than a genuine mistake. It also noted that there was credible evidence before the panel to suggest that you had not been appropriately trained on Care Partner and had no access to SCI Gateway. While the panel considered that your record keeping was not to the standard required, it was not satisfied that your failures in charge 4d(ii) constituted serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct in relation to Patient A, your fitness to practise is currently impaired.

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *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… 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;'*

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

The panel found that all of the limbs were engaged in this case.

The panel found that your actions placed Patient A at risk of harm. It considered that not to conduct any home visits between February and November, when you knew that Patient A was high-risk, posed a real risk of significant harm to Patient A. Further, by not conducting a review or risk assessment after being informed that Patient A had stopped taking lithium, you placed her at further risk of harm which could have impacted her future care.

The panel considered that you did not adhere to the standards expected of a nurse and therefore that your behaviour brought the profession into disrepute. Further, members of the public would not expect an experienced nurse to fail to visit a high-risk patient for eight months and then make dishonest representations about having done so.

The panel considered that you had breached the fundamental tenets of the profession, namely those of honesty, integrity and candour.

The panel had regard to its findings at charge 3 and considered that you had acted dishonestly.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold and protect the wider public interest, 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 noted that you accept that your fitness to practise is currently impaired, but on public interest grounds only. While this is a matter for the panel, it considered that your misconduct was serious and involved multiple breaches of fundamental tenets of the profession. It considered that a well-informed member of the public, hearing of an experienced nurse having acted like you did, and then having made dishonest representations to her employer, would have his confidence in the profession and its regulatory process undermined if a finding impairment were not made. The panel therefore determined that a finding of impairment is necessary on public interest grounds.

The panel considered whether your misconduct is capable of remediation. It determined that your clinical misconduct can be addressed through sufficient insight and retraining. The panel considered that dishonesty, in principle, is always difficult to remediate and that your dishonesty was serious. Nevertheless, the panel determined that, although it would be difficult, your dishonest misconduct is capable of remediation.

The panel considered that you have demonstrated a robust response to the concerns by way of adopting a training plan that is tailored to the areas of concern. It had regard to your training certificates which you have provided and was satisfied that you have incorporated this learning into your practice and reflected on the training, as opposed to simply providing the panel with certificates. The panel considered that the courses you have completed on Recording & Report Writing, Mental Health Crises Intervention and Support for Patients, Medical Records for Secondary Care Clinicians, Clinical Governance, Patient Safety and Human Factors and Professional Virtues in Modern Medicine are specifically relevant to the misconduct identified.

The panel also had regard to the testimonials provided on your behalf and it noted that these cover approximately 20 years of your career and are authored by a wide range of healthcare professionals and patient relatives who are aware of these regulatory

proceedings. It considered that you have demonstrated a period of five years' exemplary practice since these concerns arose. It noted the following testimonials in particular:

'Carol Young will always finish what jobs need to be done that day by wound care, to phone a dr, to find out result , phone family she so professional in her job and always keeping records to the dairy, care plan will phone the family if needed and will let head nurses know on what been going on that day.'

'Carol is so reliable in everything she does…'

'Record keeping is in the form of both paper and electronic form and Carol's skills within this remit are excellent and precise, she writes daily records for clients including risk plans, care plans and assessments of their needs. Her communication skills too are informative and accurate. All details are handed over and recorded meticulously.'

'Ms Young's clinical skills are always above standard, record keeping is impeccable for example ensuring that medication records are counter signed where necessary and ensures that current standards are being met by independently verifying other staff members' record keeping.'

'I have every trust and confidence in Carol Young's ability and professionalism as a nurse…'

The panel noted that you accept that your '*practice fell well below the standards expected*' and it considered that you have reflected on the allegations and have taken significant steps to strengthen your practice. It also noted the steps **[private]** it noted that you have worked throughout the Covid-19 pandemic in a care home.

The panel bore in mind the fact that you did not admit some of the charges does not preclude you from showing insight. While the panel considered that you could have provided a more personal insight into how your own actions impacted Patient A, your colleagues and the profession, it was satisfied that you recognise that your practice fell below the standards expected and that you have taken significant steps to strengthen your practice in the last five years.

The panel had regard to your comprehensive training plan which is tailored to the concerns raised and also includes reflections about your learning. It also had regard to your insight into the concerns, your reflective piece on dishonesty and the exemplary references provided on your behalf. The panel therefore determined that the risk of repetition was minimal. It could not identify any section of your remediation bundle that was insufficient and it considered this bundle to demonstrate your remorse, sufficient insight, reflection and the strengthening of your practice. It considered that these regulatory proceedings will have served as a salutary lesson for you and that your practice is unlikely to fall below the requisite standards again. Consequently, the panel could not identify any public safety risks so as to warrant a finding of impairment on public protection grounds.

The panel therefore concluded that a finding of current impairment is necessary on public interest grounds only.

Accordingly, the panel finds that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a caution order for a period of five years. The effect of this order is that your name on the NMC register will show that you are subject to a caution order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Ms Norman invited the panel to impose a suspension order for a period of eight months. She noted the panel's decision that there was little more you could have done to satisfy it that you have strengthened your practice. In view of this, Ms Norman advised the panel that the NMC had reduced its sanction bid from a striking off order to an eight month suspension order.

Ms Norman reminded the panel that it had found that you acted dishonestly and had identified serious misconduct. She submitted that there is significant public interest in a case involving a nurse who failed to provide adequate care and then subsequently lied about it. Ms Norman submitted that a suspension order would address the seriousness of the misconduct identified. She noted that you have been working unrestricted for over three years but submitted that deliberately breaching the duty of candour is a serious departure from the standards expected.

Mr Geering invited the panel to impose a caution order for a period of five years. He accepted the panel had found the charge of dishonesty proved and had identified serious misconduct. He submitted that there is however no principle that states that dishonest conduct requires a suspension order.

Mr Geering submitted that your dishonesty was not sophisticated, nor is there any evidence to suggest that it was premediated. He submitted that your dishonesty was in fact an isolated and panicked response.

Mr Geering invited the panel to consider the personal and professional mitigating factors in your case and submitted that you have demonstrated that you were an excellent practitioner before moving to Arran, and have been so since leaving Arran. He reminded the panel of its decision that you have done as much as is possible to address the

concerns raised. Further, you have demonstrated good insight, understand why the concerns arose and have practised safely for five years since these allegations.

Mr Geering submitted that a suspension order would impact your current employer, its residents and their families. He drew the panel's attention to a testimonial from your current employer that complimented your current practise and highlighted that the care home would struggle to replace you should you be suspended or struck off.

Mr Geering submitted that the public interest in this case would be marked by the panel's finding of misconduct and impairment. He also submitted that it is in the public interest to keep safe and competent practitioners in practice and that a caution order would strike this balance appropriately. Mr Geering further submitted that the public interest in this case would also be marked by having had these matters fully ventilated in a public regulatory proceeding, the determination of which would be a public document. He submitted that a caution order would leave no doubt as to the seriousness of the matters found proved.

Decision and reasons on sanction

The panel accepted the advice of the legal assessor who referred it to the cases of *CHRE v NMC and Leeper* [2004] EWHC 1850 (Admin), *R (ex p Abrahaem) v GMC* [2004] EWHC 279 (Admin), *Parkinson v NMC* [2010] EWHC 1898 (Admin) and *Moijueh v NMC* [2015] EWHC 1999 (Admin). He also referred the panel to Article 29(4) of the Nursing and Midwifery Order 2001 that states:

'The Committee may… decide that it is not appropriate to take any further action.'

Having found your fitness to practise currently impaired, the panel first considered if it would be appropriate to take no further action in line with Article 29(4). It had regard to its findings of serious misconduct and dishonesty, albeit that neither was premediated. The panel determined that it would be inconsistent with its earlier findings at the impairment stage to take no further action.

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

The panel did not identify any aggravating factors.

The panel considered the following as mitigating factors:

- You have demonstrated good insight.
- You have demonstrated remorse to Patient A's family and have apologised to them.
- You faced significant personal and professional issues whilst working on Arran.
- You have demonstrated a prolonged period of safe and effective practice since the allegations arose.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the NMC's guidance on caution orders that states:

> *'A caution order is only appropriate if the Fitness to Practise Committee has decided there's no risk to the public or to patients requiring the nurse, midwife or nursing associate's practice to be restricted, meaning the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise committee wants to mark that the behaviour was unacceptable and must not happen again.*
>
> *Because a caution order doesn't affect a nurse, midwife or nursing associate's right to practise, the Committee will always need to ask itself if its decision about the nurse, midwife or nursing associate's fitness to practise indicated any risk to patient safety.'*

Whilst the panel considered that dishonesty is always a serious issue, it considered that your misconduct must also be contextualised. It had regard to its earlier findings that your dishonesty was not premeditated and that it was isolated to a single, spontaneous instance. The panel also noted that you did not make any personal gain from the dishonest conduct, nor did your dishonesty pose a risk to patient safety. The panel considered that you appear to have acknowledged, particularly in your reflective statement dated April 2022, that your practice fell short and it had regard to its finding that you had significantly strengthened your practice. It had no evidence before it to suggest you had acted in a similar way before or since the concerns arose and that the testimonials provided by you speak to a caring, competent and trusted practitioner.

The panel considered that, while your insight could have been more focussed on your personal practice, you have shown remorse for your behaviour and are committed to addressing the issues raised. It noted your comprehensive training plan and the reflective pieces provided. It was satisfied that these proceedings had served as a sharp reminder of the standards expected of a registered nurse and considered that there was little risk of you behaving inappropriately again.

However, the panel determined that your misconduct must be marked to send a clear message to the nursing profession that your actions fell below the standards expected of a registered nurse.

Therefore, whilst it considered your misconduct to be a serious matter, the panel was satisfied that it could be appropriately addressed and that the public interest would be served by the imposition of a caution order. The panel noted that you have already been subject to an interim suspension order for eight months and an interim conditions of practice order for six months, at an earlier stage of this case.

With regards to the totality of the findings on the evidence, the panel has determined to impose a caution order for a period of five years. It determined that this would be the

appropriate and proportionate response to your misconduct. This outcome would mark not only the importance of maintaining public confidence in the nursing profession, but also send the public and the nursing profession a clear message about the standards required of a registered nurse. For the next five years, any prospective employer will be on notice that your fitness to practise has been found to be impaired and that you are subject to a caution order.

The panel went on to consider a suspension order, having determined that a conditions of practice order would not be suitable for a case in which impairment has been found on public interest grounds alone. It considered that a suspension would be unduly punitive in view of you having practised safely and effectively for several years since the concerns came to light. While it considered that a suspension order would also mark the public interest in this case, it determined that a caution order would also do so and was the least restrictive sanction available to the panel.

Having regard to all the circumstances involved, the panel was satisfied that a member of the public, aware of the circumstances of this case, would consider this outcome to be fair and appropriate, and that it is sufficient to satisfy the public interest considerations of this case. Furthermore, the panel determined that it would not be in the public interest to prevent an otherwise competent registered nurse from continuing unrestricted practice and utilising their skills for the benefit of patients.

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

This decision will be confirmed to you in writing.

That concludes this determination.