Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday, 22 July 2021 – Friday, 6 August 2021
&
Friday, 10 September 2021
&
Friday, 17 September 2021
&
Tuesday, 4 January 2022 – Friday, 7 January 2022

Virtual Hearing

Name of registrant:	Mrs Parminder Kaur Purewal
NMC PIN:	91Y0889E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – December 1994 Specialist Practitioner District Nurse – November 2002 V300: Nurse Independent / Supplementary Prescriber – May 2008
Area of registered address:	Birmingham
Type of case:	Misconduct
Panel members:	Philip Sayce (Chair, Registrant member) Alex Forsyth (Lay member) Kevin Connolly (Lay member)
Legal Assessor:	Maria Clarke (22 July – 6 August 2021) & (10 & 17 September 2021) John Moir (4 – 7 January 2022)
Panel Secretary:	Philip Austin (22 July – 6 August 2021) Melissa McLean (10 & 17 September 2021) Philip Austin (4 – 7 January 2022)
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter

Mrs Purewal:	Present and represented by Laura Bayley, Counsel, instructed by the Royal College of Nursing
No case to answer:	None
Facts proved by admission:	Charges 1a(ii), 1b(i), 1b(ii), 1b(iii), 1b(vi), 1e(i), 1e(vi), 1f(ii), 1f(iii), 1g(i), 1g(ii), 1g(iii), 1g(iv), 1g(v), 1g(vi), 1h(i), 1h(ii), 1h(iii), 1h(v), 1i(i), 1i(ii), 1i(iv), 1i(v), 1j(i), 1l(i), 1m(iii), 1n(i), 1n(ii), 1o(i), 1p(i), 1p(ii), 1p(v), 1q(i), 1r(i) in part, 1r(ii) in part, 1r(iii) in part, 1r(iv) in part, 1r(v), 2, 3, 4c, 5, 6 in part, 7, 8 and 9
Facts proved:	Charges 1r(iv) in part, 4a, 4b, 6 in part
Facts not proved:	Charges 1a(i), 1b(iv), 1b(v), 1c(i), 1c(ii), 1d(i), 1d(ii), 1e(ii), 1e(iii), 1e(iv), 1e(v), 1e(vii), 1f(i), 1h(iv), 1I(iii), 1j(ii), 1k(i), 1k(ii), 1m(i), 1m(ii), 1p(iii), 1p(iv), 1q(ii), 1r(i), 1r(ii), 1r(iii), and 10
Fitness to practise:	Currently impaired
Sanction:	**Suspension order – 9 months (with review)**
Interim order:	**Interim Suspension Order for 18 months**

Details of charge (Before amendments)

That you, a registered nurse, whilst employed as an Independent Nurse Prescriber at the Bloomsbury Health Centre, on 16 and/or 17 April 2019;

1) Did not practice within your clinical scope of competence, in that you;

a) In relation to Patient A;

i) Did not perform any examination/investigation to confirm the diagnosis/exclude other causes, for Patient A's possible urinary tract infection.

ii) Incorrectly prescribed Patient A with Amoxicillin 500mg tablets three times a day for a week.

b) In relation to Patient B, a paediatric patient;

i) Did not record sufficient details of Patient B's symptoms.

ii) Did not escalate the risk of sepsis following Patient B's examination.

iii) Did not record any other features associated with the possible diagnosis of sepsis.

iv) Performed a clinical consultation of Patient B, without the necessary training/competencies.

v) Prescribed Phenoxymethylpenicillin & Paracetamol for Patient B, without the necessary training/competencies.

vi) Prescribed an incorrect dose of Paracetamol at 7.5ml spoonful every 4-6 hours to Patient B.

c) In relation to Patient C, a paediatric patient;

i) Performed a clinical consultation of Patient C, without the necessary training/competencies.

ii) Prescribed olive oil ear drops for Patient C, without the necessary training/competencies.

d) In relation to Patient D, a paediatric patient;

i) Performed a clinical consultation of Patient C, without the necessary training/competencies.

ii) Prescribed Amoxicillin 250mg/5ml for Patient D, without the necessary training/competencies.

e) In relation to Patient E;

i) Did not record Patient E's symptoms relating to the exacerbation of their Chronic Obstructive Pulmonary Disease.

ii) Did not examine/asses Patient E to confirm the diagnosis/severity of their Chronic Obstructive Pulmonary Disease.

iii) Incorrectly prescribed Amoxicillin and Clarithromycin for 7 days to Patient E.

iv) Incorrectly prescribed 40mg Prednisolone tablets to Patient E.

v) Did not arrange a follow up appointment for Patient E.

vi) Did not adequately record a history of neurological symptoms for Patient E's left arm.

vii) Did not perform an adequate neurological examination of Patient E's left arm.

f) In relation to Patient F, a pregnancy related patient;

i) Performed a clinical consultation of Patient F, without the necessary training/competencies.

ii) Did not perform an abdominal examination.

iii) Did not perform a pelvic examination.

g) In relation to Patient G, a pre-diabetic patient;

i) Incorrectly diagnosed Patient G with Diabetes Mellitus.

ii) Did not record any discussion with Patient G regarding the new diagnosis.

iii) Did not refer Patient G for appropriate screening tests.

iv) Did not advise Patient G of appropriate lifestyle advice and monitoring.

v) Incorrectly prescribed Patient G with 500mg Metformin.

vi) Performed a clinical consultation of Patient G, without the necessary training/competencies.

h) In relation to Patient H;

i) Did not record Patient H's temperature.

ii) Did not conduct a neurological examination of Patient H.

iii) Incorrectly prescribed 28 tablets of Metoclopramide 10mg to be taken 3 time a day.

iv) Incorrectly prescribed sodium cromoglycate eye drops.

v) Did not record the purpose of prescribing sodium cromoglycate eye drops to Patient H.

i) In relation to Patient I;

i) Did not document any examination findings relating to the history of sciatic nerve involvement.

ii) Did not perform an examination of Patient I's condition.

iii) Did not advise Patient I of signs and symptoms indicating progressive neurological impairment.

iv) Issued Patient I with a Fit Note/Sick Note.

v) Did not prescribe gastroprotection medicine after prescribing Naproxen tablets to Patient I.

j) In relation to Patient J;

i) Did not document evidence of a thorough abdominal examination.

ii) Did not conduct an investigation to identify the cause of Patient J's symptoms.

k) In relation to Patient K

i) Did not record a full history of Patient K's leg pain.

ii) Did not perform a neurological examination of Patient K's legs.

l) In relation to Patient L;

i) Incorrectly prescribed Patient L with Colchicine 500mcg four times a day.

m) In relation to Patient M;

i) Prescribed Patient M 3 months of Progesterone contraceptive pill without providing the recommended advice.

ii) Did not inform Patient M directly that they were due a contraceptive pill review.

iii) Did not conduct an adequate assessment of Patient M.

n) In relation to Patient N;

i) Did not adequately record Patient N's patient history.

ii) Did not record Patient N's examination findings.

o) In relation to Patient O;

i) Incorrectly prescribed Patient O Solgar vitamin D3 1000iu on tablet weekly for 6 weeks.

p) In relation to Patient P;

i) Incorrectly prescribed Patient P InVita capsules 25,000iu per week for 6 weeks.

ii) Did not adequately record Patient P's patient history.

iii) Did not perform an examination for anaemia.

iv) Did not perform an examination for an iron deficiency.

v) Incorrectly prescribed Patient P with Metoclopramide 10mg 28 tablets 3 time a day.

q) In relation to Patient Q;

i) Did not check a peak flow reading to assess Patient Q's respiratory function.

ii) Did not provide Patient Q with safety netting advice after prescribing;

- Prednisolone steroid tablets 30mg
- A Salbutamol reliever
- A Clenil steroid inhaler

r) In relation to Patient R;

i) Did not record/escalate a mental health referral.

ii) Did not record/provide safety netting advice.

iii) Did not record/escalate further assessment.

iv) Did not record/consider safeguarding factors for Patient R's daughter.

v) Issued Patient R with a Fit Note without legal authority.

That you, a Registered Nurse, whilst working at Netherton Health Centre ("the Centre");

2) On 29 July 2019 breached condition 1 of the interim conditions of practice order imposed on 20 May 2019, in that you;

a) Undertook a shift at the Centre as an Independent Nurse Prescriber.

b) Prescribed medication to 15 patients as set out in schedule 1.

3) On 30 July 2019 breached condition 1 of the interim conditions of practice order imposed on 20 May 2019, in that you;

a) Undertook a shift at the Centre as an Independent Nurse Prescriber.

b) Prescribed medication to 6 patients as set out in schedule 2.

4) On or around 29/30 July 2019 breached condition 10 a) of the interim conditions of practice order, in that you;

a) Did not immediately inform your employer that you were subject to an interim conditions of practice order.

b) Did not immediately inform your employer that you were restricted from working as an Independent Nurse Prescriber.

5) On or around 29 July 2019 when completing exhibit JJ/3, inaccurately circled/answered “No” to the question “Has there been any specific circumstances impacting on your prescribing practice over the last year.”

6) Your actions at one or more of charges 2, 3, 4 & 5 above were dishonest, in that you deliberately sought to conceal the restrictions/conditions of practice order, from your employer.

7) Your actions at one or more of charges 2 & 3 were dishonest, in that you prescribed medication for one or more patients, despite knowing that you were restricted from doing so.

8) Between July 2019 & August 2019 you breached condition 7 of the interim conditions of practice order, in that you;

a) Did not inform your regulator that you had accepted a nursing appointment as an Independent Nurse Prescriber with Netherton Health Centre.

b) Did not provide your regulator with the contact details of your employers at the Netherton Health Centre.

9) Between July 2019 & August 2019 you breached condition 9 a) & 9 b) of the interim conditions of practice order, in that you, did not provide your regulator with the name/contact details of the Netherton Health Centre.

10) Your actions in charges 8 & 9 above were dishonest, in that you sought to conceal your new appointment as an Independent Nurse Prescriber at the Netherton Health Centre, from your regulator.

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

Schedule 1

1) Patient 1 – Chlorphenamine 4mg – 21 tablets.

2) Patient 2 - Flucloxacillin 500mg – 28 capsules
Chlorphenamine 4mg – 28 tablets

3) Patient 3 – Olive Oil Drops 20ml

4) Patient 4 – Omeprazole 20mg – 28 capsules

5) Patient 6 – Dermol 500 lotion – 500ml
Hydrocortisone 1% Cream – 30 gram

6) Patient 7 – Aveeno Intense Relief Hand Cream – 75ml
Dermotave 0.05% Cream – 30 gram

7) Patient 8 – Trimethoprim 50mg/5ml – 140ml

8) Patient 9 – Amoxicillin 250mg 250mg/5ml – 150ml

9) Patient 10 – Nitrofurantoin 100mg – 6 capsules

10) Patient 11 – Ciprofloxacin 0.3% eye drops – 5ml

11) Patient 12 – Co-codamol 8mg/500mg – 32 Tablets
Otomize Ear Sprat – 5ml

12) Patient 13 – Co-codamol 15mg/500mg – 56 tablets

13) Patient 14 – Movelat Cream – 125 gram

14) Patient 15 – Atorvastatin 20mg – 28 tablets

15) Patient 17 – Nitrofurantoin 100mg – 14 capsules

Schedule 2

1) Patient 18 – Dioralyte Oral Power Sachets 200ml – 4 sachet

2) Patient 19 – Chlorhexidine Gluconate 0.2% Mouthwash 10ml – 300ml
Phenoxymethylpenicillin 250mg – 80 tablets

3) Patient 20 – Doxycycline 100mg capsules – 7 capsules

4) Patient 21 – Doxycycline 100mg capsules – 7 capsules
Mirabegon 50mg – 30 tablets

5) Patient 22 – Dermole 500 Lotion – 500ml
Eumotove 0.05% - 30gram

6) Patient 23 – Co-codamol 15mg/500mg – 56 tablets

Decision and reasons on application to amend the charge

At the outset of the hearing, the panel heard an application from Mr Edwards to amend a number of the charges before it.

Mr Edwards submitted that your job title is incorrectly recorded as 'Independent Nurse Prescriber' in the stem of charge 1 and in charge 4b, as they currently read. He submitted that he was unaware as to whether such a role exists, and that this should instead be corrected to read 'Advanced Nurse Practitioner and/or Independent Nurse Prescriber'.

Furthermore, Mr Edwards submitted that the Centre has been referred to as your employer throughout the charges and that this is also incorrect. He submitted that the Centre had never formally employed you, but this charge should not fail on a technicality. Mr Edwards submitted that it was possible to still capture the alleged mischief by removing the words 'your employer' in charges 4a and 4b. However, he invited the panel to introduce a new charge 4c, stating that you '*Did not immediately disclose conditions 1 – 9 of your interim conditions of practice order to the Centre*'.

Mr Edwards submitted that the proposed amendments would not change the substance of the charges against you. Instead, they would provide clarity and better reflect the evidence presented in this case, as you were never employed by the Centre. Mr Edwards submitted that the proposed amendments were in the interests of justice, and that no prejudice would be caused to you in allowing these amendments.

Ms Bayley, instructed by the Royal College of Nursing ("RCN"), on your behalf, submitted that the proposed amendments were borne out of discussions had between the parties. She stated that in the round, she had no issues with the proposed amendments being agreed by the panel.

The panel accepted the advice of the legal assessor that Rule 28 of the NMC (Fitness to Practise) Rules 2004, as amended ("the Rules") states:

28.— (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or 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 was of the view that such amendments, as applied for, were in the interests of justice. It was satisfied that in making these amendments, the charges would provide more clarity and better reflect the evidence the panel had received.

The panel was of the view that the substance of the charges against you will remain the same. Accepting the proposed amendments would not fundamentally alter the case you have to answer.

The panel determined that you would not be prejudiced or disadvantaged in any way by virtue of the proposed amendments being allowed. It therefore granted Mr Edwards' application to amend the proposed charges.

Details of charge (After amendments)

That you, a registered nurse, whilst employed as an Advanced Nurse Practitioner and/or Independent Nurse Prescriber at the Bloomsbury Health Centre ("Bloomsbury"), on 16 and/or 17 April 2019;

1) Did not practice within your clinical scope of competence, in that you;

a) In relation to Patient A;

i) Did not perform any examination/investigation to confirm the diagnosis/exclude other causes, for Patient A's possible urinary tract infection.

ii) Incorrectly prescribed Patient A with Amoxicillin 500mg tablets three times a day for a week.

b) In relation to Patient B, a paediatric patient;

i) Did not record sufficient details of Patient B's symptoms.

ii) Did not escalate the risk of sepsis following Patient B's examination.

iii) Did not record any other features associated with the possible diagnosis of sepsis.

iv) Performed a clinical consultation of Patient B, without the necessary training/competencies.

v) Prescribed Phenoxymethylpenicillin & Paracetamol for Patient B, without the necessary training/competencies.

vi) Prescribed an incorrect dose of Paracetamol at 7.5ml spoonful every 4-6 hours to Patient B.

c) In relation to Patient C, a paediatric patient;

i) Performed a clinical consultation of Patient C, without the necessary training/competencies.

ii) Prescribed olive oil ear drops for Patient C, without the necessary training/competencies.

d) In relation to Patient D, a paediatric patient;

i) Performed a clinical consultation of Patient D, without the necessary training/competencies.

ii) Prescribed Amoxicillin 250mg/5ml for Patient D, without the necessary training/competencies.

e) In relation to Patient E;

i) Did not record Patient E's symptoms relating to the exacerbation of their Chronic Obstructive Pulmonary Disease.

ii) Did not examine/asses Patient E to confirm the diagnosis/severity of their Chronic Obstructive Pulmonary Disease.

iii) Incorrectly prescribed Amoxicillin and Clarithromycin for 7 days to Patient E.

iv) Incorrectly prescribed 40mg Prednisolone tablets to Patient E.

v) Did not arrange a follow up appointment for Patient E.

vi) Did not adequately record a history of neurological symptoms for Patient E's left arm.

vii) Did not perform an adequate neurological examination of Patient E's left arm.

f) In relation to Patient F, a pregnancy related patient;

i) Performed a clinical consultation of Patient F, without the necessary training/competencies.

ii) Did not perform an abdominal examination.

iii) Did not perform a pelvic examination.

g) In relation to Patient G, a pre-diabetic patient;

i) Incorrectly diagnosed Patient G with Diabetes Mellitus.

ii) Did not record any discussion with Patient G regarding the new diagnosis.

iii) Did not refer Patient G for appropriate screening tests.

iv) Did not advise Patient G of appropriate lifestyle advice and monitoring.

v) Incorrectly prescribed Patient G with 500mg Metformin.

vi) Performed a clinical consultation of Patient G, without the necessary training/competencies.

h) In relation to Patient H;

i) Did not record Patient H's temperature.

ii) Did not conduct a neurological examination of Patient H.

iii) Incorrectly prescribed 28 tablets of Metoclopramide 10mg to be taken 3 time a day.

iv) Incorrectly prescribed sodium cromoglycate eye drops.

v) Did not record the purpose of prescribing sodium cromoglycate eye drops to Patient H.

i) In relation to Patient I;

i) Did not document any examination findings relating to the history of sciatic nerve involvement.

ii) Did not perform an examination of Patient I's condition.

iii) Did not advise Patient I of signs and symptoms indicating progressive neurological impairment.

iv) Issued Patient I with a Fit Note/Sick Note.

v) Did not prescribe gastroprotection medicine after prescribing Naproxen tablets to Patient I.

j) In relation to Patient J;

i) Did not document evidence of a thorough abdominal examination.

ii) Did not conduct an investigation to identify the cause of Patient J's symptoms.

k) In relation to Patient K

i) Did not record a full history of Patient K's leg pain.

ii) Did not perform a neurological examination of Patient K's legs.

l) In relation to Patient L;

i) Incorrectly prescribed Patient L with Colchicine 500mcg four times a day.

m) In relation to Patient M;

i) Prescribed Patient M 3 months of Progesterone contraceptive pill without providing the recommended advice.

ii) Did not inform Patient M directly that they were due a contraceptive pill review.

iii) Did not conduct an adequate assessment of Patient M.

n) In relation to Patient N;

i) Did not adequately record Patient N's patient history.

ii) Did not record Patient N's examination findings.

o) In relation to Patient O;

i) Incorrectly prescribed Patient O Solgar vitamin D3 1000iu on tablet weekly for 6 weeks.

p) In relation to Patient P;

i) Incorrectly prescribed Patient P InVita capsules 25,000iu per week for 6 weeks.

ii) Did not adequately record Patient P's patient history.

iii) Did not perform an examination for anaemia.

iv) Did not perform an examination for an iron deficiency.

v) Incorrectly prescribed Patient P with Metoclopramide 10mg 28 tablets 3 time a day.

q) In relation to Patient Q;

i) Did not check a peak flow reading to assess Patient Q's respiratory function.

ii) Did not provide Patient Q with safety netting advice after prescribing;

- Prednisolone steroid tablets 30mg
- A Salbutamol reliever
- A Clenil steroid inhaler

r) In relation to Patient R;

i) Did not record/escalate a mental health referral.

ii) Did not record/provide safety netting advice.

iii) Did not record/escalate further assessment.

iv) Did not record/consider safeguarding factors for Patient R's daughter.

v) Issued Patient R with a Fit Note without legal authority.

That you, a Registered Nurse, whilst working at Netherton Health Centre ("the Centre");

2) On 29 July 2019 breached condition 1 of the interim conditions of practice order imposed on 20 May 2019, in that you;

a) Undertook a shift at the Centre as an Independent Nurse Prescriber.

b) Prescribed medication to 15 patients as set out in schedule 1.

3) On 30 July 2019 breached condition 1 of the interim conditions of practice order imposed on 20 May 2019, in that you;

a) Undertook a shift at the Centre as an Independent Nurse Prescriber.

b) Prescribed medication to 6 patients as set out in schedule 2.

4) On or around 29/30 July 2019 breached condition 10 a) of the interim conditions of practice order, in that you;

a) Did not immediately inform the Centre that you were subject to an interim conditions of practice order.

b) Did not immediately inform the Centre that you were restricted from working as an Independent Nurse Prescriber.

c) Did not immediately disclose conditions 1 to 9 of your interim conditions of practice order to the Centre

5) On or around 29 July 2019 when completing exhibit JJ/3, inaccurately circled/answered “No” to the question “Has there been any specific circumstances impacting on your prescribing practice over the last year.”

6) Your actions at one or more of charges 2, 3, 4 & 5 above were dishonest, in that you deliberately sought to conceal the restrictions/conditions of practice order, from the Centre.

7) Your actions at one or more of charges 2 & 3 were dishonest, in that you prescribed medication for one or more patients, despite knowing that you were restricted from doing so.

8) Between July 2019 & August 2019 you breached condition 7 of the interim conditions of practice order, in that you;

a) Did not inform your regulator that you had accepted a nursing appointment as an Independent Nurse Prescriber with the Centre.

b) Did not provide your regulator with the contact details of your employers at the Centre.

9) Between July 2019 & August 2019 you breached condition 9 a) & 9 b) of the interim conditions of practice order, in that you, did not provide your regulator with the name/contact details of the Centre.

10) Your actions in charges 8 & 9 above were dishonest, in that you sought to conceal your new appointment as an Independent Nurse Prescriber at the Centre, from your regulator.

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

Schedule 1

1) Patient 1 – Chlorphenamine 4mg – 21 tablets.

2) Patient 2 - Flucloxacillin 500mg – 28 capsules
Chlorphenamine 4mg – 28 tablets

3) Patient 3 – Olive Oil Drops 20ml

4) Patient 4 – Omeprazole 20mg – 28 capsules

5) Patient 6 – Dermol 500 lotion – 500ml
Hydrocortisone 1% Cream – 30 gram

6) Patient 7 – Aveeno Intense Relief Hand Cream – 75ml
Dermovate 0.05% Cream – 30 gram

7) Patient 8 – Trimethoprim 50mg/5ml – 140ml

8) Patient 9 – Amoxicillin 250mg 250mg/5ml – 150ml

9) Patient 10 – Nitrofurantoin 100mg – 6 capsules

10) Patient 11 – Ciprofloxacin 0.3% eye drops – 5ml

11) Patient 12 – Co-codamol 8mg/500mg – 32 Tablets
Otomize Ear Sprat – 5ml

12) Patient 13 – Co-codamol 15mg/500mg – 56 tablets

13) Patient 14 – Movelat Cream – 125 gram

14) Patient 15 – Atorvastatin 20mg – 28 tablets

15) Patient 17 – Nitrofurantoin 100mg – 14 capsules

Schedule 2

1) Patient 18 – Dioralyte Oral Power Sachets 200ml – 4 sachet

2) Patient 19 – Chlorhexidine Gluconate 0.2% Mouthwash 10ml – 300ml
Phenoxymethylpenicillin 250mg – 80 tablets

3) Patient 20 – Doxycycline 100mg capsules – 7 capsules

4) Patient 21 – Doxycycline 100mg capsules – 7 capsules
Mirabegon 50mg – 30 tablets

5) Patient 22 – Dermole 500 Lotion – 500ml
Eumotove 0.05% - 30gram

6) Patient 23 – Co-codamol 15mg/500mg – 56 tablets

Admissions

At the outset of the hearing, you provided admissions to a number of the charges against you. You made further admissions to the charges as the hearing progressed, prior to the panel considering the factual elements of the charges.

In totality, you admitted charges 1a(ii), 1b(i), 1b(ii), 1b(iii), 1b(vi), 1e(i), 1e(vi), 1f(ii), 1f(iii), 1g(i), 1g(ii), 1g(iii), 1g(iv), 1g(v), 1g(vi), 1h(i), 1h(ii), 1h(iii), 1h(v), 1i(i), 1i(ii), 1i(iv), 1i(v), 1j(i), 1l(i), 1m(iii), 1n(i), 1n(ii), 1o(i), 1p(i), 1p(ii), 1p(v), 1q(i), 1r(i) in part, 1r(ii) in part, 1r(iii) in part, 1r(iv) in part, 1r(v), 2, 3, 4c, 5, 6 in part, 7, 8 and 9.

In taking account of the above, the panel found charges 1a(ii), 1b(i), 1b(ii), 1b(iii), 1b(vi), 1e(i), 1e(vi), 1f(ii), 1f(iii), 1g(i), 1g(ii), 1g(iii), 1g(iv), 1g(v), 1g(vi), 1h(i), 1h(ii), 1h(iii), 1h(v), 1i(i), 1i(ii), 1i(iv), 1i(v), 1j(i), 1l(i), 1m(iii), 1n(i), 1n(ii), 1o(i), 1p(i), 1p(ii), 1p(v), 1q(i), 1r(i) in part, 1r(ii) in part, 1r(iii) in part, 1r(iv) in part, 1r(v), 2, 3, 4c, 5, 6 in part, 7, 8 and 9 proved by way of admission.

Background

The NMC received a referral in relation to you from Sandwell & West Birmingham CCG ("the CCG") on 18 April 2019. At the material time, you were employed as a registered nurse, namely, in the role of Advanced Nurse Practitioner ("ANP") at Bloomsbury between 15 April 2019 and 18 April 2019.

It is alleged that the majority of the regulatory concerns involved in this case arise out of an unannounced Care Quality Commission ("CQC") inspection at Bloomsbury on 17 and 18 April 2019.

Following this CQC inspection, allegations were made against you stating that you had acted outside the scope of your clinical competence as an ANP by seeing patients in consultations, when in some instances these were outside of your scope of competence. The CQC inspectors reviewed a sample of patient records for the individuals seen by you and concluded that you had placed multiple patients at a risk of harm through inadequate assessment, examination, diagnosis, treatment and management.

As a result of these concerns, the NMC applied for an interim order to restrict your nursing practice. A panel of the Investigating Committee ("IC") imposed an interim conditions of practice order ("ICOPO") on 20 May 2019, with condition 1 stating that *"You must not practise as an independent nurse prescriber"*.

After the interim order hearing on 20 May 2019, you accepted work at the Centre where, on 29 July 2019 and 30 July 2019, you allegedly breached your ICOPO by prescribing medication to patients at the Doctors' surgery. It is alleged that you failed to inform the Centre of your ICOPO and your restrictions on prescribing. This resulted in a second referral being made to the NMC.

An interim order review hearing was held on 3 October 2019, at which your ICOPO was replaced with an interim suspension order ("ISO"). This order was replaced by a further ICOPO on 20 March 2020.

It is alleged that you acted dishonestly in your actions as outlined above.

Decision and reasons on application for hearing to be held in private

Ms Bayley made a request that parts of the hearing be held in private on the basis that proper exploration of this case may involve reference to matters which are not suitable for the public domain. She referred an NMC witness to a telephone record containing multiple telephone numbers and confirmed that these would need to be redacted for the purposes of the transcript.

Ms Bayley submitted that any public interest in this part of the case being aired in public session is outweighed by the need to protect your privacy and that of others. This application was made pursuant to Rule 19 of the Rules.

Mr Edwards did not oppose the application.

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

Rule 19 states:

> 19.—(1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.
>
> (2) Subject to paragraph (2A), a hearing before the Fitness to Practise Committee which relates solely to an allegation concerning the registrant's physical or mental health must be conducted in private.
>
> (2A) All or part of the hearing referred to in paragraph (2) may be held in public where the Fitness to Practise Committee—
>
> (a) having given the parties, and any third party whom the Committee considers it appropriate to hear, an opportunity to make representations; and
>
> (b) having obtained the advice of the legal assessor, is satisfied that the public interest or the interests of any third party outweigh the need to protect the privacy or confidentiality of the registrant.
>
> (3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied—

(a) having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and

(b) having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.

(4) In this rule, "in private" means conducted in the presence of every party and any person representing a party, but otherwise excluding the public.

Having heard that there will be reference to private information that is unsuitable for the public domain, the panel determined to hold such parts of the hearing in private. The panel determined to rule on whether or not to go into private session in connection with these matters as and when such issues are raised.

Decision and reasons on application of no case to answer

The panel considered an application made by Ms Bayley that there is no case to answer in respect of all the charges against you. This application was made under Rule 24 (7) of the Rules. This rule states:

24 (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –

(i) either upon the application of the registrant, or
(ii) of its own volition…

the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.

In relation to this application, Ms Bayley referred the panel to the case of R v Galbraith 73 Cr.App.R.124 CA which gives guidance as to the proper approach to follow in relation to applications of no case to answer. She submitted that there is no case to answer for you if, at the close of the NMC's case, there is no evidence before the panel which is capable of finding a charge proved, according to the first limb in *R v Galbraith*. Furthermore, she submitted that there is also no case for you to answer if there is some evidence in relation to a charge, but it is of a tenuous nature, because of inherent weakness or vagueness or because it is inconsistent with other evidence (the second limb of *R v Galbraith*).

Ms Bayley submitted that the NMC has presented Dr 1's evidence as if it is an expert opinion. She submitted that the charges have largely been drafted on the basis of her review of your written consultation records.

Ms Bayley submitted that in Dr 1's oral evidence, she accepted that she had not made any independent enquires of Bloomsbury around the booking of follow up appointments for patients, blood tests or referrals. Ms Bayley submitted that no evidence has been presented by patients, nor is there any evidence from their follow up appointments with the CCG appointed General Practitioners ("GP").

Ms Bayley submitted that it is insufficient for the NMC to discharge its evidential burden by simply asserting *'if it is not recorded, it did not happen'*. She submitted that the allegations in this case have not been thoroughly investigated. Ms Bayley submitted that the NMC has not adduced any evidence to suggest that examinations or follow ups were not completed by you, or that advice was not given. She submitted that, taking the case at its highest, the NMC can say the required evidence has not been recorded in patients' consultation notes.

Ms Bayley reminded the panel that you have accepted that your documentation on the relevant days was below the required standard. However, this does not mean that these tasks were not undertaken by you. She submitted that there is insufficient evidence presented for a properly directed panel to find charges proved, relating to Patients A, E, I, J, K, M, P, Q and R.

Furthermore, Ms Bayley submitted that Dr 1's opinion of what falls within or outside an ANP's scope of practice is beyond her area of expertise. She submitted that *'scope'* is a regulatory matter and that no definition of "scope of practice" appears within the paperwork. Ms Bayley submitted that this is because, in reality, a practitioner's scope of practice is not defined by the NMC, or by law, but by the competencies, experience and expertise of the individual practitioner.

Ms Bayley submitted that Dr 1, by her own admission, is not an expert in Advanced Nurse Practice, but she has judged your consultations to the standard of a GP. She submitted that despite Dr 1 saying she undertakes thorough checks of ANPs in her own practice to establish competency, all the evidence in this case about your level of competence comes from a brief interview between you, Dr 1 and Ms 2. Ms Bayley submitted that there is little clear evidence on the nature and extent of this conversation, which, in any event, was not a thorough examination of your level of competence. Mr 3 took Dr 1 at her word in relation to your competencies and did not undertake any independent investigations.

Ms Bayley submitted that Ms 4 provides evidence from the relevant time concerning your level of competence, skills and experience and has stated that she had no concerns with your ability to provide care to children, following checks of your documentation. Dr 6 also confirms that she had no concerns regarding your decision-making skills at the Centre. Ms Bayley submitted that the panel will recall the evidence of Dr 1 and Ms 2, specifically, that you were not asked to provide evidence of your competencies to them, though reference is made to Dr 7 having been provided with such evidence in "*a thick folder*". She submitted that it is not your fault that copies of your competencies were not kept by Bloomsbury and therefore, not available for the CQC inspection team.

Ms Bayley submitted that in order for the NMC to prove that you acted outside the scope of your practice, cogent evidence needs to be presented to demonstrate that you did not have the relevant training, skills and competencies to see those specific patients. She submitted that no such evidence has been provided relating to Patients B, C and D.

Ms Bayley submitted that you face a number of charges that you allegedly '*incorrectly prescribed*' medication to patients. However, she submitted that the only evidence to support these charges comes from Dr 1, following the same paper-based exercise. Ms Bayley submitted that no further investigations have been carried out by the NMC to find out whether these medications were changed upon review. She submitted that, taking the evidence at its highest, the NMC can say that no rationale was provided in the consultation reports, but there is no evidence to suggest that these prescriptions were incorrect. Ms Bayley submitted that Dr 1 had the opportunity to ask you on the day of the inspection for your rationale. She submitted that no concerns were raised to you in relation to Patient E and Patient H receiving incorrect medications, either by Dr 1 on that day, or subsequently by the CCG.

Ms Bayley submitted that there is no reliable evidence to suggest that you had inadequately recorded the history of Patient K's leg pain. She submitted that the NMC has not presented expert ANP evidence about what the expectations of an ANP would be in this scenario. Ms Bayley submitted that what Dr 1 described in her oral evidence was a council of perfection, speaking about what she would have expected of a GP in those circumstances. Ms Bayley submitted that such evidence is insufficient for a panel to be able to find charge 1k(i) proved.

Ms Bayley submitted that the encounter with Patient F cannot properly be described as a clinical consultation. She informed the panel that you accept that you were not competent to treat, examine or provide care for this patient, but, as expressed to Dr 1 on the day, you wanted to ensure the patient was seen by a specialist service. You telephoned Single Point of Access ("SPA") to get an appointment for Patient F and the records demonstrate that the SPA called back with advice which was passed on. Ms Bayley submitted that there is no evidence presented by the NMC to support a finding that you were not competent to undertake this limited contact with Patient F.

Ms Bayley submitted that there has been no evidence presented by the NMC in support of charge 10. She reminded the panel that you accept that you did not inform the NMC about

your new job appointment at the Centre. However, Ms Bayley submitted that there was nothing in your interim conditions preventing you from acting as an ANP, which this job entailed. She therefore submitted that you had no motivation to be dishonest. Whilst Ms Bayley acknowledged that not informing the NMC about the new job appointment put you in breach of your interim conditions of practice order, she submitted that cogent evidence has not been presented to suggest that you acted dishonestly. Ms Bayley submitted that it would not be sufficient for an inference to be drawn, in order to find sufficient evidence to support this charge.

In conclusion, Ms Bayley submitted that the NMC has not produced sufficient evidence, such that a properly directed panel could find the outstanding charges proved. She therefore invited the panel to find that there is no case for you to answer in accordance with Rule 24(7).

Mr Edwards agreed with the legal principles set out by Ms Bayley. He invited the panel to have regard to Dr 1's evidence throughout his submissions, stating that some of the evidence in support of the allegations stem from the discussions you had had with Dr 1 and Ms 2 at the time of the CQC inspection. Mr Edwards specifically drew the panel's attention to Dr 1 stating in her NMC witness statement that "*…The Registrant told us that she completed an Advanced Nurse Certificate in 2014 and had done training in minor illness and injury, heart failure, palliative care and district nurse practitioner award. However, she had not undertaken any training in long-term conditions such as diabetes, asthma, chronic obstructive pulmonary disease, cardiovascular disease or gynaecology and had only completed online training on sepsis for paediatrics. We were also informed that the Registrant did not do smears or administer vaccinations to children under 1 year of age…".*

Specifically, in respect of charges 1b, 1c and 1d, Mr Edwards submitted that according to Dr 1's witness statement, there was a clear admission from you that you were working beyond the scope of your competence in respect of Patient B, Patient C and Patient D. This is apparent from Dr 1 stating *"…When the Registrant was asked about Patient B, the*

Registrant admitted that she did not have any training or competencies in assessing and managing paediatric patients and therefore should not had consulted with this patient…". Therefore, Mr Edwards submitted that there is a case for you to answer in respect of charges 1b, 1c and 1d.

In his submissions, Mr Edwards sought to rely on the well-known nursing principle that 'if it is not written down, it did not happen'. He submitted that a patient's record is like a book; it has a beginning, a middle and an end. However, if part of the information from this book is missing, then you have an incomplete picture of what has happened, and that can be said to be the case at this hearing. Mr Edwards submitted that when Dr 1 looked at all of the patients' records, if she could not see your work documented, she was unable to establish whether an examination of the patient had indeed taken place. Therefore, Mr Edwards submitted that it is fair for Dr 1 to say that she is unable to confirm whether the examinations happened. Mr Edwards submitted that the only person that can confirm or deny that is you and, unless the panel hears from you directly, it will not be able to make an adequate assessment of those specific charges.

Specifically in respect of charge 1a, Mr Edwards submitted that there is nothing mentioned in Patient A's notes about any examinations or investigations taking place to confirm the diagnosis of a urinary tract infection. However, he drew the panel's attention to you having documented Patient A's previous history and what examinations took place on a prior occasion, which Dr 1 accepted had been adequate in places. Therefore, Mr Edwards submitted that on this occasion, the evidence suggests that you did not carry out the examination on 16/17 April 2019 because you have not documented it.

Specifically in respect of charge 1e, Mr Edwards reminded the panel that Dr 1 had stated that you had informed her and Ms 2 that you had not undertaken any training in long-term conditions such as chronic pulmonary disease, and Patient E presented with this condition. He submitted that Dr 1 was clear in her opinion that an examination of Patient E did not take place as "…*There was no peak flow taken, no checks of the chest and nothing noted in the notes to suggest an examination had taken place…*".

Furthermore, Mr Edwards submitted that you incorrectly prescribed medication to Patient E, as Dr 1 stated in her NMC witness statement that "*…The Registrant did not issue Amoxicillin tablets alone as recommended in the local prescribing guidance for rescue medicines associated with acute exacerbation of COPD, but instead prescribed the treatment recommended for a community acquired pneumonia…*". When questioned on this during her oral evidence, Dr 1 confirmed that there was nothing in Patient E's notes to justify why you had prescribed two antibiotics, and she was of the view that this was incorrect. Mr Edwards submitted that Patient E was then placed at a risk of harm as you did not conduct an assessment to confirm the diagnosis or the severity of the patient's respiratory illness. He submitted that there is also no evidence of a follow-up appointment being arranged, nor any evidence of an adequate assessment being undertaken in respect of the neurological symptoms. Therefore, Mr Edwards invited the panel to find that there remains a case for you to answer in respect of charges 1e(ii) and 1e(iii).

In respect of charge 1f, Mr Edwards submitted that Patient F was seen twice by you in relation to her miscarriage, having had a history of recurrent miscarriages. Again, he submitted that this was a situation where you had openly admitted to Dr 1 that you had had no gynaecological training and did not feel comfortable examining her, but "*…did not want the patient to feel she wasn't getting any help…*". Therefore, Mr Edwards submitted that there is a suggestion that you may have acted outside the scope of your competence, so this charge should remain before the panel at this stage.

In respect of charge 1h, Mr Edwards referred the panel to Dr 1's NMC witness statement in which she had said "*…In addition, the Registrant prescribed the patient sodium cromoglycate eye drops, which are used to treat allergic conjunctivitis. There was no decision-making process recorded to indicate why these drops had been prescribed…*". He submitted that in Dr 1's professional opinion, this was the incorrect prescription to give, taking account of what Patient H's notes stated and their symptoms. Furthermore, Mr Edwards submitted that Dr 1 had stated that there was no clinical justification provided as to why these particular eye drops had been prescribed and, as such, there remains a case to answer in respect of charge 1h(iv).

In respect of charge 1i, Mr Edwards submitted that Dr 1 was of the view that an inadequate examination was completed, given that there was no assessment of Patient I's symptoms. He submitted that there is no evidence to suggest that you had documented checking the anal tone or whether there was any damage to the cord, which would impact on the ability to assess the patient's neurological impairment. Dr 1 states in her NMC witness statement that "*…The Registrant also did not advise the patient regarding symptoms and signs to look out for that would indicate progressive neurological impairment which would require urgent medical attention…*" so Mr Edwards invited the panel to find that there remains a case to answer in respect of charge 1i.

In respect of charge 1j, Mr Edwards submitted that there is no evidence to suggest that you undertook a thorough abdominal examination of Patient J. He submitted that according to Dr 1, there were no requests for tests to be run to check Patient J's symptoms, and that this would normally be done before making a referral. Mr Edwards submitted that there is no evidence of either of these actions being completed as it is not documented on Patient J's notes. Therefore, he invited the panel to find that there is a case for you to answer in relation to charge 1j.

In respect of charge 1k, Mr Edwards referred the panel to Dr 1's NMC witness statement, in which it is stated "*…The Registrant did not take a full history regarding leg pain or chest symptoms and did not perform any neurological examination of the legs despite symptoms suggestive of neurological involvement…*". Dr 1 then went on to say in her oral evidence that your notes for Patient K was lacking in detail, as she would expect to see notes of an examination involving the movement of the legs, reflexes, and also a rectal examination. Mr Edwards submitted that the evidence suggests that the conduct above was not documented in Patient K's notes so there remains a case for you to answer.

In respect of charge 1m, Mr Edwards submitted that Patient M's partner attended Bloomsbury for a consultation in her absence, asking for a contraceptive pill to be prescribed. He submitted that you spoke to Patient M on the telephone to confirm that she

was satisfied that her partner had made the appointment and to confirm that she had not experienced any side effects of the contraceptive pill when she had taken it previously. Mr Edwards submitted that, according to Dr 1, you would have been expected to provide Patient M with the recommended advice, given that Patient M's notes showed a history of her having been prescribed the progesterone contraceptive pill, whereby she had taken it for a period of time, had a break from it, and was about to embark on taking it again. However, Mr Edwards submitted that the advice you gave was not detailed in Patient M's notes, so the panel can surmise that this did not occur. Furthermore, he submitted that there is nothing to suggest that you informed Patient M that there would be a contraceptive pill review at a follow-up appointment. Therefore, Mr Edwards submitted that there remains a case to answer in relation to charge 1m.

In respect of charge 1p, Mr Edwards referred the panel to Dr 1's NMC witness statement, in which it was stated "*…The Registrant did not take an adequate history and did not perform any examination to find a cause for the anaemia and iron deficiency…*". Mr Edwards submitted that this is supported by the documentary evidence as there is nothing in Patient P's notes relating to her diet, or why she was anaemic. Therefore, Mr Edwards submitted that there remains a case to answer in relation to charge 1p.

In relation to charge 1q, Mr Edwards submitted that Patient Q presented with increasing shortness of breath, a cough, sore gums and teeth. Again, he submitted that there is no documentary evidence in Patient Q's notes which outlines the steps you took. This is apparent as Dr 1 attests to this, stating "*…She did not offer any safety advice given or arrange for follow up to ensure his condition was responding to treatment…*". Therefore, Mr Edwards submitted that there remains a case to answer in relation to charge 1q.

In relation to charge 1r, Mr Edwards submitted that there is nothing in Patient R's notes to suggest that a mental health referral had been made, that safety netting advice had been given, or that this concern had been escalated for further assessment. Dr 1 accepted in her evidence that the history you provided on Patient R was reasonable, albeit there was nothing in relation to bowel habits being noted, however, she would have expected to see

a referral or telephone call to the Crisis Team on the same day, given that the patient was presenting with suicidal ideations. Therefore, Mr Edwards submitted that there remains a case to answer in relation to charge 1r.

In respect of charge 10, Mr Edwards submitted that there was a clear expectation for you to inform the NMC of any new employment, whether it be paid or unpaid, according to your ICOPO. He submitted that in not providing this information to your regulator, there could be an element of dishonesty present, as you could have been attempting to conceal the nature of your new employment. Mr Edwards submitted that by withholding this information, it allowed you to continue to work as an ANP, which you were not permitted to do. He submitted that you would have been aware that your nursing practice was subject to certain restrictions, and that you would not have been able to work in the position you wanted, had you been upfront about your new details of employment. However, Mr Edwards reminded the panel that we are yet to hear testimony from you in respect of this. Therefore, Mr Edwards submitted that there remains a case for you to answer in respect of charge 10.

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel carefully reviewed all of the evidence before it at this stage and applied the test in ***R v Galbraith*** to each charge under consideration. The panel considered the quality of the evidence presented at this stage and the inferences which may be drawn from it. The panel was aware that in regulatory proceedings, it should consider whether there is any evidence upon which a properly directed panel could find the alleged facts proved. If there is such a possibility, then the panel should proceed to hear your case receiving evidence from you, alongside any supporting witnesses and documentary evidence.

In considering charge 1 in the round, the panel had regard to the evidence provided by Dr 1 at this hearing.

The panel decided that it would be possible to consider each of the sub-charges in charge 1 individually in determining whether there is a case for you to answer. However, in documenting its decision, the panel decided to categorise the sub-charges into groups, which still needed to be adjudicated on.

In relation to charges 1a(i), 1e(ii), 1e(v), 1e(vii), 1i(iii), 1j(ii), 1k(i), 1k(ii), 1m(i), 1m(ii), 1p(iii), 1p(iv), 1q(ii), 1r(i), 1r(ii), 1r(iii) where it is alleged that you '*did not'* perform a particular function, the panel noted that there was evidence provided from Dr 1 to support the view that she could be considered to be an experienced healthcare professional in primary care (as a GP), and that she had some familiarity with the principles involved in these concerns.

The panel noted that the NMC, through Dr 1, were seeking to rely on what Dr 1 considered to be a well-known healthcare principle *'if it is not recorded, it did not happen'* in considering whether there is sufficient evidence for these charges to remain before the panel. Whilst the panel accepted that just because you did not record an entry for a certain task, it does not axiomatically follow that the task was not undertaken. The panel was satisfied the evidence of Dr 1, in relation to the constituent elements of medical notes and the importance of the constituent elements was such as could justify the conclusion if matters were not noted, they were not carried out. Dr 1 provided evidence which could support the view that she had experience and knowledge of what was required in the examination in 1e(vii) as to form a view what was adequate or not. The panel was satisfied that Dr 1's evidence, taken at its highest, could amount to sufficient proof that the tasks, as laid out in the sub-charges above, were not undertaken or performed to an adequate standard.

Overall, the panel was of the view that Dr 1's evidence, in relation to these sub-charges, was not so weak, tenuous, inadequate or inconsistent for it to determine that there is no case for you to answer. It considered there to be sufficient evidence, taken at its highest, to enable a properly directed panel to find that charges 1a(i), 1e(ii), 1e(v), 1e(vii), 1i(iii), 1j(ii), 1k(i), 1k(ii), 1m(i), 1m(ii), 1p(iii), 1p(iv), 1q(ii), 1r(i), 1r(ii), 1r(iii) could be found proved.

In relation to charges 1b(iv), 1b(v), 1c(i), 1c(ii), 1d(i), 1d(ii), and 1f(i) where it is alleged that you completed a task without the '*necessary training/competencies*', the panel considered there to be some evidence before it in support of these charges. The panel noted that there was evidence provided from Dr 1 to support the view that she could be considered to be an experienced healthcare professional, and that she had some familiarity with the principles involved in the assessment and management of paediatrics and gynaecological patients in primary care.

Overall, the panel was of the view that Dr 1's evidence, in relation to these sub-charges, was not so weak, tenuous, inadequate or inconsistent for it to determine that there is no case for you to answer. It considered there to be sufficient evidence, taken at its highest, to enable a properly directed panel to find that charges 1b(iv), 1b(v), 1c(i), 1c(ii), 1d(i), 1d(ii), and 1f(i), could be found proved.

In relation to charges 1e(iii), 1e(iv) and 1h(iv), where it is alleged that you '*incorrectly prescribed*' medication to patients, the panel considered there to be some evidence before it in support of these charges. The panel noted that there was evidence provided from Dr 1 to support the view that she could be considered to be an experienced healthcare professional, and that she had some familiarity with the appropriate prescribing practices involved in these concerns.

Overall, the panel was of the view that Dr 1's evidence, in relation to these sub-charges, was not so weak, tenuous, inadequate or inconsistent for it to determine that there is no case for you to answer. It considered there to be sufficient evidence, taken at its highest, to enable a properly directed panel to find that charges 1e(iii), 1e(iv) and 1h(iv) could be found proved.

Specifically in relation to charge 10, it is alleged that you sought to conceal your new appointment as an ANP at the Centre, from your regulator. The panel heard evidence from

Mr 5 that there was no record on the NMC system which demonstrated that you had notified the NMC of your appointment at the Centre.

In considering whether your duty to inform the regulator could be viewed as dishonest, the panel had regard to the oral and documentary evidence it had received from Ms 4, who had confirmed to the panel that an ability to prescribe was an important factor in you being given the job at the Centre. Further, in taking account of the paperwork referred to by Ms 4, the panel noted that in applying for your role at the Centre, you had been asked "*Has there been any specific circumstances impacting on your prescribing practice over the last year? i.e. long term sickness*" and you had responded to this by circling '*No*' and writing "*NO SICKNESS*" in the explanation box provided.

Overall, the panel was satisfied that there was sufficient evidence, taken at its highest, that a properly directed panel could find charge 10 proved.

Therefore, in considering all of the above, the panel was satisfied that there remains a case for you to answer in respect of all of the outstanding charges against you.

Decision and reasons on application for hearing to be held in private

During your evidence, Ms Bayley made a request that parts of the hearing be held in private on the basis that proper exploration of this case may involve reference to private health matters. She again referred the panel to Rule 19 and submitted that any public interest in this part of the case being aired in public is outweighed by the need to protect the privacy of yourself and others.

Mr Edwards did not oppose the application.

The panel accepted the advice of the legal assessor.

Having heard that there will be reference to private health matters which are unsuitable for the public domain, the panel determined to hold such parts of the hearing in private. The

panel determined to rule on whether or not to go into private session in connection with these matters as and when such issues are raised.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took account of all the oral and documentary evidence in this case, together with the submissions made by Mr Edwards, on behalf of the NMC, and by Ms Bayley, instructed by the RCN, on your behalf.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard oral evidence from the following witnesses called on behalf of the NMC who, at the time of the events, were employed in the following roles:

- Dr 1: National Clinical Advisor for General Practice and GP Specialist Advisor at the CQC
- Ms 2: Inspector at the CQC
- Mr 3: Primary Care Quality Lead for the CCG.
- Mr 4: Investigations Team Manager in the Professional Regulation Directorate at the NMC.

- Ms 5: Practice Manager at the Centre.

The panel heard oral evidence from the following witness, called on your behalf:

- Ms 8: Director of Education at a training company you had attended.

The panel also heard oral evidence from you.

The panel first considered the overall credibility and reliability of the witnesses in the order it had heard from them and it made the following conclusions:

The panel found Dr 1 to be a thorough and knowledgeable witness who had a good recollection of the inspection that she undertook alongside Ms 2 at Bloomsbury on 17 and 18 April 2019. It noted that Dr 1 remained consistent with her NMC witness statement throughout her evidence, and it considered her to have been unwavering in her approach in answering questions. However, during her oral evidence, it became apparent that Dr 1 had formed a preconceived opinion of your competence based on your clinical notes on the days of the CQC inspection. This witness seemed to be unwilling to take account of any contextual factors that may have arisen in this case. Dr 1 had set views on your standard of performance from this paperwork, and it appeared to inform her opinion that she had to intervene to stop you from delivering nursing services. Dr 1 gave evidence of her opinion of what might be expected of an ANP in primary care, but she was at times uncompromising and somewhat fixed in her view.

Overall, the panel found Ms 2 to be a direct, credible and reliable witness when giving her oral evidence. However, it considered her to have demonstrated some resistance in accepting any point that challenged the quality of the inspection or the process around it.

The panel found Mr 3 to be a credible, reliable and straightforward witness. It was of the view that Mr 3 offered an honest, fair and balanced account to the panel. He did not

attempt to embellish or exaggerate in his oral evidence, and he was open to considering the context of the situation. Mr 3 was clear from the start that much of his evidence had been based on what Dr 1 had told him, as he was not a direct witness to any of the alleged events. His primary involvement was nothing to do with investigating your alleged failures. Therefore, whilst the panel found Mr 3's evidence to be helpful, it recognised that he could only provide a limited amount of assistance in considering the allegations.

The panel found Mr 4 to be a helpful, credible and reliable witness. It noted that Mr 4's evidence was fairly limited in scope, but he was prepared to make concessions and admit the mistakes he had made in attempting to locate certain documentary evidence. Mr 4 was able to explain the steps he took to the panel and he took responsibility for his actions.

The panel found Ms 5 to be a credible and generally reliable witness. However, it considered her to have some difficulties in recollecting matters due to the lapse in time, which limited the extent of her evidence. In some aspects, parts of Ms 5's oral evidence was corroborated by the witness statement of Ms 9 and by other documentary evidence.

The panel found Ms 8 to be a credible, reliable and straightforward witness. It noted that she was called to give expert evidence on your behalf, and this consisted of a witness statement and oral evidence. The panel considered Ms 8 to be knowledgeable in the particular areas of concern. It found her to have been balanced in her approach in answering questions and it was satisfied that she did not seek to embellish her evidence in any way. Instead, the panel was of the view that she had attempted to assist it to the best of her knowledge and belief.

The panel was mindful that a number of the charges were admitted and the evidence that you gave in relation to the remaining charges, in respect of patient consultations, was consistent and credible. On balance and in this regard the panel found you to be helpful, transparent and able to recognise when you had fallen short of the standards expected of you. However in respect of the dishonesty charges, the panel found your evidence to be at times self-serving and elusive and not particularly credible or reliable. The panel was of

the view that your responses to questioning did not always make sense; and, this appeared to be a combination of you not understanding what was expected of you or of you disregarding your professional obligations. However, the panel acknowledged that you were giving evidence for a lengthy period of time, and it considered this may have impacted on the quality of your evidence.

The panel reminded itself that you had admitted a large number of the charges, after they had been amended. The panel had already announced that these were found by way of your admissions.

Therefore, the panel then moved on to consider each of the disputed charges and it made the following findings.

Charge 1a(i)

That you, a registered nurse, whilst employed as an Independent Nurse Prescriber at the Bloomsbury Health Centre, on 16 and/or 17 April 2019;

1) Did not practice within your clinical scope of competence, in that you;

a) In relation to Patient A;

i) Did not perform any examination/investigation to confirm the diagnosis/exclude other causes, for Patient A's possible urinary tract infection.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you.

The panel took into account Dr 1's witness statement in which she states: "*The Registrant failed to perform any examination or investigations to confirm the diagnosis of urinary tract*

infection or exclude other causes for the symptoms…" and "*By failing to perform any examination or investigations, the Registrant placed patient A at risk of having an undiagnosed condition which is not being appropriately treated or receiving ineffective treatment of an ongoing urine infection*".

The panel bore in mind your oral evidence that you requested a urine sample from Patient A and "*gave him a sample bottle, and he had full understanding that he needs to provide me with the urine and bring it back to reception, and that we have to send it off for processing*".

The panel accepted that although your examination of Patient A may have been incomplete or not to a level of standard required, the panel was of the view that it had no evidence before it to suggest that you did not perform ***any*** examination/investigation to confirm the diagnosis/exclude other causes, for Patient A's possible urinary tract infection. The panel had sight of the contemporaneous notes of Patient A's records which demonstrates that you made arrangements for Patient A to be followed up after your consultation. In addition, the panel had no evidence to suggest that Patient A's urine sample was not returned or if there was a subsequent investigation carried out into Patient A's symptoms.

Therefore, in taking into account all of the above, the panel found charge 1a(i) not proved on the balance of probabilities.

Charges 1b iv), 1c (i) and 1d(i)

b) In relation to Patient B, a paediatric patient;

iv) Performed a clinical consultation of Patient B, without the necessary training/competencies.

c) In relation to Patient C, a paediatric patient;

i) Performed a clinical consultation of Patient C, without the necessary training/competencies.

d) In relation to Patient D, a paediatric patient;

i) Performed a clinical consultation of Patient C, without the necessary training/competencies.

These charges are found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1, Dr 6 and of you.

The panel considered charges 1b(iv), 1c(i), 1d(i) together. The panel bore in mind all the evidence before it and noted that you have relevant training certificates which pre-date these allegations and relate to competencies for working with children. It also noted your oral evidence in which you stated that you have been working with paediatric patients since 2012. The panel accepted this evidence.

The panel took into account Dr 1's written statement in which she stated "*By undertaking consultations for Patient's B, C and D without the necessary training, competencies or skills, the Registrant placed these children at risk of inadequate assessment, examination, diagnosis, treatment and management."*

The panel considered that the CQC inspection was of the establishment and not of your competencies. Dr 1's statement above was based on a discussion she says took place with you in relation to your paediatric expertise. However Dr 1 was not aware of your training certificates and appeared not to be aware that you had practical experience with paediatric patients since 2012.

The panel bore in mind that the burden of proof lies on the NMC, the panel reminded itself of the wording of the charges and was of the view that it had no evidence before it to

suggest that you were performing without the necessary training and/or competencies. Therefore, in taking into account all of the above, the panel found charges 1b(iv), 1c(i), 1d(i) not proved on the balance of probabilities.

Charges 1b(v), 1c(ii) and 1d(ii)

b) In relation to Patient B, a paediatric patient;

v) Prescribed Phenoxymethylpenicillin & Paracetamol for Patient B, without the necessary training/competencies.

c) In relation to Patient C, a paediatric patient;

ii) Prescribed olive oil ear drops for Patient C, without the necessary training/competencies.

d) In relation to Patient D, a paediatric patient;

ii) Prescribed Amoxicillin 250mg/5ml for Patient D, without the necessary training/competencies.

These charges are found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1, Dr 6 and of you.

The panel considered charges 1b(v), 1c(ii) and 1d(ii) together. The panel took into account that you have been a qualified independent prescriber since 2002. It also took into account your certificates which pre-date April 2019 which demonstrate your training and competencies in relation to managing paediatric minor illnesses.

The panel bore in mind Dr 6's written statement in which she states "*When inspecting the Registrant's consultation notes, all medications she had prescribed seemed absolutely appropriate and I had no concerns with the Registrant's clinical decision making for these*

patients". The panel also considered the medical records that Dr 6 refers to and noted that in some cases these appeared to relate to paediatric patients. The panel was of the view that Dr 6's inspections of your examinations and treatments occurred shortly after these charges arose.

The panel accepted Dr 1's oral evidence in which she stated that your choice of medication prescribed was not justified in relation to Patient D, however the panel was minded of the charge. It was of the view that the charge does not relate to your decision to prescribe that particular medication but that you prescribed medication without the necessary training/competencies. However the panel bore in mind that your training pre-dated your consultation with Patient D and that your qualification as an independent nurse prescriber was achieved in 2002 and therefore concluded you were not working outside of the necessary training/competencies. Therefore, in taking into account all of the above, the panel found charges 1b(v), 1c(ii) and 1d(ii) not proved on the balance of probabilities.

Charge 1e(ii)

e) In relation to Patient E;

ii) Did not examine/asses Patient E to confirm the diagnosis/severity of their Chronic Obstructive Pulmonary Disease.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you and Patient E's clinical notes.

The panel noted Dr 1's written statement which states, "*The Registrant did not record any details of Patient E's symptoms and there was no examination undertaken, therefore the Registrant was unable to assess the severity of the patient's illness or adequately assess if the patient required admission*".

The panel noted that Dr 1 also stated in evidence that Patient E had apparently brought a letter from University Hospitals Birmingham (UHB) to her appointment with you as she was under their care but Dr 1 could not access it.

The panel was of the view that if Dr 1 had not been able to access the letter she would not know the contents of the document. It noted that Dr 1 could not confirm that you had not examined or assessed Patient E before prescribing any medication. The panel accepted that Dr 1 concluded that in the absence of any patient notes from you that an examination had not taken place.

The panel took into account your oral evidence in which you stated, "*we went from one part of her assessment and examination to the next very, very quickly, and it was just continuous, so therefore… Because there's a letter from her consultant, which I'd gone by. I'd gone by the exact management plan of her respiratory consultant from the UHB. I definitely remember that. She produced a letter."* The panel also noted your written statement which states, "*The patient explained she is under the care of a hospital physician and presented a letter requesting rescue medications. This letter included a detailed management plan from the respiratory physician and rescue medications which I prescribed accordingly as per physicians' management plan (sic)".*

The panel was of the view that your evidence is succinct in that you remembered your appointment with Patient E clearly. The panel noted Dr 1's evidence is consistent in that Patient E had a letter but Dr 1 could not access it. The panel also took into account Patient E's clinical record, it noted that you made notes which demonstrate an assessment of Patient E's symptoms. The panel was satisfied that you had carried out an assessment of Patient E. The panel therefore preferred your evidence due to the corroboration of your evidence and the contemporaneous notes you made under Patient E's clinical records. Therefore, in taking into account all of the above, the panel found charge 1e(ii) not proved on the balance of probabilities.

Charge 1e(iii) and 1e(iv)

e) In relation to Patient E;

iii) Incorrectly prescribed Amoxicillin and Clarithromycin for 7 days to Patient E.

iv) Incorrectly prescribed 40mg Prednisolone tablets to Patient E.

These charges are found NOT proved.

The panel considered charges 1e(iii) and 1e(iv) together. In reaching this decision, the panel took into account the evidence of Dr 1, of you and Patient E's clinical notes.

The panel took into account Dr 1's written statement in which she stated, "*…I was unable to open the Docman correspondence processing software to confirm if the medicines and dosages prescribed by the Registrant were as recommended by the hospital consultant. The Registrant did not issue Amoxicillin tablets alone as recommended in the local prescribing guidance…"* The panel bore in mind the evidence as in charge 1e(ii) in that Dr 1 had not had sight of the consultation letter Patient E had brought to her appointment with you.

The panel also took into account Dr 1's oral evidence in which she stated, "*There was nothing in the record that I could access that would suggest that there was any reason, and there was nothing documented in the Registrant's consultation, to suggest why she had used unusual antibiotics and a longer dose of steroids at a higher dose than would normally be required."*

The panel bore in mind your oral evidence in which you stated, "*So the letters that the lady produced, this was her rescue meds plan from her UHB consultant, her respiratory physician, and that's why I prescribed those medications from that letter*". In also noted your written statement which states, "*This letter included a detailed management plan*

from the respiratory physician and rescue medications which I prescribed accordingly as per physicians' management plan."

The panel was of the view that it had no evidence before it to suggest that you provided Patient E with an incorrect prescription. It noted that the NMC had not provided the consultation letter Patient E had, to conclude that you provided her with any incorrect prescriptions. The panel was therefore of the view that it had insufficient evidence to suggest that you incorrectly prescribed Amoxicillin and Clarithromycin for 7 days and that you incorrectly prescribed 40mg Prednisolone tablets to Patient E. On the balance of probabilities, the panel find these charges not proved.

Charge 1e(v)

e) In relation to Patient E;

v) Did not arrange a follow up appointment for Patient E.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1, of you and Patient E's clinical notes.

The panel took into account Dr 1's written statement in which she states, "*There were no safety netting or follow-up arrangements made*". It also bore in mind Dr 1's oral evidence in which she states, "*I didn't check the system but there's nothing documented about follow-up or safety netting in the consultation records*".

The panel also took into account your written statement in which you stated, "*I discussed respiratory specialist nurse input and social care input referral as patient E explained social and physical problems and the patient explained this had been suggested via her respiratory consultant during her previous outpatients' appointment and she declined as she felt someone else worse off than herself would benefit from respiratory nurse input*

and she wishes to remain independent. The patient agreed to revisit respiratory nurse input with her consultant…"

It also noted Patient E's clinical records which demonstrate that further investigations have been requested. The panel acknowledged that it would be best practice to record any follow-up recommendations in a patient's clinical records, however the panel had no evidence to suggest that you did not arrange a follow up appointment for Patient E as there were no further investigations to ascertain if a follow-up appointment had been made or not. The panel was therefore of the view that it had insufficient evidence to find this charge proved. On the balance of probabilities, the panel find charge 1e(v) not proved.

Charge 1e(vii)

e) In relation to Patient E;

vii) Did not perform an adequate neurological examination of Patient E's left arm.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1, of you and Patient E's clinical notes.

The panel noted Dr 1's written statement in which she states, "*The Registrant did not record adequate history, as she did not ask about other neurological examination of the arm, as she did not check sensation or reflexes in the arm."* It also noted Dr 1's oral evidence when asked if you asked Patient E to raise her arm, Dr 1 stated, "*She has, but the neurological examination and examination of an arm is far more than just asking the patient to raise their arm above the neck and head region. There's a confusion between what are symptoms and what are examination findings in this examination section. And it appears that the only investigation was that she could – she'd asked her to lift her arm,*

and that she was unable to move her thumb, which again suggests that there's some significant neurological deficit there".

The panel noted that Dr 1's evidence points to deficiencies in your examination. However it took into account Patient E's clinical notes which Dr 1 relies on to suggest that Patient E was experiencing deterioration in her symptoms. The panel was of the view that this must indicate that there was some adequacy to the examination of Patient E made by you. The panel also noted your oral evidence, when asked if you performed a neurological examination of Patient E's left arm, you stated, "*Yes, I did. I asked her to lift it up, and she couldn't. She couldn't go above her shoulder, I think I've written. She explained that she's unable to move her thumb, so I was checking for sensitivity and touch, by touching her.*"

The panel was of the view that it did not have evidence before it to suggest that you did not perform an adequate neurological examination of Patient E's left arm. The panel therefore find this charge not proved.

Charge 1f(i)

f) In relation to Patient F, a pregnancy related patient;
    i) Performed a clinical consultation of Patient F, without the necessary training/competencies.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1, of you and Patient F's clinical notes.

The panel noted Dr 1's written statement in which she stated *"…the Registrant needed to seek advice regarding management because she did not have the necessary knowledge, skills or experience to manage this patient. This places the patient at risk of a misdiagnosis, inappropriate treatment and mismanagement*."

The panel took into account your oral evidence in which you stated, "*I knew that I couldn't examine her because of my scope of practice and I wasn't able to do an internal examination, which I explained to her."* The panel also took into account your written statement which states, "*I confirm I had to intervene with the patient as she presented with a complaint outside of my scope of practice, however, due to the lack of any senior clinicians on site; I felt I had a duty of care for the patient and acted in her best interes*t…"

The panel noted that you are not a registered midwife, it also noted that you had no control over the patients that you saw. The panel was of the view that you had a basic consultation with Patient F and referred her to the appropriate clinician. It considered Dr 1's oral evidence in which she stated, "*I'm not saying that she should have turned her away because the patient's sitting there and she has a duty of care to the patient. But what she does have is a duty of care to make sure that she's taken sufficient information to be able to make a reasonable judgment, to be able to pass sufficient information on so other people can make a judgment*."

The panel accepted your evidence in that Patient F was clearly distressed and that you tried your best to help her in some way. It bore in mind Patient F's clinical record in which it refers to a referral being made. The panel was therefore of the view that you made the required referral to the appropriate clinician when you reached the limits of your competence. The panel had no evidence to suggest that you performed a clinical consultation of Patient F without the necessary training or competencies. The panel therefore find this charge not proved.

Charge 1h(iv)

h) In relation to Patient H;

iv) Incorrectly prescribed sodium cromoglycate eye drops.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you.

The panel took into account Dr 1's written statement which states, "*…the Registrant prescribed the patient sodium cromoglycate eye drops, which are used to treat allergic conjunctivitis. There was no decision-making process recorded to indicate why these drops had been prescribed*."

The panel was of the view that although your decision to prescribe sodium cromoglycate eye drops may not have been justified, this does not mean that the decision was incorrect. The panel considered Dr 1's oral evidence in which she states, *"So there just isn't any clinical rationale for why they were prescribed. And, as I mentioned earlier, I doubt they would have done any harm. It's just not clear what the clinical rationale was and there isn't any examination documented regarding the eyes*." The panel reminded itself of the charge, 'Incorrectly prescribed sodium cromoglycate eye drops', it was of the view that the evidence it has been presented with does not indicate that your decision was incorrect.

The panel also took into account your oral evidence in which you stated, "*Yes, I just pulled down her lower eye, just to have a look, and I couldn't see any infection, so therefore I didn't go for an eyedrop that contains antibacterial properties such as chloramphenicol, and I was happy with what she'd told me. Therefore I prescribed the sodium cromoglycate."*

In light of the above, the panel was of the view that it had insufficient evidence before it to conclude that you incorrectly prescribed sodium cromoglycate eye drops to Patient H. The panel therefore find this charge not proved.

Charge 1I(iii)

I) In relation to Patient I;

iii) Did not advise Patient I of signs and symptoms indicating progressive neurological impairment.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you.

The panel took into account Dr 1's written statement in which she states, "*The Registrant also did not advise the patient regarding symptoms and signees to look out for that would indicate progressive neurological impairment which would require urgent medical attention (sic)*".

The panel also noted your oral evidence in which you stated, "*Yes. I feel I did because of the questions – well, in the examination I've written that he's got no saddle paraesthesia, he's got no involuntary bowel or bladder control, and I feel that if I was going through that list rigorously in the examination, I would have told him that these are the red flags that he needs to look out for. That's why I've denied that charge, on those basis, but again I haven't written it down*." The panel accepted this evidence.

The panel bore in mind that Dr 1 indicated that you did not follow up with Patient I to confirm whether he was advised of the signs of symptoms indicating progressive neurological impairment by you. The panel was of the view that at its highest it can conclude that the advice given had not been documented. The panel did not have sufficient evidence before it which positively supports the charge that you did not advise Patient I with the relevant advice in relation to neurological impairment. The panel therefore find this charge not proved.

Charge 1j(ii)

j) In relation to Patient J;

ii) Did not conduct an investigation to identify the cause of Patient J's symptoms.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you and Patient J's clinical notes.

The panel took into account Dr 1's written statement in which she states, "*The Registrant performed a rectal examination, but there is no documented evidence of a thorough abdominal examination. A referral to gastroenterology was agreed but no investigations were requested to identify the cause of the patient's symptoms".*

The panel also considered Dr 1's oral evidence in which she accepts that Patient J's clinical notes make reference to an abdominal examination. It noted Patient J's clinical notes under the heading 'Examination' make reference to a number of symptoms experienced by Patient J which were recorded by you. The panel concluded that due to the documentary evidence of Patient J's records and your evidence, you did conduct an investigation to identify the causes of Patient J's symptoms.

The panel also noted in Dr 1's oral evidence where she stated, "*so it looks like it's potentially the locum that has rung the patient to find out how they are, rather than it being the patient attending for an appointment. And it's a telephone consultation, so actually it looks like they were just ringing up to check how the patient was and to check, confirm that they'd got the appointment*".

In relation to this charge, the panel preferred your evidence. It had no evidence to suggest that you did not conduct an investigation to identify the cause of Patient J's symptoms. The panel therefore find this charge not proved.

Charge 1k(i)

k) In relation to Patient K

i) Did not record a full history of Patient K's leg pain.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you and Patient K's clinical notes.

In considering this charge the panel bore in mind Patient K's clinical notes which under 'History' sets out the history of Patient K's symptoms such as "*Reports right leg pain for 1 month*".

The panel took into account Dr 1's written statement which states, "*The Registrant did not take a full history regarding the leg pain or chest symptoms*", it also noted Dr 1's oral evidence when referring to the documented history of Patient K's leg pain stated, "*The history is reasonable."*

The panel bore in mind your oral evidence in which you stated, "*…There's enough information there to explain that the type of pain…"*

The panel was of the view that it had evidence before it to suggest that you did record a full history of Patient K's leg pain. Therefore this charge is found not proved.

Charge 1k(ii)

k) In relation to Patient K

ii) Did not perform a neurological examination of Patient K's legs.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you.

The panel took into account Dr 1's written statement in which she states, "*The Registrant … and did not perform any neurological examination of the legs despite symptoms of neurological involvement*".

The panel noted your written statement in which you state, "*a verbal discussion obtaining a full history verbally was obtained, the history included identifying the seven categories of a neurological examination which include the patient's mental status, cranial nerves, motor system, reflexes, sensory system, coordination, and gait. A neurological examination occurred covering the seven categories*."

It also noted your oral evidence in relation to you performing a neurological examination of Patient K's legs, you stated, "*A neurological examination is quite in-depth, so it's looking at particularly that type of – well, you're looking at the cranial nerves and you're looking at the motor reflex and the sensory reflexes. I would have looked at the limb and done that, but maybe not as in-depth as [Dr 1] expected*". The panel also noted that you made reference to Patient K not having pins and needles. The panel was of the view that oral evidence is consistent with your written statement in relation to Patient K's neurological examination.

The panel was therefore satisfied that it is more likely than not that you did perform a neurological examination of Patient K's legs. The panel therefore find this charge not proved.

Charge 1m(i)

m) In relation to Patient M;

i) Prescribed Patient M 3 months of Progesterone contraceptive pill without providing the recommended advice.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you.

The panel took into account Dr 1's written statement in which she stated, "*The Registrant prescribed another 3 months of progesterone only contraceptive pill without providing the*

patient with any of the recommended advice. For example, she did not give the patient information about…" The panel also took into account Dr 1's oral evidence in which she stated, "*a husband turning up, asking for his wife's contraception when there's really no good reason why the wife couldn't come to an appointment to have that done and to be prescribed safely, in my opinion, shouldn't have been prescribed."*

The panel also bore in mind your written statement which states, "*I acknowledge the husband of patient M attended on her behalf requesting her oral contraceptive pill, as a result a telephone consultation occurred with the patient, her husband and myself. I can confirm a clinical history was obtained over the telephone from the patient*."

The panel noted your oral evidence in which you outlined the advice you gave to Patient M over the telephone and discussed other contraceptive methods. The panel was of the view that although Patient M did not attend the appointment face to face, the recommended advice of the prescription could still have been provided over the telephone. The panel was of the view that it had not been provided with evidence to suggest that you did not provide Patient M with the recommended advice before prescribing her with 3 months of a Progesterone contraceptive pill. The panel therefore find this charge not proved.

Charge 1m(ii)

m) In relation to Patient M;

ii) Did not inform Patient M directly that they were due a contraceptive pill review.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you.

The panel took into account Dr 1's oral evidence in which she stated, "*And that there should have been a further appointment should have been prescribed and a further*

appointment should have been made with the wife to come and have all the checks and have that explained."

The panel noted your written statement which states, "*I acknowledged and explained she required a face-to-face review and monitoring of her contraceptive pill which she consented to her husband arranging next week*". The panel also noted your oral evidence in which you stated, "*Because I would have said to her verbally that, 'You need to come in.' I knew she couldn't come in that day, so I would have said, even if I'm signposting her to other healthcare emergency contraceptive clinics, I would have said that she needed to be seen and she needs to come in and see us. And she said, quite forthcoming, that she's happy to come in and see both me and [Dr 7], upon his arrival from holiday. So she did agree to that. And she was apprehensive because she didn't want to be seen by a male clinician*".

In light of the above the panel was satisfied that it is more likely than not that you did inform Patient M directly that they were due a contraceptive pill review. The panel therefore find this charge not proved.

Charge 1p(iii) and 1p(iv)

p) In relation to Patient P;

iii) Did not perform an examination for anaemia.

iv) Did not perform an examination for an iron deficiency.

These charges are found NOT proved.

The panel considered charges 1p(iii) and 1p(iv) together. In reaching this decision, the panel took into account the evidence of Dr 1 and of you.

The panel noted Dr 1's written statement, "*The Registrant did not take an adequate history and did not perform any examination to find a cause for the anaemia and iron deficiency*." The panel also noted Dr 1's oral evidence in which she agreed in cross examination that whilst any examination may not have been recorded, it cannot be assumed that it did not happen.

The panel took into account your written statement which states:

> *"I acknowledged if the patient had any jaundice, spleen disorders and bleeding disorder history from her clinical records and I also acknowledged prior medical treatment and medications such as aspirins."*
>
> *"I clarified for blood loss and explored pregnancies, abortions and menstrual loss, the patient reported nil heavy periods."*
> *…*
> *"An examination for Patient P included looking at the patient to ascertain malnutrition or chronic illness, skin and mucous membranes were reviewed for any bruising and swelling, pallor, jaundice, the conjunctiva, and sclera which can show signs of pallor."*

The panel was of the view that it had no direct evidence to suggest that you did not perform any examinations. The panel noted Dr 1's oral evidence that, "*any competent medical practitioner would have recorded an examination of some sort, and undertaken it."* The panel accepted this, however it was of the view that this is not evidence that an examination had not been carried out. The panel was therefore satisfied that it is more likely than not that you did perform an examination for anaemia and for an iron deficiency in relation to Patient P. The panel therefore find charges 1p(iii) and 1p(iv) not proved.

Charge 1q(ii)

> q) In relation to Patient Q;

ii) Did not provide Patient Q with safety netting advice after prescribing;

- Prednisolone steroid tablets 30mg
- A Salbutamol reliever
- A Clenil steroid inhaler

This charge is found NOT proved

In reaching this decision, the panel took into account the evidence of Dr 1 and of you.

The panel took into account Dr 1's written statement, "*She did not offer any safety netting advice or arrange for follow up to ensure his condition was responding to treatment."* It also noted Dr 1's oral evidence in which she stated, "*What I've got is what I recorded on the day and from my review of the consultation, I've recorded that she didn't offer any safety netting advice or a range for follow-up to ensure that the condition was responding to treatment*." In addition to this, Dr 1 acknowledged in her oral evidence that if the safety netting advice was not recorded, it does not mean it did not take place.

In your oral evidence in response to how confident you are that you would have given Patient Q safety netting advice, you stated "*I'm absolutely confident that I would have. I would not have sent him away with just inhalers. I would have talked through the treatment as well, like I described initially. There's two inhalers and the blue one is the reliever; the brown one is preventative. I would have explained the prednisolone. I would have explained what is actually going on with the lungs inside, so there's swelling; there's exudate around your lungs."*

The panel preferred your evidence in relation to this charge. The panel considered the evidence in relation to this charge and noted that it had not been provided with the consultation notes of your appointment with Patient Q. The panel was not presented with any evidence from the NMC with regards to if a follow up appointment had been arranged.

The panel was satisfied that it is more likely than not that you did provide Patient Q with safety netting advice after prescribing the medications set out in the charge. The panel therefore find this charge not proved.

Charge 1r(i), 1r(ii) and 1r(iii)

r) In relation to Patient R;

i) Did not record/escalate a mental health referral.

ii) Did not record/provide safety netting advice.

iii) Did not record/escalate further assessment.

These charges are found NOT proved

The panel considered charges 1r(i), 1r(ii) and 1r(iii) together. The panel noted that you made part admissions to these charges on the basis that in relation to Patient R you did not record a mental health referral, you did not record safety netting advice and that you did not record a further assessment.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you.

The panel took into account Dr 1's written statement, **"***There was no evidence that the Registrant provided any safety netting advice or made a referral to metal health services for psychological support or further assessment…"*

In Dr 1's oral evidence she confirmed to the panel that she was not aware that a referral had been made nor did she check if a referral was made.

The panel also bore in mind your written statement:

"I had decided during the consultation a mental health referral will be sought this afternoon upon discussing with the practice manager, patient R was verbally

informed I would need to discuss her further with the practice manager following surgery and a fast-track referral to Birmingham Mental Health services would be initiated or resent if already commenced."

"I commenced a referral requiring further practice manager support which would be followed by the admin team to process the referral. Patient R was informed she requires the RAID team (Crisis mental health services intervention) for further assessment."

The panel also took into account your oral evidence in which you stated that you referred Patient R to the RAID team (Crisis mental health services intervention). The panel was of the view that your oral evidence was consistent with your written statement. In your oral evidence in relation to providing Patient R with safety netting advice, you stated, "*She was voluntarily telling me that she had the appropriate safety-netting advice, so she knows exactly who she can contact."*

The panel considered the evidence in relation to these charges and noted that the NMC had not presented any evidence from the Crisis mental health team to suggest that you did not escalate Patient R or make a mental health referral. In addition, the panel had no evidence before it to suggest that you did not provide safety netting advice to Patient R. The panel was satisfied that it is more likely than not that in relation to Patient R you did escalate a mental health referral, you did provide safety netting advice and that you did escalate further assessment. The panel therefore find charges 1r(i), 1r(ii) and 1r(iii) not proved.

Charge 1r(iv)

r) In relation to Patient R;

iv) Did not record/consider safeguarding factors for Patient R's daughter.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and of you.

The panel noted that you made an admission to this charge on the basis that you did not record any safeguarding factors for Patient R's daughter.

The panel bore in mind Dr 1's written statement:

> *"There was no evidence that safeguarding factors were considered in relation to the patient's daughter".*
>
> *In addition, as safeguarding concerns were not considered in relation to Patient R's daughter, this also places her at risk"*

The panel noted your written statement, "*I confirm the patient's daughter accompanied her mother and I felt reassured both patient and daughter presented in a loving, supportive and caring relationship at no point during this consultation did I feel an inclination that the patients daughter was unsafe and in danger due to her mother*." In addition to this, in your oral evidence you stated, "*There was nothing there for me to protect the daughter as such. I know her mum is suicidal, but I didn't feel there was an immediate harm to her that I needed to place her with the safeguarding team there and then*."

The panel was of the view that you used a visual observation throughout your appointment with Patient R and her daughter to make an assessment with regards to safeguarding as opposed to making a clinical decision. It was also of the view that a safeguarding assessment should be made from the perspective of a child and should be a separate consideration from the patient. The panel noted from the evidence you provided that as you assumed that Patient R and her daughter were in a loving relationship you did not consider the risks presented to the daughter.

The panel was therefore satisfied, on the balance of probabilities, that it is more likely than not that you did not consider safeguarding factors for Patient R's daughter.

Charge 4a

4) On or around 29/30 July 2019 breached condition 10 a) of the interim conditions of practice order, in that you;

a) Did not immediately inform the Centre that you were subject to an interim conditions of practice order.

This charge is found proved.

In reaching this decision, the panel took account both your and Ms 5's evidence.

The panel noted that in Ms 5's NMC witness statement, she states, "*The Registrant commenced working at the Practice on 29 July 2019. My first interaction with the Registrant was on this date, when I welcomed her to the Practice and showed her to the consulting room she would be working within…On Tuesday 30 July, I was approached by [Ms 9], from Dudley CCG. [Ms 9] informed me that the Registrant was working under the conditions of an interim order. [Ms 9] then showed me an Interim Order Hearing Outcome Document…Once I was made aware of the Registrant's interim order by [Ms 9], I immediately removed the Registrant from the CCG's register of authorised non-medical prescribers and removed her access rights from our clinical system and waited for the Registrant to return from her patient visit…Once the Registrant returned from her patient visit, I took her in to a room to discuss her interim order. I presented the Registrant with the Interim Order Hearing Outcome Document and asked if the Registrant was aware of the circumstances surrounding her Interim Order, and if so why the Registrant did not disclose this information to the Practice. The Registrant admitted that there was an investigation ongoing in to her practising registration, but that the Royal College of Nursing were 'looking in to it'. I then informed the Registrant that she would not need to leave the Practice but would be removed from prescribing duties for the remainder of the day*" [sic].

Ms 5 was consistent with this approach in her oral evidence, as she maintained that you did not inform her that you were subject to an ICOPO in any respect, let alone a particular condition which restricted your right to prescribe medication to patients.

The panel noted that whilst Ms 5 could not remember the specifics of the conversation had with you, she was adamant that she did not know about the ICOPO you were subjected to, prior to being told by Ms 9 on 30 July 2019. Ms 5 stated in her oral evidence that this incident really stuck out in her mind as she probably would not have hired you for the role of ANP, had she been aware of the restrictions imposed on your nursing practice. This was due to the fact that Ms 5 wanted an ANP who was capable of prescribing medications to patients at that particular time.

The panel noted that there is also documentary evidence which supports the evidence of Ms 5, as you were asked directly whether there was any issue with your ability to prescribe medication when you completed the job application form for the Centre. However, instead of ticking the box for '*yes*' and documenting your restrictions, you ticked the box '*no*' to confirm that there were no issues with your prescribing capabilities. Whilst you state that you made telephone calls to the Centre on 24/25 July 2019 to speak to them about your ICOPO. The telephone call log confirms that telephone calls were made, but Ms 5 does not recall you speaking to her about these concerns.

The panel considered you to have been aware of the restrictions imposed on your nursing registration, and it considered you to have been aware of the professional obligation placed on you to tell the Centre that you were subject to an ICOPO. This was also made clear in the ICOPO itself, as there was a condition requiring you to tell any employer of these restrictions. Whilst you sent a copy of your ICOPO to the recruitment agency, you appeared to minimise the nature of the interim conditions imposed on your nursing registration, and made assurances that these were going to be removed. There is no other evidence to suggest that you informed the Centre of your ICOPO on any other occasion prior to Ms 5 challenging you about it on 30 July 2019.

The panel did not consider there to be any scope for misunderstanding; there was a clear direction made by your regulator and you had accepted that you understood the terms of your ICOPO during your oral evidence.

In taking account of all the above, the panel preferred the clear and compelling evidence of Ms 5, to that of your evidence. It was satisfied that you did not immediately inform the Centre of your ICOPO in order to give yourself the best chance of being employed by them.

Therefore, the panel found charge 4a proved on the balance of probabilities.

Charge 4b

> b) Did not immediately inform the Centre that you were restricted from working as an Independent Nurse Prescriber.

This charge is found proved.

In reaching this decision, the panel took account both your and Ms 5's evidence.

In finding that you had not informed the Centre of your ICOPO, as specified in charge 4a, the panel determined that it was more likely than not that you had also chosen not to inform them that you were restricted from working as an Independent Nurse Prescriber.

It had found you to be aware of your professional obligation to tell the Centre that you were subject to an ICOPO, and it considered that the terms of the condition was clear, as condition 1 of your ICOPO stated "*You must not practise as an independent nurse prescriber*".

You had told the panel that you contacted the centre on 24/25 July 2019 to inform them of your ICOPO. However, whilst the panel had evidence of two phone calls being placed, the

nature of the telephone calls was unknown. Furthermore, your evidence was contrary to the evidence provided by Ms 5, who had stated that she did not have a conversation with you about you being subject to an ICOPO. This was also supported by the documentary evidence before the panel, as you had ticked '*no*' in the box to confirm that there were no circumstances impacting on your prescribing practice over the last year on the Centre's application form.

During your oral evidence you did not propose another point in time for when you may have notified the Centre of your ICOPO or, specifically, the condition restricting you from working as an Independent Nurse Prescriber.

Therefore, the panel found that you did not immediately inform the Centre of the condition restricting you from working as an Independent Nurse Prescriber. It found charge 4b proved on the balance of probabilities.

Charge 6

> 6) Your actions at one or more of charges 2, 3, 4 & 5 above were dishonest, in that you deliberately sought to conceal the restrictions/conditions of practice order, from the Centre.

This charge is found proved.

In reaching this decision, the panel took account of both your and Ms 5's evidence.

It noted that you had admitted that your actions were dishonest in relation to charges 2, 3 and 5. You denied your actions were dishonest solely in relation to charge 4.

The panel had regard to the case of *Ivey v Genting Casinos Ltd t/a Crockfords [2017] UKSC 67* in determining whether you had been dishonest in your actions, as outlined in charge 4. In particular, the panel noted in paragraph 74:

"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."

In considering dishonesty in relation to charge 4, the panel reminded itself that it had found that you did not immediately inform the Centre of your ICOPO, or any specific condition contained within it, particularly the one which prevented you from working as an Independent Nurse Prescriber.

In having regard to the totality of the evidence before it, the panel noted that the evidence supported the view that you had sought to mislead staff at the Centre into thinking that there were no restrictions imposed on your nursing practice. The panel did not believe that you had informed Ms 5 that you were subject to an ICOPO, and the documentary evidence corroborated this, as you ticked the box to indicate that there were no circumstances impacting on your prescribing practice over the last year. The panel determined that you would have been aware that informing the Centre of your ICOPO, or any particular condition, could have seriously impacted on your suitability for this role at the Centre. By withholding this information, you would have been aware that you stood a better chance of becoming employed by the Centre, so you chose not to disclose it.

Furthermore, the panel reminded itself that it had preferred the consistent, compelling and robust evidence of Ms 5 to that of your evidence in this respect. Ms 5 was adamant that you had not informed her of your ICOPO and she was able to give strong reasons for why she would have remembered the conversation had you have done so.

Therefore, in the absence of any compounding evidence to the contrary, the panel considered you to have fabricated a version of events that was not supported by the other evidence it had received. It did not find your account to be plausible, in light of the oral and documentary evidence before it. The panel was satisfied that you had intended to mislead others into thinking that there were no restrictions imposed on your nursing registration.

Therefore, the panel was of the view that when you had sought to create a misleading impression by not immediately informing the Centre of your ICOPO, and by indicating that there were no specific circumstances impacting on your prescribing practice over the last year.

The panel was not satisfied that you had made an honest mistake and it determined that ordinary and decent people would consider your actions to have been dishonest.

Therefore, the panel found charge 6 proved on the balance of probabilities.

Charge 10

> 10) Your actions in charges 8 & 9 above were dishonest, in that you sought to conceal your new appointment as an Independent Nurse Prescriber at the Centre, from your regulator.

This charge is found NOT proved.

In reaching this decision, the panel took account of your evidence, along with the evidence of Mr 4, Ms 5 and Ms 9.

The panel noted that in Mr 4's supplementary NMC witness statement, he states "*There is no correspondence from the Registrant or their representative notifying us of the Registrant's appointment as an Advanced Nursing Prescriber at Nethertons Health Centre. All we received was notification of booking attempts for training courses*".

In considering this charge, the panel was of the view that there was insufficient evidence that you sought to conceal your employment by not notifying the NMC within seven days of appointment as required. You were made aware that an NMC referral was going to be made in respect of your nursing practice, and you explained that you then waited to receive correspondence from them before responding to the concerns.

The panel noted that whilst you did not inform the NMC of your employment at the Centre, there was no clear evidence that you made a deliberate attempt to conceal this from your regulator.

Therefore, in taking into account all of the above, the panel was not satisfied that you sought to conceal your new appointment at the Centre from your regulator. The panel found charge 10 not proved on the balance of probabilities.

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. Firstly, 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Edwards referred the panel 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'.* He also referred the panel to the cases of *Calhaem v GMC [2007] EWHC 2606 (Admin)* and *Nandi v GMC [2004] EWHC 2317 (Admin)*.

Mr Edwards invited the panel to take the view that your conduct amounted to breaches of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) ("the Code"). He then directed the panel to specific paragraphs and identified where, in the NMC's view, your actions amounted to misconduct.

Mr Edwards submitted that the concerns in this case relate to your clinical nursing practice, as well as your conduct and behaviour. He submitted that you placed patients at an unwarranted risk of harm through your actions.

Mr Edwards submitted that you were an experienced registered nurse at the time of the events, and your behaviour would be considered to be deplorable by other members of the nursing profession.

Mr Edwards submitted that your actions fell far below the standards expected of a registered nurse and are sufficiently serious to constitute misconduct in all the circumstances.

Ms Bayley reminded the panel that you had accepted your dishonesty, as well as a number of the clinical failings at the outset of these proceedings. She stated that you also

accepted that your actions amounted to misconduct and that you do not seek to dissuade the panel from finding that your fitness to practise is currently impaired. Ms Bayley submitted that your attitude in accepting the above ought to be taken into account in a favourable manner.

Submissions on impairment

Mr Edwards 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)*.

In respect of the future risk of harm to patients, Mr Edwards referred the panel to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)*. He invited the panel to consider whether your misconduct is capable of remediation, whether it has indeed been remediated, and whether it is highly unlikely to be repeated.

Mr Edwards submitted that, by its very nature, dishonesty can be more difficult to remediate than clinical concerns as honesty, integrity and trustworthiness are the bedrock of the nursing profession. He therefore submitted that some of the concerns identified may be easier to remediate than others.

Mr Edwards submitted that during the period this hearing went part-heard, you have attempted to reflect on the position you found yourself in at the time of the events. However, he submitted that in having regard to all of the factors identified, you have only been able to demonstrate a developing level of insight in relation to the concerns, which can only be said to be limited in scope. He reminded the panel that, during your oral

evidence, you sought to deflect blame on to other staff, or the situation you found yourself in when on shift, instead of taking responsibility for your own actions.

Mr Edwards submitted that you have not been able to demonstrate a sufficient level of insight for the panel to find that your fitness to practise as a registered nurse is not currently impaired. He submitted that in the absence of sufficient insight and remediation in relation to your dishonest conduct and clinical deficiencies, there remains a risk of unwarranted harm to the public and a real risk of repetition of similar incidents occurring again in future.

Mr Edwards submitted that your misconduct raises public interest concerns as to whether you can be trusted to tell the truth, and whether you can provide safe and effective clinical care. He submitted that your conduct undermines public confidence in the nursing profession as colleagues, patients and their families must be able to trust registered nurses with their lives and the lives of their loved ones. In order to justify that trust, Mr Edwards submitted that registered nurses must be honest, open and act with integrity. He submitted that a fully informed member of the public would be deeply concerned by your actions, and would expect a finding of current impairment to be made.

In light of the above, Mr Edwards invited the panel to find that your fitness to practise as a registered nurse is currently impaired. He concluded by saying that current impairment can be found on the basis that there is a continuing risk of harm to the public, and in relation to public confidence in the nursing profession and the NMC as regulator would be undermined if such a finding were not made. Mr Edwards submitted that such a finding is required in order to protect the public and to maintain public confidence in the nursing profession by upholding proper professional standards.

Ms Bayley provided the panel with the following written submissions in respect of impairment:

"*16. …The clinical concerns and record keeping deficiencies have however been remediated, following several years of reflection [Ex8, p16-38], training and strengthened practise [Ex8, p85-441]. This was tested significantly in her oral evidence [30 July 2021, p44-74, 2 August 2021 p3-67, 3 August 2021 p20-40 and p50-73 and 4 August 2021 p31-42]. The panel can be confident that Mrs Purewal's clinical errors are remediable, have been remediated and are highly unlikely to recur.*

17. It is acknowledged that dishonesty is not so straightforward to remediate. Although it was left for the panel to decide whether charge 4 (and the corresponding part of charge 6) was proven as a matter of fact, Mrs Purewal has always accepted and understood her professional failings and the potential impact of dishonesty on her profession. This is expressed in her statements [January 2022 bundle, p and Ex8, p3 onwards, p15 in particular], in her oral evidence [see in particular 2 August 2021, p87-88, 4 August 2021 p26-28]. It is acknowledged that as a registered nurse, she was responsible for her practice and for informing her employer about the interim restrictions on her practise. Mrs Purewal writes in her most recent reflection: 'Upon recognising my breach in interim conditions and examining my actions I accept I failed to maintain and facilitate my interim conditions correctly to the Netherton Health centre, my patients, my colleagues, and the regulatory body...'

18. Mrs Purewal has been proactive in undertaking relevant training and independent learning, targeted at her clinical failings [January 2022 bundle, p65-119, Ex8 p85-263], in order to strengthen her practise. All of this was done with patient safety in mind, patient safety being of paramount importance to her.

19. In compliance with her Interim Order, Mrs Purewal has been attending supervision with her employer [January 2022 bundle, p127-138]. The supervisions are overwhelmingly positive. As can be seen, this role has taken Mrs Purewal back to the basics of nursing, at which she is excelling.

20. Mrs Purewal fully engaged with the NMC Fitness to Practise Process, beginning in May 2020. She has been subjected to almost three years of a rigorous disciplinary assessment of her fitness to practise. Mrs Purewal has engaged throughout proceedings, made admissions, submitted herself to questioning in these proceedings – over four gruelling days – and fully cooperated with the NMC fitness to practise process. She has accepted responsibility and accountability for her misconduct in this case. Mrs Purewal has demonstrated insight into and genuine remorse for her failings. She has done so in order to atone for her failings, to ensure that her mistakes are never repeated and accept accountability for her misconduct.

21. Mrs Purewal has been subject to restrictions on her practice, interim suspension for just under six months and conditions for approximately two years and two months as follows:

- *a. Interim Conditions of Practice imposed on 20 May 2019;*
- *b. Interim Conditions replaced with an Interim Suspension order on 3 October 2019;*
- *c. Interim Suspension replaced with an Interim Conditions of Practice Order on 20 March 2020;*
- *d. Interim Conditions varied and continued on 26 June 2020;*
- *e. Interim Conditions varied and continued on 18 December 2020;*
- *f. Interim Conditions varied and continued on 19 May 2021; and*
- *g. Interim Conditions continued on 17 October 2021.*

22. Mrs Purewal has reflected on the events of April and July 2019 and taken reflection into her practice. In Mrs Purewal's most recent reflection, she includes: "I have continued to reflect on my breach in conditions daily and I have learnt from this and ensured this has not re-occurred..." Mrs Purewal has not repeated any of her failings and continues to demonstrate her honesty and the ability to practise safely, in accordance with guidelines and the Code of Conduct. The trials of the

Fitness to Practise process have been a salient lesson, allowing Mrs Purewal to reflect more deeply on the Code of Conduct and the paramount importance of honesty and integrity in the profession. Mrs Purewal has no desire to appear before her regulator again. The panel can be satisfied that her dishonest misconduct is highly unlikely to recur.

23. Considering the impact of her misconduct, Mrs Purewal gave evidence demonstrating an appreciation for the importance of the maintenance of public confidence in nursing. This insight is evidenced in her reflections, where she has sought to consider her actions from a number of perspectives and with reference to the NMC Code of Conduct, and in her oral evidence [see in particular 2 August 2021, p87-88]. The panel can be assured that Mrs Purewal has a true understanding of what she did wrong, why it was wrong, what she ought to have done and what she would do if faced with a similar situation in the future. Further, Mrs Purewal has considered what impact her misconduct had on her patients, her colleagues, as well as the wider reputation of the nursing profession. Mrs Purewal has a true understanding of the importance of complying with her interim order and the seriousness of her failure to do so [see in particular 2 August 2021, p90-93]. Mrs Purewal has done all she can to remediate her past misconduct.

24. The panel has the benefit of a number of testimonials and feedback forms [January 2022 bundle p1-29, p133 and p139, and Ex8, p67-84] from colleagues and patients. They describe Mrs Purewal as "...caring, honest, professional, hardworking..." [p2], "a very caring professional, providing exceptional care... a nurse who is capable of working at the highest levels in the community, in a professional caring and supportive manner..." [p3], "a very professional member of the team, knowledgeable and thorough..." [p4], "a highly skilled, autonomous, caring, supportive nurse specialist, who has demonstrated through her years of dedication to nursing and patient care what an asset she is to the nursing profession..." [p10]. The combined effect demonstrates that her conduct in April and July 2019 was the exception and completely out of character. The NMC witnesses

acknowledged Mrs Purewal's lack of support at Bloomsbury, which should be taken into consideration as significant contextual evidence. Mrs Purewal truly is a nurse with a lengthy unblemished career and this case represents isolated incidents of misconduct.

25. In accepting responsibility and accountability for her actions, the consequences of events of 2019 have, on any view, been serious and life changing. There are now findings of fact and likely misconduct and impairment arising from these proceedings which will stay with Mrs Purewal for the remainder of her professional career. Mrs Purewal's failings amount to a significant departure from her usual high standards of practise and clearly represent a very personal shame and anguish.

26. Given the insight and strengthened practice demonstrated by Mrs Purewal, as well as the positive evidence of her previous and current good practice, previous lengthy unblemished career in nursing and her demonstration of dedication to continued good practise in the profession, the risk of repetition of any similar misconduct must be considered to be extremely low. Her misconduct is highly unlikely to recur, therefore the risk of harm to the public ought likewise to be considered extremely low. The panel may properly conclude that Mrs Purewal presents no greater risk to patients than any other registrant in unrestricted practise. In such circumstances, a finding of impairment on public protection grounds would not be required…

27. The panel should note that nothing within these submissions is intended to detract from Mrs Purewal's professional accountability. A finding of current impairment on public interest grounds is anticipated. For the reasons outlined above, the panel is invited to consider, notwithstanding any findings of misconduct, that Mrs Purewal's fitness to practise is not currently impaired on public protection grounds"[sic].

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

The panel noted that you had admitted many of the charges at the outset of this hearing, and that you had accepted that these amounted to misconduct.

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and it considered them to have amounted 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*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *To achieve this, you must:*
> *3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages*
> *3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*
>
> ***6 Always practise in line with the best available evidence***
> *To achieve this, you must:*
> *6.1 make sure that any information or advice given is evidence based including information relating to using any health and care products or services*

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

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
13.5 complete the necessary training before carrying out a new role

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

To achieve this, you must:
16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:
17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:
18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs
18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs
18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

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

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times…

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body."

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, in these circumstances, the panel decided that your actions in each of the charges found proved fell significantly short of the standards expected so as to justify a finding of misconduct.

The panel noted that the concerns identified relate to your clinical nursing practice, as well as your conduct and behaviour. It considered all of the charges proved to be serious, particularly the two findings relating to dishonesty.

Specifically in respect of the clinical concerns, the panel noted that there were multiple failures relating to prescribing medication, record keeping, and acting outside the scope of

your competence. The panel considered there to be evidence of extensive failings involving basic and fundamental aspects of nursing practice, which had the potential to expose patients in your care to a risk of unwarranted harm. The panel was satisfied that your actions in relation to all of the clinical deficiencies were sufficiently serious so as to amount to misconduct.

Specifically in respect of the dishonesty concerns, the panel noted that it had found you to have breached an interim conditions of practice order imposed on you by your regulator, and it had found you to have mislead a former employer in relation to its existence. It considered you to have acted in a dishonest manner for concentrated periods of time, and it noted that this related to direct patient care which, in turn, had the potential to expose patients to a risk of unwarranted harm. The panel was satisfied that your dishonest actions were sufficiently serious so as to amount to misconduct.

The panel was of the view that other registered nurses would consider your actions to be deplorable in the particular circumstances of this case.

The panel found that your actions in charges 1a(ii), 1b(i), 1b(ii), 1b(iii), 1b(vi), 1e(i), 1e(vi), 1f(ii), 1f(iii), 1g(i), 1g(ii), 1g(iii), 1g(iv), 1g(v), 1g(vi), 1h(i), 1h(ii), 1h(iii), 1h(v), 1i(i), 1i(ii), 1i(iv), 1i(v), 1j(i), 1l(i), 1m(iii), 1n(i), 1n(ii), 1o(i), 1p(i), 1p(ii), 1p(v), 1q(i), 1r(i) in part, 1r(ii) in part, 1r(iii) in part, 1r(iv), 1r(v), 2, 3, 4a, 4b, 4c, 5, 6, 7, 8 and 9 did, both individually and collectively, fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, your 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. To justify that trust, registered nurses must be honest, open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

The panel considered all of the above limbs to be engaged in this case, both as to the past and to the future.

The panel had found patients in your care to have been exposed to an unwarranted risk of harm as a result of your misconduct. Furthermore, the panel considered you to have acted in a way that would have brought the nursing profession into disrepute, and it considered you to have breached a fundamental tenet of the nursing profession in being dishonest.

In assessing your level of insight, the panel had regard to the documentary evidence provided by you, as well as the oral evidence you gave at the facts stage of this hearing. The panel considered you to have reflected on the incidents over the adjourned period, to a point where it can now be said that you have developing insight into your clinical failings and dishonest conduct. It was satisfied that you had demonstrated remorse for your conduct and it considered these proceedings to have acted as a salutary lesson for you. The panel noted from your reflective piece that you had stated the following in relation to your dishonesty:

"*…Failure to comply with the code of conduct results in serious professional misconduct. Dishonesty in consideration to my professional duty of candour now emerges. The seriousness of dishonesty cannot be over emphasised by the NMC. My honesty is regarded as paramount to protect and uphold public confidence in nursing and integrity is defined as the quality of being honest and fair, possessing high moral principles. Upon recognising my breach in interim conditions and examining my actions I accept I failed to maintain and facilitate my interim conditions correctly to the Netherton Health centre, my patients, my colleagues,*

and the regulatory body. The consequences and seriousness of my actions leave me feeling ashamed, irresponsible, and appalled by my actions. I have revisited these incidents repeatedly and question how and why did I let this occur? I understand the law about healthcare regulation makes it clear that a nurse, midwife, or nursing associate who has acted dishonestly will always be at risk being removed from the register. Upon reflection, I realised I had made a ludicrous, senseless mistake. I should have not prescribed, and I sincerely apologise for my actions and feel remorse and confirm and recognise I have portrayed myself and acted dishonestly. Nevertheless, within my 27 years of service have I shown honesty in my character, furthermore, my accompanying testimonial letters also state I am a honest nurse. As a result, I am extremely ashamed of my actions, and will not allow this to happen again…"[sic].

However, whilst the panel noted that you had accepted that your nursing practice had fallen below the standards expected, it was not satisfied that you had fully understood or appreciated the potential consequences of your own actions, both in respect of the clinical failings and your dishonest conduct. You knew that what you were doing was wrong and that you should have acted differently.

The panel acknowledged that you had found yourself to be in a difficult position professionally at the time of the initial incidents, but it did not consider this to have exonerated your own performance and behaviour. In contrast, it took the view that you made active decisions to practise beyond your capabilities.

Overall, the panel found you to have offered insufficient insight in respect of how your actions could have impacted upon patients, colleagues, the nursing profession, and the wider public as a whole.

In considering whether you have remediated the concerns identified, the panel had regard to the case of *Cohen*.

The panel considered behavioural concerns to be more difficult to remediate than clinical nursing concerns; albeit not impossible to address. It determined that your actions were capable of remediation, in principle. However, the panel was not satisfied that you have been able to demonstrate that the outstanding public protection concerns have fully been addressed.

You have provided the panel with relevant training certificates, demonstrating the clinical training that you have undertaken subsequent to the events. You also provided the panel with references from colleagues and former patients, all of which attested positively to your work ethic and clinical nursing practice.

The panel also had sight of a meeting record, which you provided, documenting the termination of your employment by ‘Circle’ after you had administered a flu vaccination contrary to a management direction in 2020. The panel noted that you had only consulted management with your concerns after you had administered the vaccination. In light of all the above, the panel had insufficient evidence before it to allay its concerns that you currently pose a risk to patient safety.

Therefore, the panel could not be satisfied that there was a minimal risk of repetition at this point in time. The panel considered there to be a continuing risk of harm to patients in your care should adequate safeguards not be imposed on your nursing practice. As such, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/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 there to be a high public interest in the consideration of this case. It was of the view that a fully informed member of the public would be shocked by your actions, particularly working outside the scope of your practice, and your dishonest conduct. It concluded that public confidence in the nursing profession and in the regulator would be undermined if a finding of impairment was not made in this case. Therefore, the panel 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 your fitness to practise as a registered nurse is currently impaired.

Sanction

The panel has considered this case carefully and has decided to make a suspension order for a period of nine months, subject to a review. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Mr Edwards took the panel through aggravating and mitigating factors which, in the NMC's view, were present in this case.

Mr Edwards informed the panel that the NMC sanction bid was that of a striking-off order. He submitted that there is no other sanction that would satisfactorily address the public protection and public interest elements involved in this case.

Mr Edwards submitted that there are no workable conditions that would allay the concerns that your behaviour would not be repeated, particularly in having regard to your dishonest conduct. He submitted that there has been severe dishonesty on a number of occasions,

which lasted for a period of time. Mr Edwards submitted that your behaviour is very difficult to remediate, taking account of all the evidence received.

Ms Bayley reiterated that the purposes of a sanction is not to punish a registrant, but to satisfy any outstanding public protection and public interest concerns. She submitted that you have fully engaged with these rigorous fitness to practise proceedings and have recognised the severity of the charges against you.

Ms Bayley reminded the panel that you had made early admissions to the NMC and accepted that your actions amounted to misconduct. She submitted that you have gone on to recognise the seriousness of your mistakes and have demonstrated genuine insight, remorse and remediation. However, she submitted that if the panel do not think that you have fully addressed the outstanding concerns at this time, you should be afforded a further opportunity to demonstrate this to a future reviewing panel.

Ms Bayley submitted that you have undertaken training which was targeted at the areas of concern. She referred the panel to the testimonials you provided which attested positively to your good character and clinical skills.

Ms Bayley submitted that ongoing NMC registration could be justifiable in the particular circumstances of this case. She submitted that you have been able to demonstrate that you can practise safely and effectively in compliance with an interim conditions of practice order, and are currently doing so.

Ms Bayley invited the panel to allow you to continue your nursing career by imposing a substantive conditions of practice order, or if the panel are not minded to agree with this, a suspension order for a period of the panel's choosing. Ms Bayley submitted that the public interest can be satisfied by either of these outcomes which would demonstrate that this case has been taken seriously to protect the integrity of the NMC register.

Ms Bayley submitted that the maximum amount of time a panel can impose a suspension order for is 12 months, whereas a conditions of practice order could be imposed for up to three years. She submitted that the panel have identified that your misconduct is capable of remediation.

Alternatively, Ms Bayley submitted that if the panel were to make a suspension order it would send a clear message to the nursing profession about upholding proper standards of conduct and behaviour. She submitted that whilst it would prevent you from working as a registered nurse for the foreseeable future, it would allow you time to reflect on the panel's findings with the intention of returning to demonstrate further insight to a future reviewing panel. Ms Bayley submitted that you are very sorry for your misconduct and stated that you deserve a second chance, having already demonstrated some insight and changed your nursing practice to prevent you from repeating your clinical errors.

Ms Bayley submitted that you have sustained damage to your reputation, career, self-confidence and your health. She submitted that whatever sanction the panel goes on to impose, its impact will remain with you for the rest of your life.

Ms Bayley reminded the panel that the current Covid-19 pandemic continues to heavily impact the nursing profession. She said that '*every nurse counts*' in a healthcare crisis.

Decision and reasons on sanction

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

Having found your 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

NMC Sanctions Guidance ("SG"). The decision on sanction is a matter for the panel independently exercising its own judgement.

In respect of aggravating factors, the panel has considered the following as relevant:

- Your dishonesty was serious, calculated and repeated for a concentrated period of time.
- Your dishonesty was motivated, in part, by personal gain.
- You exposed patients in your care to a risk of unwarranted harm.

In respect of mitigating factors, the panel has considered the following as relevant:

- You made many admissions to the charges and accepted that your actions amounted to misconduct at the outset of the hearing.
- You have demonstrated remorse.

The panel noted that you have engaged with your regulator throughout these proceedings, and have attended this hearing in its entirety.

The panel first considered whether to take no action but concluded that this would be wholly inappropriate in view of the seriousness of this case. Taking no further action would place no restriction on your nursing registration and would therefore not protect the public. Furthermore, it would not sufficiently address the public interest concerns identified, particularly in relation to your dishonesty.

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 determined that your misconduct was not at the lower end of the spectrum of fitness to practise and that a caution order would be inappropriate in view of the

seriousness of the case and also the risk of repetition that has been identified. The panel decided that it would not be proportionate, sufficient to protect the public, or in the public interest to impose a caution order.

The panel next considered whether placing a conditions of practice order on your nursing registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel is of the view that there are no practical or workable conditions that could be formulated at this stage, given the nature of the concerns identified. Whilst the panel had determined that the concerns were capable of remediation in principle, it was not satisfied that a conditions of practice order was sufficient to address your dishonest conduct at this time having regard to the public protection and public interest elements of this case. You had been dishonest for a concentrated period of time. You had previously been made subject to an interim conditions of practice order and you had gone on to breach this direction from your regulator.

The panel noted that despite having had a significant period of time to reflect on these incidents, you have only managed to demonstrate a developing level of insight. You have not yet demonstrated that you fully understand or appreciate the potential consequences of your actions, and have not sufficiently reflected on how your actions could have impacted upon patients, colleagues, the reputation of the nursing profession, or the wider public as a whole.

Therefore, the panel determined that a conditions of practice order was not the appropriate or proportionate sanction to impose at this time.

The panel then went on to consider whether a suspension order would be the appropriate sanction.

The panel considered whether the seriousness of this case could be addressed by temporary removal from the NMC register and whether a period of suspension would be sufficient to protect patients and satisfy the wider public interest concerns. When considering seriousness, the panel took into account the extent of the departure from the standards to be expected of a registered nurse and the risk of harm to the public interest caused by that departure.

The panel decided that a suspension order would be the appropriate and proportionate sanction in this case.

Although there had been a clear breach of fundamental tenets of the nursing profession and a departure from the standards of the Code, the panel had determined your misconduct is, in principle, capable of remediation. Notwithstanding that a significant period of time has lapsed since the incidents, you have demonstrated remorse for your actions and have begun to reflect and understand the severity of your misconduct. For example, in having sight of your letter dated 7 January 2022, you had stated:

> "*…Upon receiving the determination, I am deeply saddened by the panels overall reaction and overall decision stating that 'I have been unable acknowledge the panel are not satisfied that I have fully understood and appreciated the potential consequences of my own actions'. Nevertheless, I hope this final letter demonstrates that I sincerely regret April 2019 and July 2019 and cannot express the shame I continue to hold, and I do and have taken the panels decisions extremely seriously and fully acknowledge my actions upon patients, colleagues, the nursing profession and the wider public.*
>
> *The NMC Code (2018) is a fundamental standards benchmark which nurses must adhere to and maintain; nurses are expected to provide safe, responsible, accountable aspects of care to each of their patients set out in each domain within their scope of practice.*

Upon meeting with [Dr 7] and [Ms 10] it should have been agreed initially, I work alongside [Dr 7] at the practice. This would ensure my needs of support are met, [Dr 7]'s expectations and requests fulfilled, clinical supervision occurred and documented, my accountabilities and responsibilities were protected and most importantly patient safety not impaired. Nevertheless, this placed a risk to patients, as patients were being booked to see me that clearly required GP review. I had no other clinician (senior lead) available to ensure patient safety and my own limitations posed potential risks to patients.

Due to the above failings, I consented to continue working independently as an ANP without any lead GP cover. However, I should have refused to work in the absence of a lead clinician, explaining highlighting and rationalizing my refusal.

Additionally, I take full responsibility, accountability for all my actions and I hope you will all understand my intentions were never to violate public safety and mistrust. I understand completely my reactions, my attitudes and my actions together with all the evidence presented to you all will determine my sanction and if I could only reverse my actions of April 2019, I should have never worked at the Bloomsbury Health centre and July 2019 and met with practice manager [Ms 5] during July 2019. I should have explained and provided my interim work order conditions and apologized for being unable to accommodate [Ms 5] and not worked at the Netherton Health centre. I certainly should have never prescribed and incorrectly completed a privilege form authorizing myself to continue prescribing, I clearly recognise these actions failed my professional obligations as a registrant. My actions of 2019 certainly had put patients at risk and additionally I feel I have tarnished my reputable character as an honest, loyal nurse. I am extremely ashamed of my actions. I completely understand I am required by my regulatory body, my employer and the public to always remain honest and transparent. Therefore, I am determined for these repercussions never to re-occur again.

Professional integrity is valuable and over the last 32 months integrity has contributed to my attitudes, actions and remains a core of my learning. Furthermore, the more I continue to grow in the nursing profession the more I am growing as a person, and I am determined to continue remediating my actions…"[sic].

The panel bore in mind its finding that it could not yet exclude the risk of similar misconduct occurring in the future. You failed to provide evidence to demonstrate that you have fully remediated the concerns and failed to demonstrate an adequate understanding of how and why your nursing practice fell significantly below the standards expected of a registered nurse. Nonetheless, you have acknowledged that your shortcomings were serious; you have attempted to reflect on your behaviour and you have taken some steps to address some of the clinical concerns identified.

The panel had specific reference to the NMC's guidance on dishonesty. It noted that whilst dishonesty can often be difficult to remediate, it may nonetheless, be capable of remediation. The panel bore in mind that dishonesty is always serious for a registered nurse, however, not necessarily fundamentally incompatible with ongoing NMC registration.

The panel determined that, albeit very serious, your misconduct is not fundamentally incompatible with ongoing registration and that the public interest considerations can be satisfied by a less severe outcome than permanent removal from the NMC register. The panel was of the view that you should be afforded the opportunity to demonstrate your insight, remorse and remediation to a future reviewing panel.

The panel determined that a striking-off order would be disproportionate, having regard to the remorse shown and the development in your insight. You have reflected on your misconduct and demonstrated some remediation after having recognised that there are shortcomings in your nursing practice. You also provided testimonials attesting positively

to your clinical skills and behaviour from people that you currently and previously worked with.

The panel was satisfied that whilst your behaviour may have initially suggested that there was an underlying concern in respect of your attitude, including towards your regulator, the panel determined that there was not an underlying attitudinal concern involved in this case. Therefore, the panel was of the view that the lesser sanction of suspension would satisfy the public protection and public interest concerns identified in this case.

Balancing all of these factors, the panel has concluded that a suspension order is required to mark the seriousness of the misconduct. It decided that public confidence in the nursing profession and the NMC can be maintained by the imposition of a suspension order for nine months, subject to a review. The panel determined that this was the appropriate length of time for the period of suspension, having regard to the high public interest considerations.

The panel noted that this suspension order will prevent you from working as a registered nurse during the period in which it is in force. However, the panel considered that this order is necessary to mark the importance of maintaining public confidence in the nursing profession, and to send to the public and the profession a clear message about the standards of behaviour required of a registered nurse.

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

Any future panel may be assisted by:

- Your continued engagement with the NMC.
- A reflective piece from you, using a recognised model, demonstrating any further development in your insight;

- Any evidence of relevant training undertaken by you in relation to the areas of concern, as well as any other evidence of you having kept your nursing skills up to date.
- Any up to date testimonials or references from employers, whether in paid or unpaid employment.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. The panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or is in your own interest until the suspension order takes effect.

Submissions on interim order

Mr Edwards invited the panel to impose an interim suspension order for a period of 18 months. He submitted that this interim order is necessary on the grounds of public protection and it is also in the public interest.

Ms Bayley did not oppose the application for an interim order. However, she invited the panel to impose an interim suspension order for nine months to mirror the substantive order.

Decision and reasons on interim order

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

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the suspension substantive order. Owing to the seriousness of the misconduct in this case and the risk of repetition identified, it determined that your actions were sufficiently serious to justify the imposition of an interim suspension order until the substantive order of suspension takes effect. In the panel's judgment, public confidence in the regulatory process would be damaged if you were to be permitted to practise as a registered nurse, prior to the substantive order coming into effect.

The panel did not accept Ms Bayley's submission that a nine month interim suspension order mirroring the substantive order would be sufficient to cover any appeal through the court system.

The panel decided to impose an interim suspension order in the circumstances of this case. To conclude otherwise would be incompatible with its earlier findings.

The panel therefore imposed an interim suspension order for a period of 18 months.

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

This will be confirmed to you in writing.

That concludes this determination.