Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
4 – 11 March 2022

Virtual Hearing

Name of registrant:	Miss Joycelyn Annette Roberts
NMC PIN:	87C0851E
Part(s) of the register:	RN1- Adult nurse - Sub part 1, Level 1(16 January 1991) RM-Midwife, Midwives part of the register (13 December 2001) (Lapsed) RHV/V100 - Community practitioner nurse prescriber (17 August 2004)
Area of registered address:	Walsall
Type of case:	Misconduct
Panel members:	Anthony Mole (Chair, Lay member) Susan Tokley (Registrant member) David Lancaster (Lay member)
Legal Assessor:	Fiona Moore
Hearings Coordinator:	Parys Lanlehin-Dobson
Nursing and Midwifery Council:	Represented by Sharmistha Michaels, Case Presenter
Miss Roberts:	Present and represented by Tope Adeyemi instructed by Thompson Solicitors
Facts proved (by admission):	Charges 1, 3, 4, 5, 6, 7, 8, 9, 10a and 11
Facts not proved:	Charges 2, 10b, 12
Fitness to practise:	Impaired
Sanction:	Caution Order (1 year)
Interim order:	N/A

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Michaels, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charge 10 b.

The proposed amendment was to correct the error in 10b by replacing “Mother A” with “Mother B”. It was submitted by Ms Michaels that the proposed amendment would provide clarity and more accurately reflect the evidence.

Ms Adeyemi on your behalf indicated that she supported this application and agreed with the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to correct the error, and ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered nurse employed as a public health nurse health visitor:

1) *After Baby A was placed on a child protection plan on 2 February 2016, did not organise safeguarding supervision with a safeguarding nurse within 10 days.*

2) *On 1 March 2016, when you weighed Baby A and noted her weight had dropped from between the 9th and 25th percentile down to the 9th percentile, did not take any steps to establish the reason for her slow weight gain.*

3) *On 1 March 2016, when informed by Mother B of a domestic violence incident several days prior to your appointment, did not escalate concerns to the safeguarding lead.*

4) *Between 8 March 2016 and 2 June 2016, did not visit and assess Baby A at least every 4 weeks.*

5) *Following a no access visit to Baby A on 18 March 2016:*

    a) *Did not attempt to rearrange the visit for three weeks,*
    b) *Did not inform Baby A's social worker of the unsuccessful visit for three weeks.*

6) *On 19 April 2016, when you weighed Baby A and noted her weight had dropped below the 0.4th percentile:*

    a) *Did not refer Baby A to her GP for further investigation;*
    b) *Did not initiate weekly weighing of Baby A;*
    c) *Did not weigh at least monthly as required by Baby A's child protection programme;*
    d) *Did not share this information about Baby A's weight with:*

        i) *Her social worker,*
        ii) *Her safeguarding nurse.*

7) *On 2 June 2016, when you weighed Baby A and noted her weight remained below the 0.4th percentile:*

    a) *Did not refer Baby A to her GP for further investigation;*
    b) *Did not advise Mother B on weaning;*
    c) *Did not share this information about Baby A's weight with:*

        i) *Her social worker,*

ii) Her safeguarding nurse.

8) Did not inform Baby A's social worker that she was not brought to appointments on:

a) 17 June 2016,
b) 24 June 2016.

9) Following a visit on 4 July 2016, when you noted Baby A was not making any sounds, did not:

a) Follow up with this concern,
b) Refer for further investigation.

10) In relation to Baby A's immunisation appointments:

a) Did not make sure you were aware of the dates of these appointments,
b) Did not remind Mother B to attend these appointments.

11) Provided misleading information when giving evidence on oath at the Coroner's Inquest in relation to Baby A in response to questions relating to seeing Baby A in that you stated or implied between 19 April 2016 and 2 June 2016:

a) You were on leave;
b) You were on sick leave;
c) You "probably would have seen her (Baby A) before if I hadn't been on leave or sick leave."

12) Your actions at charges 11(a) and/or 11(b) and/or 11(c) above was dishonest in that you knowingly misled the Coroner that you were unable to attend Baby A during this period due to leave and/or sick leave when this was not the case.

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

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

During the hearing, it became apparent that proper exploration of your case involves reference to your health. In this respect the panel of its own volition proposed that this hearing should be heard in private, if reference is made to your health, pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Both Ms Michaels and Ms Adeyemi indicated that they supported this to the extent that any reference to your health should be heard in private.

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.

The panel heard and accepted the advice of the legal assessor and determined to go into private session when such issues arise relating to your health.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Adeyemi, who informed the panel that you made admissions to charges 1, 3, 4, 5, 6, 7, 8, 9, 10a and 11,

The panel therefore finds these charges proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Michaels on behalf of the NMC and by Ms Adeyemi.

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

will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Clinical Team Leader employed by Leicestershire Partnership Trust and your line manager

- Witness 2: Expert witness who produced Nursing Practice Report in relation to your case

The panel also heard evidence from you under affirmation.

Background

The charges arose whilst you were employed as a registered health visitor by Leicester Partnership Trust (The Trust). You were referred to the NMC on 1 November 2017 in relation to the following allegations:

1. Failure to carry out core tasks expected of a Health Visitor
2. Failure to safeguard or appropriately escalate concerns
3. Misleading the Coroner around leave taken between 19 April 2016 and 2 June 2016, precluding her seeing Baby A

Baby A was born prematurely at 29 weeks on 24 October 2015. You were allocated as health visitor to Baby A and her family. Your first meeting with the family took place on 5 January 2016 at Baby A's discharge from hospital.

It was agreed that you would visit Baby A fortnightly, due to Baby A being a premature baby and also as the family was already known to social services. Baby A was placed on a child protection plan on 2 February 2016 following a case conference.

It is alleged that the first issues identified concerning Baby A's weight (rate of increase had slowed significantly crossing two centiles) arose around April 2016. Baby A's weight remained on the same centile for a period thereafter gaining approximately 700 grams in the period to 20 June 2016.

Further there was a decrease in Baby A's weight of 50 grams identified as having occurred during the space of a week from 20 June to 27 June 2016.

On 20 July 2016 Baby A passed away. Paramedics were called to the family's home after Baby A was found not to be breathing.

The Trust conducted an internal investigation into the unexplained death which concluded on 12 October 2016 with a Serious Incident Investigation Report, which in turn recommended implementation of an action plan for you.

On 7 February 2016 an inquest was opened by H.M. Coroner for Leicester City and South Leicestershire into the death of Baby A. The cause of death was recorded as unexplained.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Ms Adeyemi.

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

Charge 2

2) On 1 March 2016, when you weighed Baby A and noted her weight had dropped from between the 9th and 25th percentile down to the 9th percentile, did not take any steps to establish the reason for her slow weight gain.

This charge is found NOT proved.

In reaching this decision, the panel considered the evidence put forward by the NMC in relation to this charge. It noted that the NMC relied on the Nursing Practice Report by Witness 2 dated 30 July 2019. The report stated the following:

"On the 01/03/16 Baby A's weight had slowed and dropped to sit on the 9th centile line. The decrease on the centile chart wasn't acted on by HV2, "Baby A's weight gain continues on the same centile 9th" (PHCR page 20). Considering the slow weight and that Baby A was vulnerable and on a CPP, the health visitor would be expected to discuss the feeding routine, or any other factors that may be affecting Baby A's weight gain. I can see no evidence that this was completed with the evidence provided. 8.1.3 With the slight drop down to the 9th centile on 01/03/16, HV2 visited a week later 08/03/16 to weigh Baby A whose weight had remained static. At this point, as there appeared to be no apparent reason why Baby A's weight had slowed, weekly weighing should have been initiated until her weight increased or a referral made for further investigations, particularly as Baby A was premature and on a safeguarding plan, (see section 5.6.1 of this report)".

The panel also had regard to the growth chart from the Trust which showed the actual recording of the weights at the relevant period.

You explained to the panel that during that period, whilst there had been a very small drop in weight as recorded in the growth chart, the baby's weight remained in the 9th to 25th percentile and had not dropped to the 9th centile.

The panel noted the Nursing Practice report had relied on the Serious Incident report which had been prepared by a 3rd party who had summarised your notes. Your original notes were not available to the panel and importantly were not made available to

Witness 2, despite her requesting these prior to her preparing her expert report. Witness 2 was advised to prepare her report based on the summary of events referred to in the chronology of the Trust's Serious Incident Report, which contained a summarisation or interpretation of the information recorded on System 1 (the Trusts electronic record). It was not a verbatim reference to the matter recorded on System 1, by you. You explained to the panel that the language used in the expert's report is not the language you would use and how you recorded it in System 1. The panel accepted your explanation of how you recorded your notes. You directed the panel to the actual weights that were recorded on the growth and measurement chart

The panel carefully considered the wording of the charge and the evidence relied upon by the NMC and concluded that the evidence before it does not substantiate this charge. Having examined the growth and measurement chart, the panel noted that Baby A was still between the 9th and 25th percentile and considered on the evidence available it had not dropped to the 9th percentile on 1 March 2016.

In light of the above the panel determined that the NMC had not discharged its burden of proof and it therefore did not find this charge proved.

Charge 10 b)

10). In relation to Baby A's immunisation appointments:

b) Did not remind Mother B to attend these appointments.

This charge is found NOT proved.

In reaching its decision the panel considered the evidence forwarded by the NMC in the Nursing Practice report by Witness 2 namely:

"*When asked by the coroner during the inquest if it was the health visitor's role to ensure families attended appointments, Ms A Roberts replied in her testimony, "HV role*

not to check whether they attend any appointments, that is up to parents." (See section 8.1.6 of this report). Families with children subject to a CPP often need frequent reminders to take their children to hospital appointments and to have their immunisations on time. Part of the health visitor's role with these families is to regularly check appointments are being attended and questioning if they are not, (See section 5.1.2 and 5.1.8 of this report). 8.4.4 When questioned by the coroner during the inquest of what HV2 would base her assumptions on that Baby A had attended her appointments? HV2 responded, "Mum and I had a good rapport. If she had missed, I would have expected her to tell me. Mum engaged with me and baby thriving". (see section 7.1.12 of this report). With the history of the family in failing to engage with services, HV2 should not have assumed Baby A had attended her appointments and should have checked out whether in fact they had been attended. (See section 5.2.2 and 5.3.1 of this report)"

The panel had regard to your oral evidence. You told the panel that you were not aware of the exact dates of the scheduled appointments, but did inform Mother B of when they would likely be and confirmed that you had done so on the System 1 data base in the tick box section. You also informed the panel it was generally a topic that was discussed at relevant contacts and your practice at the time was to only use System 1 tick box and you did not record the conversation in the Red Book, which is the health record retained by the parent for Baby A. You acknowledged that it is good practice to make such notes in the Red Book and that you now do so.

Further when you were made aware that the parents did not attend the scheduled appointments you addressed the issue with the parents and Baby A's GP.

The panel considered the evidence before it and accepted your explanation. It considered that on the balance of probabilities that you had discussed with the parents the schedule of appointments required with the information that was made available to you. You told the panel some immunisations had been given at the hospital at the early stages and you were aware the parent had consented. It considered that, whilst it was good practice, there was no evidence before the panel to demonstrate a legal requirement for you as a health visitor, to compel parents to attend appointments for

their children. It further noted that you queried the missed appointments with the parents and the GP as soon as you became aware of the non-attendance to the scheduled appointments arranged at the GP practice.

The panel therefore found this charge not proved.

Charge 12:

12) Your actions at charges 11(a) and/or 11(b) and/or 11(c) above was dishonest in that you knowingly misled the Coroner that you were unable to attend Baby A during this period due to leave and/or sick leave when this was not the case.

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

This charge is found **NOT** proved.

In reaching this decision the panel had regard to the transcript from the coroner's inquest and the oral evidence you provided at this hearing. It also had regard to the Serious Incident Investigation Report dated 11 October 2016, and the evidence of Witness 1 your line manager.

The panel had regard to the following statements in the report:

"Health visitors work to the Standard Operating Guidance (SOG) for health visiting (2015) and the Safeguarding Children Practice Guidance (2016), within the SOG it states that the 'NICE/ WHO guidelines from the Healthy Weight Pathway must be followed and timely referral to an appropriate service must be made' (p30). The SOG references the World Health Organisation Child Growth guidelines (http://www.who.int/childgrowth/en/), therefore HV2 did not recognise or act appropriately when Baby A's weight gain faltered. On 19th April 2016 Baby A's weight was static as she had only gained 120g in 6 weeks, hence she had crossed two centile lines and her weight was below the 0.4th centile. HV2 advised the investigator that she had intended to monitor the weight gain herself by seeing Baby A on a regular basis.

However this plan of action was not put into place as HV2 did not weigh Baby A again until 2nd June, which was another six week period."

A review of HV2's other universal plus records showed that in other cases she had actively managed the care of babies who were preterm and her record keeping is clear and contemporaneous. Therefore the investigator is assured that HV2 is not an unsafe practitioner."

The panel has not had sight of the transcript of the meetings held with you by the author of the Serious Incident Investigation Report, and therefore has no information as to the extent to which the six week period in issue was a focus of scrutiny or not. The panel has carefully considered the transcript of your evidence to the coroner and it is of the view that this is consistent with your evidence before the panel; namely that you were describing what would normally happen, as opposed to what you did. This was supported by Witness 1, who confirmed that when she discussed this with you, after the NMC made contact in 2019, your explanation was the same.

The panel also had regard to the following statements from the coroner's inquest transcript:

"Ms A Roberts:
I think from April it probably wasn't until… the 2nd of June

HM Coroner:
Is that a reasonable amount of time considering the fact that she has dropped down one and half centiles?

Ms A Roberts:
Well, usually she would have been weighed monthly. So on this occasion, at this time, I was on leave and then sick leave… so there was, sort of, an extended (inaudible) plan. I probably would have seen her before if I hadn't been on leave or sick leave"

At this hearing you told the panel that at the time of the coroner's inquest you believed that the only possible explanation as to why you did not attend Baby A during the six week gap was because you were either off sick or on leave and you did not have your exact leave information to hand. You told the panel that you wanted to answer all the questions asked of you at the inquest but did not deliberately intend to mislead.

The panel also considered the oral evidence of Witness 2, she told the panel that when the NMC had made enquiries regarding the dates, she contacted you and you told her that you must have been off sick or on leave during the time in question. The panel considered that your reasons have been consistent since the issue was raised as reflected in your statement given to the panel for this hearing.

"The reason I said sick leave and/or annual leave is because these are the only circumstances that I would think of wherein I would not see a child. I referred to sickness ***[PRIVATE].*** *109.I also usually took annual leave around April each year. I had annual leave for a week in March and at the time of the inquest, that's what was on my mind and that's why I said annual leave"*

The panel noted Witness 2 had made comment in the report regarding this charge, however, the panel did not consider that expert evidence is appropriate in relation to a decision on dishonesty

The panel finds no evidence that the issue of the six week gap was discussed with you in any detail prior to the inquest, and is of the view that the transcript demonstrates that you were not being evasive in your answers, but doing your best to assist the coroner. The panel was of the view that you were asked an unexpected question for which you were not prepared and does not believe your answer to be a deliberate attempt to mislead. The panel had regard to the legal test for dishonesty in the case Ivey V Genting Casinos [2017] UKSC 67 and applied that test in reaching its decision. The panel has concluded that you regrettably provided misleading information to the coroner, but that this was not dishonest and there was no intention to mislead.

The panel did not find this charge proved.

Submission on misconduct and impairment:

Having announced its finding on all the facts, 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.

Ms Michaels, on behalf of the NMC, made submissions on misconduct and impairment. She referred the panel to the case of *Roylance v GMC (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. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a* [nursing] *practitioner in the particular circumstances*."

Ms Michaels submitted that this is a serious case involving the death of a baby. Further this case led to a serious incident investigation and a referral from the coroner to the NMC. She submitted that your actions fell significantly short of the standards expected of a registered nurse, given the failures identified and admissions made by you.

Ms Michaels invited the panel to take the view that your actions and omissions amount to a breach of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) ("the Code"). She then directed the panel to specific paragraphs and standards and identified where, in the NMC's view, your actions amounted to a breach of those standards.

Ms Michaels reminded the panel that although breaches of the code do not automatically result in a finding of misconduct it is submitted that your failings in Baby A's care and actions in misleading the coroner amount to misconduct.

Ms Michaels submitted that in light of these breaches, your actions fell below the standards expected of a registered nurse and are sufficiently serious to constitute

misconduct. Further she submitted that confidence in the nursing profession would be undermined if your failures and omissions were not found to amount to misconduct.

Ms Michaels then 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. Ms Michaels referred the panel to the cases of *Cohen v GMC* [2008] EWHC 581 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin). She submitted that limbs a, b and c of Dame Janet Smith's test, as set out in the Fifth Shipman Report, were engaged by your past actions.

Ms Michaels submitted that the charges found proved are collectively and individually serious and while you were not responsible for Baby A's death, your conduct put Baby A at risk of serious harm by missing key factors, failing to escalate concerns and missing opportunities for Baby A to be referred for further investigation. She submitted that your misconduct has breached multiple provisions of the code and breached fundamental tenets of the nursing profession and therefore brought the reputation of the nursing profession into disrepute.

In assessing future risk, Ms Michaels submitted that the panel will be assisted by the test set out in the case of *Cohen*, namely is the misconduct easily remediable, has it been remedied and is it is highly unlikely to be repeated. She submitted that given the evidence of your subsequent practice and reflective statement, the panel may take the view that you do not pose a risk to the public.

Ms Michaels then went on to remind the panel that in addition to ensuring the public are protected, it must also consider the public interest, maintaining confidence in the profession and declaring and upholding proper standards of professional conduct.

She submitted that there is a clear public interest in the circumstances in this case given the death of Baby A. A fully informed member of the public would be concerned by the facts found proven and if a finding of misconduct is made on the basis that your actions

fell significantly short of the conduct and standards expected of a nurse, further, public confidence would be undermined if a finding of impairment was not made. Ms Michaels submitted that your actions brought the profession into disrepute and your failures were wide ranging and substantial.

In light of these factors she invited the panel to find you currently impaired.

Ms Adeyemi submitted, on your behalf, that you admitted to the majority of the charges at the outset of the hearing. In determining whether the facts found proved amount to misconduct, she invited the panel to consider the fact that you accepted your practice at that time was not the appropriate and good standard of practice expected of a nurse. Ms Adeyemi submitted that submissions had been advanced on your behalf, as well as you providing oral evidence, throughout the hearing, demonstrating that you have accepted responsibility for your actions.

Ms Adeyemi submitted that although charges 1, 3 and 11 were found proved by admission, upon review of the oral witness evidence and the panel's findings on the facts, these charges do not amount to misconduct.

In relation to charge 1, Ms Adeyemi submitted that it was not standard practice at the time for a health visitor at the Trust, to organise supervision within 10 days of a baby being placed on a child protection plan and Witness 2 confirmed this in her oral evidence.

In relation to charge 3, Ms Adeyemi submitted that you did not escalate to the safeguarding lead nurse because you had escalated to the social worker, who was the safe guarding lead for the child protection plan that Baby A was subject to.

In respect of charge 11, Ms Adeyemi submitted that when looking at the test set out in Roylance it can be seen that your one incorrect answer, out of a series of many questions and answers, though misleading (unintentionally), did not delay or derail the coroner's findings and as such does not amount to misconduct.

Ms Adeyemi submitted that you had reflected and shown insight and remorse into what happened. She submitted that you were able to identify where you went wrong, how the errors had occurred and you were able to recognise how you would prevent similar errors occurring in the future.

Ms Adeyemi reminded the panel that you are still employed by the Trust as a registered nurse. Further she submitted that since the internal investigation and coroner's inquest you have remediated and addressed the concerns raised in relation to the charges, through actions plans and retraining, and there have been no concerns raised regarding your practice since.

Ms Adeyemi took the panel through a number of references submitted by you from colleagues who had worked with you for a substantial period and who spoke highly of your practice. Your line manager, Witness 1, also gave positive evidence as to your current practice.

Ms Adeyemi further submitted that as you are currently practicing safely and have remediated your practice an informed member of the public would not consider a finding of impairment on public interest grounds necessary.

She submitted that there was no risk of repetition, and invited the panel to find that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result, of that misconduct.

Decision on misconduct

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

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

The panel was of the view that your actions fell significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. The panel considered that the following sections of the Code were engaged in this case:

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity
To achieve this, you must:

…
1.2 make sure you deliver the fundamentals of care effectively
…
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

…

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

Work co-operatively

To achieve this, you must:

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

…

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered whether the facts found proved amounted to misconduct. In doing so, it considered the charges individually and collectively.

The panel considered the submissions made by Ms Adeyemi in relation to charges 1, 3 and 11 and whether they amounted to misconduct.

In respect of charge 1 the panel considered the safeguarding guidance that was in place at the relevant time. It had regard to the Safeguarding Children Practice Guidance which was adopted by the Trust on 6 March 2013 and acknowledged that this guidance required safeguarding supervision with a safeguarding nurse within 10 days, as to referred to by Witness 2 in her expert report. However the panel heard evidence that this policy had been superseded by updated guidance in 2016 that did not require the supervision within 10 days. This was confirmed by Witness 1 as the practice at the time of the incident. It therefore determined that your actions in charge 1 did not amount to misconduct.

In respect of charge 3, the panel had regard to your written statement in which you provided the following explanation:

“21. On 1 March 2016, Mother B informed me of a domestic violence incident that had occurred several days prior to our appointment. I admit that I did not escalate concerns to the Safeguarding named nurse when Mother B informed me of this.

22. Following the disclosure from mother I telephoned the social worker by telephone, on my return from the visit with mother, to inform him of the disclosure, but I could not get through and there was no facility to leave a message for him.

23. I called the social worker again on 3rd March by telephone, and I discussed the disclosure with him, and he reported that he was already aware of the domestic violence incident. This is documented on SystmOne

24. The safeguarding named nurse is not the social worker. The social worker works for the Local Authority and is the Lead in a child protection case. The safeguarding named nurse is who I can go to for safeguarding support and advice when I need it, for example, if my case is complicated or if I have concerns about my management of the case."

The panel accepted your explanation and was of the view that as you did escalate the concern to the social worker, who was the safeguarding lead in respect of Baby A's case and child protection plan, your failure to escalate concerns to the safe guarding nurse, did not in these circumstances amount to misconduct.

In its consideration of charge 11, the panel formed the view that although you did not intentionally set out to mislead the coroner the information you provided was incorrect and by your own admission misleading. The panel considered that the nature of Baby A's case was very serious and the inquest was conducted to establish the facts and what had gone wrong. The panel considered that your decision to answer this question without being certain it was correct was conduct which fell below the standard expected of a registered nurse. In these circumstances the panel decided that your action as found proved in charge 11 did amount to misconduct.

In its consideration of the remaining charges found proved and whether they amounted to misconduct, the panel considered that you failed to uphold the standards and good practice expected of a registered nurse. It considered the seriousness of Baby A's Case and the vulnerability of Baby A and the tragic outcome of events. The panel was of the

view that your series of admitted failings over a period of time in a high priority case amounted to serious misconduct.

Decision on impairment

The panel next went on to decide if as a result of this misconduct your fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses 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 judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) in reaching its decision. In paragraph 74 she said:

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

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

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

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

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

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

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

The panel considered that limbs a, b and c of the above test were engaged by your past actions. The panel considered that your actions brought the profession into disrepute. It considered that working to the standards expected at all times is a fundamental tenet of the profession, which you breached through your past actions and omissions.

The panel went on to consider whether you were liable to act in a way to bring the profession into disrepute and to breach fundamental tenets of the profession in the future. In doing so, the panel assessed your level of insight and remediation, and it had regard to your nursing practice both prior and subsequent to this incident.

In relation to insight, the panel considered that during your oral evidence given at this hearing, you showed that you had reflected on your past actions and are aware of what should have been done. The panel considered that you had recognised that your actions were wrong. The panel considered that you had provided explanations for your conduct, which included issues with the policies for safeguarding in place at the trust, at that time. The panel considered that you have demonstrated what you would do to prevent this conduct from recurring in the future, including your understanding of the

correct procedures, following your retraining and completion of the action plan put in place.

The panel had regard to your previous nursing practice, prior to this incident, as well as your subsequent practice. It noted that prior to this incident, no concerns had ever been raised regarding your clinical practice and performance. It noted that you are still employed at the Trust and there was no evidence of any concerns raised to date, since the referral. The panel had regard to the positive references before it, from colleagues and the evidence provided by Witness 1, which was complementary of your clinical practice and performance and the care you provide to patients and which have raised no concerns in relation to your fitness to practise.

The panel considered that although your misconduct was serious this was a single, isolated incident involving one case over a period of time. Given the evidence of your developed insight, the evidence regarding your previous and subsequent practice, and the positive references before it, the panel was satisfied that the misconduct in this case had been remediated, and that it was unlikely to be repeated.

The panel determined that a finding of impairment is not 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 wellbeing of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession.

The panel carefully considered the circumstances of this case as to whether a finding of impairment was required in the public interest and to maintain public confidence in the nursing profession and to uphold proper professional standards.

The panel determined that your actions at the time were serious and your failings were related to a high priority case involving a vulnerable baby The panel considered that

your actions displayed a disregard for Baby A's care. The panel considered that an informed member of the public and members of the nursing profession would consider this behaviour to fall below the standards expected of a registered nurse, and would expect it to be appropriately marked as unacceptable. The panel considered that public confidence in the nursing profession and the NMC as a regulator would be undermined if a finding of impairment were not made in the circumstances. The panel therefore determined that a finding of impairment is necessary on public interest grounds.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired, on public interest grounds alone.

Determination on sanction:

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

In reaching this decision, the panel had regard to all the evidence in this case. The panel heard submissions from Ms Michaels, on behalf of the NMC, and those made by Ms Adeyemi, on your behalf. The panel accepted the advice of the legal assessor. The panel bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance ("SG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

Ms Michaels, on behalf of the NMC, outlined the sanction bid for six months suspension order with a review, which she submitted was the only suitable and appropriate sanction to address the regulatory concerns. She submitted that the purpose of a sanction in this case was to address public interest concerns, and she referred the panel to the principle of proportionality. Ms Michaels outlined aggravating and mitigating factors for the panel to consider.

Ms Michaels dealt with the sanctions in ascending order, and submitted that a caution order would not be suitable, as the concerns were not at the lower end of the spectrum. She submitted that a conditions of practice order would not be appropriate, as there were now no identifiable areas of your practice in need of retraining, and given that the concerns involved the public interest only.

In considering a suspension order, Ms Michaels referred the panel to the SG, and the following factors which may suggest such a sanction would be appropriate:

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

Ms Michaels submitted that this was a case involving a single instance of misconduct albeit over a period of time. Ms Michaels reminded the panel of the seriousness of your case and the vulnerability of Baby A.

Ms Michaels submitted that a suspension order may be appropriate where the misconduct is not fundamentally incompatible with continuing to be a registered nurse, and the public interest can be satisfied by a less severe outcome than permanent removal from the register. She submitted, in this case a suspension order would be sufficient to maintain public confidence in nurses and to uphold professional standards.

Ms Michaels invited the panel to impose a suspension order for a period of six months with a review.

Ms Adeyemi, on your behalf, submitted that you fully accept the seriousness of this matter as identified, and reiterated that you are very sorry for what had happened and are committed to maintaining a high standard of practice. She submitted that a caution order is the most appropriate and proportionate sanction to impose.

Ms Adeyemi submitted that your colleagues have been very complimentary of your work.

Ms Adeyemi submitted that the panel had found that the misconduct in this case has been remediated and is unlikely to be repeated. It had determined that a finding of impairment is not necessary on public protection grounds, but is only necessary in respect of the public interest.

Ms Adeyemi submitted that a conditions of practice order would not be appropriate in this case as there are no public protection issues. She submitted that you are supported by the Trust and your colleagues and you have supervision sessions regularly.

Ms Adeyemi submitted that a suspension order would be wholly disproportionate in this case, as there is no evidence of any deep seated attitudinal issues and that you have learned from your past mistakes, therefore there is no concern that would justify a temporary removal from the register.

To conclude her submissions, Ms Adeyemi submitted that a caution order is sufficient to meet the objective that the panel has identified in its decision on misconduct and impairment. She reminded the panel that the caution order will remain against your registration and on the NMC website for the length of the order.

Ms Adeyemi invited the panel to impose a caution order for a period of one year.

The panel first considered what it deemed to be the aggravating and mitigating factors in this case and determined the following:

Aggravating factors:

- Your actions placed Baby A (a baby on a child protection plan) at risk of harm

Mitigating factors

- Single isolated incident albeit over a period of time
- You have no other NMC referrals either before or since these incidents.
- You made admissions.
- You have shown insight and remorse
- You have strengthened your clinical practice, such that the panel is satisfied that there is no risk of repetition.
- You have already been subject to an action plan to improve your practice, imposed by the Trust.
- You have been working unrestricted for over five years since the incidents with no further repetition of any concerns.
- You have a number of positive testimonials.
- No public protection issues

The panel then went onto consider what action, if any, to take in this case.

The panel first considered whether public confidence would be maintained if it were to take no further action. The panel bore in mind that taking no further action at the sanction stage is an exceptional course of action which will only be appropriate in rare cases.

The panel had regard to the fact that it had found that you no longer present a risk to the public or patients. It was satisfied that you have remediated your previous clinical failings and implemented the learning from the action plan imposed by the Trust.

However, the panel also bore in mind the serious nature of this case. It was aware that a number of years have passed since these events and that you have been subject to intense scrutiny through various investigations. However, the panel did not consider that the passage of time diminished the severity of the case or the level of public interest. The panel as previously identified considered your clinical failings had fallen short of the standards expected of a registered nurse and in the panel's view, needs to be marked. In the professional judgment of the panel, taking no further action would not satisfy the public interest in this case and some form of sanction is required to maintain public confidence in the profession and in the NMC as its regulator.

The panel therefore moved on to consider a caution order. The Sanctions Guidance indicates that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise committee wants to mark that the behaviour was unacceptable and must not happen again'.* A caution order would not restrict your practice, but would be a public marking of your misconduct.

The panel considered that whilst this case was serious, it had also determined that you pose no ongoing risk to patients or the public. Its finding of impairment had been made on public interest grounds only, to maintain public confidence in the profession and in the NMC as its regulator. It had found that you have demonstrated remorse and insight into the incident and you have completed retraining, which you have reflected upon, and have been working unrestricted for a number of years. The panel also had a number of positive testimonials from your colleagues and evidence attesting to your practice from Witness 1. In these circumstances, it considered that the public interest could be maintained by a caution order.

The panel considered whether a more restrictive sanction was required to maintain public confidence in the profession. It decided that a conditions of practice order would serve no useful purpose in the absence of any recent concerns about your clinical practice or attitude.

It also decided that a suspension order would be disproportionate. While the panel was of the view that a sanction is required to maintain public confidence in the profession and the NMC as its regulator, it also bore in mind that there is a public interest in allowing safe nurses to practise. The maintenance of public confidence in the NMC as a regulator also includes reaching a proportionate outcome. Having regard to the fact that you have remediated the concerns about your clinical practice, shown insight into the impact of your failings and your professional responsibilities as a registered nurse, and have been working safely without restriction for over five years, the panel considered that suspending you from the register would be disproportionate, punitive and more than is required to maintain public confidence.

The panel therefore concluded that a caution order was the appropriate and proportionate sanction which would maintain public confidence in the profession and the NMC as its regulator. The panel considered that a caution order for one year struck the appropriate balance between the serious nature of the case and the gravity of your failings as a registered nurse, against the work you have done since to learn from these events and improve your practice.

At the end of the one year period the note on your entry in the register will be removed.

For the next year, your employer or any prospective employer will be on notice that your fitness to practise has been found to be impaired and that your practice is subject to a caution order. At the end of this period the note on your entry on the register will be removed. However, the NMC will keep a record of the panel's finding that your fitness to practise has been found impaired. If the NMC receives a further allegation in respect of your fitness to practise, the record of this panel's finding and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed in writing.

That concludes this determination.