Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 9 May 2022 – Tuesday, 17 May 2022

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	**Jane Mary Gathard**
NMC PIN:	84C1384E
Part(s) of the register:	Registered Nurse – Sub-part 1 Adult Nursing – 14 June 1988
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Sadia Zouq (Chair, Lay member) Linda Pascall (Registrant member) Jan Bilton (Lay member)
Legal Assessor:	Ben Stephenson
Hearings Coordinator:	Philip Austin
Nursing and Midwifery Council:	Represented by Molly Dyas, Case Presenter
Mrs Gathard:	Present and represented by Matthew Turner, instructed by the Royal College of Nursing
Facts proved by admission:	Charges 6a, 6b and 7 in its entirety
Facts proved:	Charges 1, 2, 4 and 5
Facts not proved:	Charge 3
Fitness to practise:	Currently impaired
Sanction:	Suspension order – 12 months (with review)
Interim order:	Interim suspension order – 18 months

Decision and reasons on application to admit hearsay evidence

Ms Dyas, on behalf of the NMC, invited the panel to admit a record of a telephone note between Patient A's mother and the NMC into evidence. She submitted that Rule 31 of The Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ("the Rules") permits the admission of evidence in so far as it is 'fair and relevant'.

Ms Dyas informed the panel that charges 1, 2, 3 and 4 relate to Patient A, a male child who had complex health needs, and who was four years old at the time of the alleged events. She submitted that the NMC has not been able to obtain a witness statement from Patient A's mother, so are seeking to adduce a telephone note of a conversation that was had between her and an officer of the NMC on 29 July 2020.

Ms Dyas stated that the telephone note dated 29 July 2020 contains 21 paragraphs of narrative answers to questions put by an officer of the NMC to Patient A's mother, and this can be considered by the panel as a reliable document. She submitted that there is some evidence from the documentation before the panel which supports the narrative set out in the telephone note, namely, your response to the concerns by email dated 30 October 2019 and the meeting notes between you and Ms 2 dated 14 November 2019.

Ms Dyas provided the panel with a bundle of documents which set out the attempts made by the NMC to contact Patient A's mother in relation to this case. She submitted that the NMC have attempted to obtain an NMC witness statement from Patient A's mother subsequent to the date of the telephone note, when Patient A's mother confirmed that she would not be willing to give evidence at a hearing, but would be willing to provide a statement. Ms Dyas submitted that the NMC contacted Patient A's mother to obtain a formal NMC witness statement by email on 20 October 2021, by letter on 10 November 2021, and by email again on 17 March 2022 but was unsuccessful in eliciting a response.

Ms Dyas submitted that the telephone note is not the sole and decisive evidence in support of charges 1 – 4, as the panel will also hear from Ms 1, Clinical Lead and

Development Manager at Emergency Personnel Limited ("the Service"), who received a similar email from Patient A's mother setting out her concerns, particularly in respect of the alleged medication error, around the time of the alleged incident. Ms Dyas submitted that Ms 1 is warned to attend to give oral evidence to this panel, and she can be questioned about the account she received from Patient A's mother.

Ms Dyas said that the question the panel has to ask itself is whether the telephone note can be considered to be demonstrably reliable and, in the NMC's submission, she submitted that it is. Ms Dyas stated that the panel can attach the appropriate weight to the telephone note dated 29 July 2020, having regard to the fact that Patient A's mother cannot be cross-examined.

Ms Dyas concluded by saying that it would be relevant and fair to admit the telephone note dated 29 July 2020 into evidence.

Mr Turner, instructed by the Royal College of Nursing ("RCN"), on your behalf, opposed the application.

Mr Turner submitted that there are real concerns around the admissibility of the telephone note dated 29 July 2020. He submitted that it is '*shocking*' that the NMC are seeking to rely on this hearsay evidence in support of their case, as this is a clear example of the NMC trying to introduce evidence '*by the backdoor*'. Mr Turner referred the panel to the cases of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*, *Nursing and Midwifery Council v Ogbonna [2010] EWCA Civ 1216* and *R (Bonhoeffer) v General Medical Council [2011] EWHC 1585*.

Mr Turner submitted that a witness statement has not been obtained from Patient A's mother, despite her indicating that she would give one, nor has a witness statement been provided by the officer of the NMC who conducted the telephone call.

Mr Turner submitted that the Case Management Form ("CMF") that you were sent by the NMC had indicated that Patient A's mother would be attending the hearing as a witness to give evidence. He submitted that no cogent reason has been given for her non-attendance at this hearing; in fact there has been no reason given at all.

Mr Turner submitted that, in his view, the NMC's attempts to engage Patient A's mother in these proceedings has been '*utterly inadequate*' as not enough has been done to keep in touch with her since the telephone note was made on 29 July 2020. He submitted that there was a '*desperate*' attempt to re-engage Patient A's mother in March 2022, shortly before the hearing was due to commence. Mr Turner submitted that it is clear that the NMC did not consider what steps it should take to re-engage Patient A's mother, or how her non-attendance could impact on your case.

Mr Turner submitted that the telephone note itself was not produced by Patient A's mother, and it was not sent to her for her to confirm the validity of its contents. He submitted that a witness statement requires a person to think carefully about what they remember and set out very clearly what they would be willing to attest to in court proceedings, but this has not happened in these circumstances. Mr Turner submitted that the telephone note is just an officer of the NMC noting down what they think is the answer given to their question, and this process is very different to how a witness statement is normally produced. For example, he drew the panel's attention to the fact that there is no statement of truth at the end of the telephone note, and this has not been sent to Patient A's mother for it to be signed and dated. Mr Turner submitted that if the panel is willing to adduce evidence in this manner, there would be no point in having statements of truth at the end of witness statements in future.

Mr Turner submitted that there is a lot of evidence contained in the telephone note dated 29 July 2020; it is not a single matter that is evidentially contested. He submitted that you are not able to test the reliability or credibility of the evidence without Patient A's mother attending to give evidence.

Mr Turner accepted that whilst the telephone note is not the sole evidence in support of charges 1 – 4, it would be decisive evidence, as Patient A's mother comments on being a direct witness to the alleged events. He submitted that there is a factual dispute as to what happened in this case; whether there was a medication error, and who had incorrectly connected the PEG tube. Mr Turner submitted that it would not be appropriate to ask Ms 1 what Patient A's mother had said.

Mr Turner concluded by saying that these are serious charges, and they have the potential to significantly impact on your nursing career if found proved. He invited the panel to reject the application to admit the telephone note dated 29 July 2020 into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 of the Rules provides that, so far as it is 'subject only to the requirements of relevance and fairness', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He referred the panel to the case of *Thorneycroft*, and also the case of *El Karout v Nursing and Midwifery Council [2019] EWHC 28 (Admin)*.

In determining this application, the panel considered the telephone note to be relevant to the matters it was being asked to adjudicate upon. It noted that Patient A's mother had indicated that she would not be willing to attend a hearing to give oral evidence, however, she had said that she would provide a witness statement for the purposes of it being relied upon. The evidence provided by Patient A's mother speaks to charges 1 – 4, and she was allegedly a direct witness to the concerns identified.

The panel went on to consider whether it would be 'fair' to admit the telephone note into evidence. It was of the view that whilst the evidence contained within the telephone note was not the sole evidence in support of charges 1 – 4, it could be decisive, as it goes to the very heart of the factual dispute in this case.

The panel was aware that an officer of the NMC had recorded the answers Patient A's mother had given in response to questions asked of her in some detail. However, the panel had no confirmation to suggest that the recorded answers completed by the officer of the NMC had been shared with Patient A's mother, or that she had been asked to confirm their accuracy. The telephone note itself did not contain a statement of truth, and there was nothing signed and dated by Patient A's mother. In absence of any evidence to the contrary, the panel could not be satisfied that Patient A's mother had had the opportunity to confirm the validity of what had been recorded.

Furthermore, the panel had sight of the bundle of documents which showed the attempts made by the NMC to contact Patient A's mother. It considered the overall attempts to engage her to be unsatisfactory, noting as it did, that she had previously indicated that she would be willing to provide an NMC witness statement for court proceedings. The panel noted that the NMC had only sent one letter and two emails to her in just under two years.

As Patient A's mother was not in attendance at the hearing, Mr Turner was deprived of the opportunity to challenge her evidence, on your behalf, as was the panel, who would not be able to ask her questions. In taking this into account, the panel was of the view that it would have difficulty assessing the reliability and credibility of Patient A's mother in her absence, and what weight could possibly be attached to her evidence.

In taking account of the above, the panel decided not to admit the telephone note dated 29 July 2020 into evidence, in the particular circumstances of this case. The panel determined that it would be unfair to you to admit this hearsay evidence. It therefore rejected Ms Dyas' application.

Details of charge (Before amendments)

That you a registered nurse;

1. On the 24 October 2019, on one or more occasions, incorrectly mixed salbutamol with colymycin and administered them to Patient A.

2. Failed to report and/or escalate the medication error/s that was administered to Patient A on 24 October 2019.

3. On the 5 November 2019 incorrectly connected Patient A's PEG feed to the gastrostomy tube instead of jejunostomy tube.

4. In the alternative to charge 3, on the 5 November 2019 failed to identify that Patient A's PEG feed was incorrectly connected to the gastrostomy tube.

5. Prior to the 13 July 2020, failed to report and/or escalate that Patient C was left without a tracheotomy tube in his emergency box for over 2 weeks.

6. On the 17 March 2020 failed to disclose to the director of HFH Healthcare;
   (a) That you were currently under investigation by the NMC.
   (b) That you had been under investigation by your previous employer, Emergency Personnel.

7. Your actions in charge 6(a) and/or 6(b) were dishonest in that you intended the director of HFH Healthcare to believe that you had an unblemished employment record.

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

Decision and reasons on application to amend the charges

After having the charges read, the panel, of its own volition, decided to propose a typographical amendment to charge 1.

The panel noted that charge 1 currently reads:

> "*1. On the 24 October 2019, on one or more occasions, incorrectly mixed salbutamol with colymycin and administered them to Patient A*".

The panel was of the view that the medication 'colymycin' had been incorrectly spelled in the charge, as the correct spelling of the medication is 'colomycin'.

The panel invited submissions from the parties, both of whom raised no objection to the proposed amendment being allowed.

The panel accepted the advice of the legal assessor that Rule 28 of 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 considered the proposed amendment to charge 1 was in the interests of justice. It was satisfied that the proposed amendment did not alter the substance of the charge against you. The proposed amendment was to correct a typographical error, and it decided that amending this would provide clarity and better reflect the evidence the panel had received.

The panel determined that you would not be prejudiced or disadvantaged in any way in amending charge 1 in the way proposed. It therefore decided to amend charge 1 to the following:

> "*1. On the 24 October 2019, on one or more occasions, incorrectly mixed salbutamol with colomycin and administered them to Patient A*".

Furthermore, prior to closing submissions, Ms Dyas proposed a typographical amendment to charge 5. Charge 5 currently reads:

> "*5. Prior to the 13 July 2020, failed to report and/or escalate that Patient C was left without a tracheotomy tube in his emergency box for over 2 weeks.*"

Ms Dyas submitted that Ms 5 told the panel, during her evidence, that charge 5 relates to a female teenage patient. She submitted that this point was clarified with Ms 5 and she was clear in this respect. Therefore, Ms Dyas invited the panel to change 'his' to 'her'.

Mr Turner did not oppose the application.

The panel agreed with the proposed amendment. It was satisfied that the proposed amendment did not alter the substance of the charge against you. The panel took your evidence into account that Patient C was female. The concern you are having to answer

remains unchanged. The panel determined that amending charge 5, as proposed, would provide clarity and better reflect the evidence it had received.

Therefore, the panel decided to amend charge 5 to the following:

> "*5. Prior to the 13 July 2020, failed to report and/or escalate that Patient C was left without a tracheotomy tube in her emergency box for over 2 weeks*".

Details of charge (After amendments)

That you a registered nurse;

1. On the 24 October 2019, on one or more occasions, incorrectly mixed salbutamol with colomycin and administered them to Patient A.

2. Failed to report and/or escalate the medication error/s that was administered to Patient A on 24 October 2019.

3. On the 5 November 2019 incorrectly connected Patient A's PEG feed to the gastrostomy tube instead of jejunostomy tube.

4. In the alternative to charge 3, on the 5 November 2019 failed to identify that Patient A's PEG feed was incorrectly connected to the gastrostomy tube.

5. Prior to the 13 July 2020, failed to report and/or escalate that Patient C was left without a tracheotomy tube in her emergency box for over 2 weeks.

6. On the 17 March 2020 failed to disclose to the director of HFH Healthcare;
   (a) That you were currently under investigation by the NMC.

(b) That you had been under investigation by your previous employer, Emergency Personnel.

7. Your actions in charge 6(a) and/or 6(b) were dishonest in that you intended the director of HFH Healthcare to believe that you had an unblemished employment record.

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

Admissions

Upon having the charges read, you provided admissions to charges 6a, 6b and 7 in its entirety, through your representative, Mr Turner.

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

In taking account of the above, the panel found charges 6a, 6b and 7 proved by way of admission.

NMC Opening

The NMC received a referral in relation to you on 14 November 2019, from Ms 2, Lead Nurse at the Service. At the material time, you were working as an agency registered nurse at the Service.

It is alleged that on 24 October 2019, you were providing care to Patient A at his home address, along with Patient A's mother and Ms 3, a Healthcare Assistant ('HCA'). It is alleged that when Patient A required his medication, you realised the medication box was empty, so you went into the living room to get some more medication, made up the

medication and administered it to Patient A. However, a few hours later, it is alleged that Patient A's mother believed you to have made a medication error as the medication box that was taken from the living room was salbutamol instead of 0.9% saline. Patient A allegedly suffered physical effects of the medication error in that they became agitated, hyperactive and had a raised pulse. You allegedly failed to report and/or escalate the medication error or call for advice on what to do.

It is also alleged that on 5 November 2019, you were caring for Patient A at his home along with Patient A's mother and Ms 3, when you incorrectly attached Patient A's PEG feed to the gastrostomy tube and not the jejunostomy tube. This was allegedly discovered when Patient A's mother came into the room, as she noticed that Patient A was bloated and that his feeding tube had been incorrectly attached to the wrong line. Patient A's mother corrected the feed and ensured that Patient A was safe. It is alleged that Patient A's PEG feed had been correctly set up the in the morning when you had first administered the feed, but you were allegedly seen "*handling*" Patient A's PEG feed at a later point by Ms 3.

Following these incidents, a local investigation was commenced and you were dismissed from your agency contract with the Service on 23 January 2020.

On 17 March 2020, you were allegedly interviewed by Ms 4, Director of HFH Healthcare Limited ("HFH") for the role of Nurse Case Manager. It is alleged that during this interview, you were asked, "*Are you, or have you been at any time, subjected to an investigation by the NMC or a previous employer?*" to which you responded "*no*", despite there being an open NMC investigation relating to the above concerns. You were successful in securing the post after the interview.

During the week of 13 July 2020, you were allegedly part of a joint care team caring for Patient C who had a tracheotomy tube in place. It is alleged that Ms 5, Regional Lead Nurse for North, Central and North East London, was carrying out a handover to you and another nursing colleague when you told her that you remembered there had not been a

spare tracheotomy tube in the emergency box at Patient C's home address on the last two occasions you had visited. Ms 5 rectified this and ensured that a tube was sourced immediately for Patient C. It is alleged that you failed to escalate the concern appropriately, that being that there was not a spare tracheotomy tube in the emergency box at Patient C's house and this could have put the patient at risk of harm.

It is alleged that on 17 August 2020, HFH was contacted by the NMC and they informed it that you were under investigation for clinical concerns at a previous employment. You were summarily dismissed from HFH on 26 August 2020 due to your alleged dishonesty, and the alleged incident regarding Patient C's tracheotomy tube.

Decision and reasons on facts

Upon having the charges read, you admitted charges 6a, 6b and 7 in its entirety. The panel had announced these proved by way of admission.

In reaching its decisions on the disputed facts, the panel took account of all the oral and documentary evidence adduced, together with the submissions made by Ms Dyas, on behalf of the NMC, and the submissions made by Mr Turner, instructed by the RCN, in support of your case. It also 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:

- Ms 1: Clinical Lead and Development Manager at the Service.
- Ms 3: Healthcare Assistant for the Service.
- Ms 5: Regional Lead Nurse for North, Central and North East London for HFH.

The evidence of Ms 4 was accepted by you, so this was taken as read into the record.

You opened your case and you gave oral evidence to the panel.

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

Charge 1

1. On the 24 October 2019, on one or more occasions, incorrectly mixed salbutamol with colomycin and administered them to Patient A.

This charge is found proved.

In reaching this decision, the panel took account of Ms 1 and Ms 3's evidence.

The panel had sight of the meeting notes dated 14 November 2019. It noted that it is recorded within these meeting notes that:

> "*[Ms 2]: Ok, please explain the incident on 24/10/2019, regarding the Saline and Salbutamol.*

Jane: *There were a couple of saline left, mum keeps the rest of the saline ampoules in a different room, I went and picked up what I thought was more saline and put it next to the saline that was already left out, there were about 3 saline left which had been administered, I was not aware that I picked up salbutamol instead of saline. I administered colymycin mixed with what I thought was saline, and other medication, later in the day, Mum noticed that I had salbutamol.*

[Ms 2]: *So, it was mother that noticed? How much salbutamol do you think [Patient A] may have had?*

Jane: *Yes., 1 or may be 2 salbutamol had been given, I am not sure*

[Ms 2]: *What did you do?*

Jane: *Mum had seen, mum become anxious, mum monitored very closely, [Patient A] become tachycardiac at times, we recorded the finding during the day.*

[Ms 2]: *Did you not phone NHS 111 or 999 or call his medical team?*

Jane: *There were no signs of ill affect, no sign of difference until the afternoon. Mother does not ever want an ambulance to be called…*"[sic].

During your oral evidence, you told the panel that you contested the accuracy of the meeting notes. You initially told the panel that you had refused to sign the meeting notes when they were provided to you as you disagreed with the contents, however, the panel noted that your refusal is not documented anywhere. The panel was of the view that had you disagreed with the contents of the meeting notes, you would have raised this as a concern when they were provided to you, as you would have wanted to set the record

straight. In any event, you were repeatedly asked to identify what was incorrect within the meeting notes in cross-examination, but you stated that you were not able to recall. The panel determined that if you were so sure that aspects of these meeting notes were incorrect, you would have been able to identify what you believed to be inaccurate and articulate your reasons why to the panel at this hearing.

The panel did not place any weight on the evidence of Ms 3 in respect of this charge, as it found her evidence to be inconsistent and unreliable.

The panel noted from the meeting notes that you did not appear to deny administering salbutamol to Patient A. However, at this hearing, you told the panel during your oral evidence that you did not administer salbutamol mixed with colomycin. You stated that you did pick up a box of salbutamol instead of saline, but you were stopped from administering this by Patient A's mother who had noticed this. The panel did not find your account to be convincing. The panel noted that the meeting notes do not show this account recorded anywhere. Instead, the panel deemed your responses from the meeting notes to be positive confirmation that you did administer salbutamol to Patient A.

Furthermore, the panel considered your response at the meeting that you were looking for signs of '*ill effect*' to be corroborative of you having administered salbutamol to Patient A. There would have been no need for you to be looking for signs of '*ill effect*' if you had administered the correct medication. You had also stated that you would "c*ontact the office*" if a similar situation unfolded, which suggested to the panel that there was an incident of sorts. This was further supported by your email dated 30 October 2019, in which you give consideration to Patient A being "stable" and not showing any signs of "*adverse effects*". The panel was of the view that, judging by the way the email is phrased, you were referring to having administered salbutamol to Patient A, as opposed to having simply picked up the wrong box of medication. You also told the panel during cross-examination that Patient A did not look unwell despite his vital signs being '*up and down*'.

The panel rejected your account, that you were apologising for picking up the wrong box of medication. It considered the evidence shows that you were in fact apologising for incorrectly mixing colomycin with salbutamol and subsequently administering this to Patient A.

Therefore, on the balance of probabilities, the panel was satisfied that on the 24 October 2019, on one or more occasions, incorrectly mixed salbutamol with colomycin and administered them to Patient A.

Accordingly, the panel found charge 1 proved.

Charge 2

2. Failed to report and/or escalate the medication error/s that was administered to Patient A on 24 October 2019.

This charge is found proved.

In considering this charge, the panel was of the view that in order for you to have '*failed*' to do something, there must have been a duty imposed on you to act in a certain way.

As the registered nurse responsible for Patient A's health and wellbeing on 24 October 2019, the panel did consider there to be a duty imposed on you to report and/or escalate any medication error/s in respect of Patient A.

The panel noted from the submissions of Mr Turner that he appeared to be in agreement with this, as he confirmed that if charge 1 is found proved, it would follow that charge 2 would also be found proved.

The panel had sight of the meeting notes dated 14 November 2019. It noted that it is recorded within these meeting notes that:

> "*[Ms 2]: Did you call the office or complete an incident reporting form?*
>
> *Jane: I did not complete any incident reporting form, and I should have phoned the office.*
>
> *[Ms 2]: If this happened again, then what would you do?*
>
> *Jane: I will contact the office; mum does not want the ambulance to be called and does not want [Patient A] to be admitted to hospita*l".

Whilst you had told the panel that you disagreed with the contents of the notes of the meeting, the panel considered the above to be consistent with the email response you provided on 30 October 2019, as you stated:

> "*On reflection I know I should have documented the incident, handed it over advised the night staff and called for a ambulance*"[sic].

The panel considered the above evidence to be demonstrative of you accepting that you failed to report and/or escalate the medication error/s that was administered to Patient A on 24 October 2019.

Therefore, the panel was satisfied that you failed to report and/or escalate the medication error/s that was administered to Patient A on 24 October 2019.

Accordingly, the panel found charge 2 proved.

Charge 3

3. On the 5 November 2019 incorrectly connected Patient A's PEG feed to the gastrostomy tube instead of jejunostomy tube.

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence provided by Ms 3, who was present alongside you at the home address of Patient A on 5 November 2019.

In the email correspondence between Patient A's mother and the Service, Patient A's mother states that Ms 3 had told her that you were the person who incorrectly connected Patient A's PEG feed to the gastrostomy tube instead of jejunostomy tube. However, during her oral evidence at this hearing, Ms 3 initially stated that she did not see you connect Patient A's PEG feed to the gastrostomy tube instead of jejunostomy tube. This evidence then changed during panel questions, as Ms 3 then told the panel that she did see you connect Patient A's PEG feed to the gastrostomy tube instead of jejunostomy tube.

Due to the inconsistencies in the accounts provided, as shown above, the panel determined that it could not rely on Ms 3's evidence in support of this charge. It reminded itself that it had previously found Ms 3's evidence to be inconsistent and unreliable.

During your oral evidence, the panel noted that you could not remember whether it was you that had connected Patient A's PEG feed to the gastrostomy tube instead of jejunostomy tube, or whether it was someone else. This was corroborated by the meeting notes dated 14 November 2019, in which it is recorded that you had stated:

> "*There had been so many misunderstandings during the night, as the night staff had been giving the wrong feed, so now feed is only administered by day staff. feed had been stopped in the morning for 2 hours, Recommenced the feed, I can't*

remember who commenced the feed me or the carer, the feed runs at 55ml/hr, mum came in and thought that [Patient A] was bloated, saw that the feed had been connected to the gastro port, mum had aspirated and took majority of the feed out, only about 25ml had been administered. [Patient A] was fine, previously has been fed throughout the whole night, through gastro.

Mum does not want to call the office and does not want anyone to get involved"[sic].

In taking account of all the evidence received, the panel was not satisfied that the NMC had been able to discharge its burden of proof in respect of this charge. The panel considered there to be insufficient evidence to confirm that you were the person that had fitted Patient A's PEG feed incorrectly.

Therefore, the panel was not satisfied that on the 5 November 2019, you incorrectly connected Patient A's PEG feed to the gastrostomy tube instead of jejunostomy tube

Accordingly, the panel found charge 3 not proved.

Charge 4

4. In the alternative to charge 3, on the 5 November 2019 failed to identify that Patient A's PEG feed was incorrectly connected to the gastrostomy tube.

This charge is found proved.

In considering this charge, the panel was of the view that in order for you to have '*failed*' to do something, there must have been a duty imposed on you to act in a certain way.

The panel noted that you, through Mr Turner, accepted that you did not identify that Patient A's PEG feed was incorrectly connected to the gastrostomy tube. You denied charge 4 in so far as it was a 'failure'.

However, during your oral evidence, you appeared to accept that it was the responsibility of the registered nurse to ensure that Patient A's PED feed was correctly connected to the gastrostomy tube instead of jejunostomy tube. Furthermore, this was also supported by the evidence contained in your reflective piece, where you stated:

> "*As the nurse in charge, I oversee all care given by other staff and family members. I should ensure that anyone performing the above procedures has had the correct training, understands why the feed is given in the way prescribed, what can happen if it is not given via the route prescribed and knows when to stop the feed and phone for medical intervention and hospitalization*
>
> *It is imperative that everything given via any port is documented.*
>
> *I have had palliative clients where it has been necessary to drastically reduce and then stop their feeds as their absorption decreases.*
>
> *To ensure that the client is fed and medicated via the correct port it is important to follow medical advice, ensure that the administration is correctly written up for each client, the client should be observed for any signs of discomfort during medication or feed administration.*
>
> *All vital signs should be monitored to ensure that the client is absorbing their feed or medications correctly. If there are any abnormalities in the delivery of the feed it should be stopped and medical advice should be sort.*
>
> *Careful note taking are very important and it is important that any problems with the delivery of the feed or medications are shared with colleagues, medical staff*

and the organisation the nurse is working for.

When attaching a feed to any port great care should be taken to connect the right feed to the right port. This will vairy with each client. No feed should be administered until the nurse is confident that the feed has been attached to the correct port…"[sic].

The panel also had sight of the meeting notes dated 14 November 2019. It noted that it is recorded within these notes that:

"*[Ms 2]:* *But the feed is prescribed via jej. This is a nurse package, you are required to protect the child and your nursing pin, you must escalate any concerns or incidents to the office and always work in the best interest of the child*

Jane: *I will call the ambulance and the office, if this incident were to occur again.*

[Ms 2]: *You have clinical experience; you must protect your registration.*

Jane: *I am sorry*".

In taking account of the above, as the registered nurse responsible for Patient A's health and wellbeing on 5 November 2019, the panel did consider there to be a duty imposed on you to identify that Patient A's PEG feed was incorrectly connected to the gastrostomy tube.

Therefore, on the balance of probabilities, the panel was satisfied that on the 5 November 2019, you failed to identify that Patient A's PEG feed was incorrectly connected to the gastrostomy tube.

Accordingly, the panel found charge 4 proved.

Charge 5

5. Prior to the 13 July 2020, failed to report and/or escalate that Patient C was left without a tracheotomy tube in her emergency box for over 2 weeks.

This charge is found proved.

In reaching this decision, the panel took account of Ms 5's witness statement, in which it was stated:

> "*On the week beginning 13 July 2020, we had a client who we had been looking after collectively. I was at the client's house doing the handover with Jane and a new nurse...During the handover, Jane remembered something said 'by the way, on the last 2 occasions when I visited the client's house, he didn't have a tracheotomy tube in emergency box'. When I heard this, I stopped breathing because I became so worried. She then said to me 'did I not say?' And I answered 'no you did not'*".

The panel considered the above to be consistent with the email Ms 5 sent to you on 16 July 2020, which states:

> "*As discussed earlier it is very important to escalate any emergency equipment that is needed and to allow me to guide and support you. Today you made me and new nurse that their was not an emergency tracheostomy in the box and you had noticed this on two visits you had done for this client. This is leaving the client unsafe and also leaving the carer and an ambulance staff, the opportunity to use it if needed. You apologised and said you forgot but I have explained the implication for HFH Healthcare and the client…*"[sic].

The panel noted that Ms 5 had initially referred to Patient C as being a male patient, however, it did not consider this to be an issue that goes to her credibility. To the contrary, it found her to be a compelling witness who had attempted to assist the panel to the best of her knowledge and belief. It considered her to be fair and balanced in giving her oral evidence.

You told the panel that as Patient C was not your client, you did not think it was your responsibility to report and/or escalate that Patient C was left without a tracheotomy tube in her emergency box. You stated that, in hindsight, you could have done more to resolve this, but there were other registered nurses who had attended Patient C's home address previously and had done nothing about it either.

In taking account of the above, the panel was of the view that, had you made the telephone call to Ms 5 as you say you did, this matter would have been resolved much sooner than it was. The panel had no evidence to confirm that you had made a telephone call to Ms 5 to inform her that Patient C was left without a tracheotomy tube in her emergency box and, based on the evidence before it, the panel determined that such a telephone call was not made. In her oral evidence, Ms 5 explained to the panel that she was '*shocked*' by your inaction in getting this issue resolved, and that correcting this would have been a priority, had she been aware. The panel accepted this evidence.

In any event, the panel determined that, if you had made the telephone call as you say you did, you would have been advised not to leave Patient C's home address until this concern had been addressed.

Therefore, on the balance of probabilities, the panel was satisfied that prior to the 13 July 2020, you failed to report and/or escalate that Patient C was left without a tracheotomy tube in her emergency box for over 2 weeks.

Accordingly, the panel found charge 5 proved.

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

During your oral evidence at misconduct and impairment, the panel suggested that parts of the hearing should be held in private on the basis that proper exploration of this case involves reference to your health and wellbeing, along with the health and wellbeing of vulnerable third parties. The panel was of the view that any public interest in these parts of the case being aired in public session is outweighed by the need to protect your privacy, and the privacy of the vulnerable third parties, in this respect. This application was made pursuant to Rule 19 of the NMC (Fitness to Practise) Rules 2004, as amended ("the Rules").

The parties did not raise any objection to parts of your oral evidence being heard in private session.

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 the references to your health and the health of vulnerable third parties, 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.

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

In her submissions, Ms Dyas 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'.* She also referred the panel to the case of *Nandi v GMC [2004] EWHC 2317 (Admin)*.

Ms Dyas 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"). She then directed the panel to specific paragraphs and identified where, in the NMC's view, your acts and omissions amounted to misconduct.

Ms Dyas submitted that the panel can use its professional judgment to find that there is misconduct in this case.

Ms Dyas submitted that all of the charges found proved are serious, particularly, your dishonest conduct. She submitted that through being dishonest, you circumvented the necessary requirements for HFH to assess the risk in employing you, and this goes directly to your integrity and level of trustworthiness. Ms Dyas submitted that this was not

a single instance of dishonesty; you did not tell HFH whilst you were working for them so your behaviour was ongoing.

Ms Dyas submitted that the clinical concerns do not relate to a one-off incident; there was a direct risk of significant harm being caused to two patients in your nursing care between October 2019 and July 2020.

Ms Dyas submitted that the potential effect of your acts and omissions could have had a significant impact upon patients in your nursing care. She submitted that your nursing practice fell below the standards expected of a registered nurse.

Ms Dyas invited the panel to find that your acts and omissions amounted to misconduct.

Mr Turner submitted that he agreed with the case law referenced by Ms Dyas. He also referred the panel to the cases of *Preiss v General Dental Council (GDC) | [2001] HRLR 56* and *Meadow v General Medical Council [2007] 1 All ER 1*.

Mr Turner invited the panel to consider the charges individually as the level of seriousness may vary.

Submissions on impairment

Ms Dyas 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 uphold proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. She 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)*.

Ms Dyas also referred the panel to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)* and invited the panel to determine whether your conduct is capable of remediation, whether it has been remediated, and whether it is highly unlikely to be repeated again in future.

Ms Dyas submitted that the panel will need to consider whether you have demonstrated any insight into your conduct and decide whether you now fully appreciate the extent of your shortcomings. She submitted that your insight and remediation goes '*to the heart*' of whether your conduct is likely to be repeated, as you need to understand what went wrong in order to correct it. In addition to this, Ms Dyas submitted that the panel should also have regard to any remorse expressed by you, as well as any relevant training you may have undertaken in an attempt to remediate the professional deficiencies identified.

In the NMC's view, Ms Dyas submitted that the panel may find your lack of insight into your acts and omissions to be concerning. She submitted that whilst you admitted the dishonesty charges at the outset of this hearing, your reflection into these concerns have been generalised, and you do not appear to accept that you had intended to mislead HFH. Furthermore, Ms Dyas submitted that you do not appear to accept the panel's findings at facts in respect of the clinical issues identified.

Ms Dyas submitted that the panel may also find you to have been evasive in giving your oral evidence at this stage of proceedings. She submitted that you have sought to deflect blame on to technological difficulties whilst working at the Service, and diminish your own wrongdoing.

Ms Dyas also submitted that you have raised concerns about [PRIVATE] at the time of applying to work for HFH. [PRIVATE]. Ms Dyas submitted there is very little information before the panel today in respect of your [PRIVATE].

Ms Dyas submitted that you have not undertaken any efforts to undertake training or keep your knowledge up to date. She submitted that it is your responsibility to take control of

your own nursing practice and development, but you have done very little to demonstrate that your conduct and behaviour will not happen again.

In taking account of the above, Ms Dyas submitted that the concerns in this case are highly likely to reoccur.

Ms Dyas invited the panel to find that your fitness to practise as a registered nurse is currently impaired on the grounds of public protection and public interest.

Mr Turner submitted that the panel must consider current impairment as of today's date. He submitted that the matters found proved took place two years ago, and no actual harm was caused to any patients.

Mr Turner submitted that context is an important factor to consider in these scenarios. He submitted that there were too few nurses and healthcare assistants caring for a large number of patients in the community around the time of the concerns.

Mr Turner disagreed that you have not shown any insight in relation to the concerns. He submitted that you have repeatedly outlined what you would do differently, should you be faced with a similar set of circumstances in future.

Mr Turner stated that you told the panel, during your oral evidence, that you would be much more careful when storing and administering medication to patients. He submitted that you outlined the importance of the '*six rights*'. Mr Turner further stated that you accepted responsibility for the overall care of Patient A, and recognised that, as the registered nurse in charge, you should have escalated the medication issue immediately.

Mr Turner informed the panel that you have a 30-year nursing career across all settings.,

Mr Turner submitted that these proceedings can operate as a salutary lesson for registrants. He submitted that training courses are not the only way to demonstrate learning and, in some cases, they can be quite tokenistic.

Mr Turner submitted that you have been pragmatic and thoughtful in analysing what went wrong and why. He submitted that the panel can be satisfied that the risk of repetition in this case is low from the evidence provided.

Mr Turner took the panel through your previous health concerns, and the impact this had on your decision-making abilities. He submitted that you are not seeking to excuse your dishonest conduct, but it is important to understand the mindset behind your behaviour at the time. Mr Turner submitted that you have given '*a lot of colour*' in respect of what has happened since, and you recognise that your dishonesty has had severe consequences.

Mr Turner explained your current personal and financial circumstances to the panel. He submitted that you have struggled to reflect on what has happened since the incidents because it has been '*too painful*'. However, Mr Turner submitted that it is to your credit that you have continued to work in different capacities since the incidents, given that you have not been able to work as a registered nurse during the covid-19 pandemic.

Mr Turner informed the panel that you want to return to the nursing profession, but you do not want to work in the community, where these concerns arose. He submitted that the concerns identified have been remediated, and there is evidence before the panel to suggest that you are a good, competent registered nurse.

Mr Turner invited the panel to have regard to the references submitted on your behalf, all of which attest positively to your clinical nursing practice.

Decision and reasons on misconduct

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

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

The panel was of the view that your acts and omissions did fall significantly short of the standards expected of a registered nurse, and it considered them to amount to several breaches of the Code. Specifically:

"8 Work cooperatively
To achieve this, you must:
8.2 maintain effective communication with colleagues
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice
This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.
To achieve this, you must:
10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:

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

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

To achieve this, you must:

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

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

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…"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It went on to consider each charge individually in determining whether your acts and omissions were sufficiently serious so as to amount to misconduct. In so doing, the panel noted that there were four main areas of concern, namely, your medication management and administration, identifying issues with PEG feeds, escalating/reporting the condition of patients and dishonest conduct.

In respect of charges 1 and 2, the panel found you to have made a medication error by incorrectly mixing salbutamol with colomycin on one or more occasions, and found that you failed to report and/or escalate that this was administered to Patient A. In considering

whether your acts and omissions amounted to misconduct in respect of these charges, the panel had regard to the NMC witness statement of Ms 1, who said that:

> "*If 2 ample of salbutamol were administered, there would be a risk of the patient's heart rate increasing. This would cause him to be shaky and anxious but it would not be life threatening.*
>
> *It is particularly concerned that Ms Gathard hasn't notified us. Once a drug error has been made, Ms Gathard should have documented it and notified the handover nurse and Emergency Personnel. Once notified, Emergency Personnel would have conducted an investigation to ensure there doesn't happen again, thereby minimising the risk to the patient*"[sic].

The panel considered that Patient A was exposed to an unwarranted risk of harm through you administering incorrect medication and failing to report and/or escalate this. The panel noted that you took no steps to minimise the unwarranted risk of harm that Patient A had been exposed to as you took no steps to notify the handover nurse, or the Service. The panel considered your medication management and administration to have amounted to misconduct in these particular circumstances.

In respect of charge 4, in failing to identify that Patient A's PEG feed was incorrectly connected to the gastrostomy tube, the panel had regard to Ms 1's NMC witness statement, in which she stated:

> "*The patient's mother came into the room and saw that her son was bloated. She corrected the feed and straight away aspirated him. At worst, the patient was an aspiration risk, thereby affecting his breathing…*".

The panel considered it to be your overall responsibility to identify if the PEG feed was incorrectly attached to the wrong tube, something which you later accepted during your oral evidence. The panel was of the view that there was a potential risk of significant harm

caused to Patient A, had this not been identified by Patient A's mother. Patient A's respiratory effort would have been compromised as a consequence of his PEG feed being incorrectly connected to the gastrostomy tube. The panel was satisfied that in failing to identify that the PEG feed was incorrectly connected to the gastrostomy tube, your omission was sufficiently serious to amount to misconduct.

In respect of charge 5, the panel noted that it had found you to have failed to report and/or escalate that Patient C was left without a tracheotomy tube in her emergency box for over two weeks. The panel considered Patient C to have been exposed to a significant risk of harm through your omission, as the potential consequences could have been life threatening for Patient C. The panel was of the view that in identifying that Patient C was left without a tracheotomy tube in her emergency box, the appropriate action would have been to escalate this as a priority, something which it had found you not to have done. Furthermore, in your oral evidence, the panel considered you to have demonstrated an inappropriate attitude to the significant risk of harm, as you had rhetorically asked "*Patient C's mother was not able to find a tracheotomy tube, so where was I going to find one?*". You were the registered nurse in charge of Patient C's care in the community on the day you visited, and the panel considered it to have been your responsibility to report and/or escalate that Patient C had been left without a tracheotomy tube in her emergency box. The panel was satisfied that your behaviour in omitting to report and/or escalate this concern was serious and amounted to misconduct.

In respect of charges 6 and 7, the panel determined that you had deliberately attempted to mislead HFH into believing that you had an unblemished employment record. The panel considered honesty, integrity and trustworthiness to be the bedrock of the nursing profession and, in being dishonest, it found you to have breached a fundamental tenet of the nursing profession. You did not disclose to HFH that you had previously been under investigation by the Service, nor did you disclose that you were under investigation by the NMC at the time of the interview, or subsequently. Your behaviour in concealing these concerns prevented HFH from conducting a proper risk assessment of you in order to determine whether you were a suitable candidate for the job. Your dishonesty was

motivated by personal gain as you were seeking new employment. To characterise your actions as anything other than misconduct would send the wrong message about the nursing profession. Therefore, the panel was in no doubt that your actions in being dishonest amounted to misconduct.

In the round, the panel was of the view that other registered nurses would consider your acts and omissions to be deplorable in the particular circumstances of this case.

The panel found that your acts and omissions above did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct in all of the charges found proved.

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 and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *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 limbs above to be engaged, both as to the past and to the future.

The panel had found patients in your nursing care to have been exposed to an unwarranted risk of harm, some more so than others. It had also found you to have breached fundamental tenets of the nursing profession, including by acting dishonestly,

and it found you to have brought the reputation of the nursing profession into disrepute by virtue of your acts and omissions.

The panel noted that the clinical concerns arose in a community setting, and that your dishonesty was directly linked to your nursing practice. The panel considered there were three separate incidents of misconduct which evidence a pattern of poor nursing practice.

The panel had regard to the case of *Cohen*, and considered whether the concerns identified in your nursing practice are capable of remediation, whether they have been remediated, and whether there is a risk of repetition of the incidents occurring at some point in the future.

The panel considered the concerns identified in respect of your clinical nursing practice to be capable of remediation, in principle. It considered dishonest conduct to be more difficult to remediate as it could be suggested that there is an underlying attitudinal issue present, although not impossible.

In deciding whether you have sufficiently remediated the concerns identified, the panel was of the view that your level of reflection and understanding would be key in determining whether you present an ongoing risk of harm to patients.

In assessing your level of insight, the panel noted that you admitted the charges relating to dishonesty when the charges were put to you at this hearing. It considered you to have reflected on your dishonest behaviour in the first of two reflective pieces provided, and it noted that you accept that you should have behaved in a different manner at the interview for HFH. You stated in this reflective piece that:

> "*Dishonesty is saying something which isn't true or misleading another individual.*
>
> *It is very important that a registered nurse is truthful at all times. It is only by being transparent about everything in their practice and daily life that they can be trusted.*

Registered nurses are professionals and need to have the credibility of the general public and their peers…

Registered nurses are responsible for the safe treatment of the general public. We are advocates for our clients. Therefore, it is vital that registered nurses can be believed.

I deeply regret misleading HFH with regards to my status and the allegations made against me. This was totally the wrong thing to do. I am very remorseful for this.

I care passionately about my profession and would hate to bring it into disrepute. I can see on reflection how damaging this could be to all my colleagues and potentially to my clients.

I have had many months to think about my actions and to analyse how damaging they were and potentially could be.

Colleagues need to be informed of any allegations made against other colleagues so that they can decide whether to employ someone and if the registered nurse is honest about allegations, then the work team, she is employed with can make sure that the registered nurse is sufficiently supervised to ensure the safety of the general public…

I'm sure my colleagues were very disappointed to learn of the allegations made against me and my dishonesty. I put them in a very difficult situation. For this on reflection I'm deeply sorry. I know that these are only words but I do deeply regret what I did.

This was totally out of character I care a great deal about each and every one of my clients and the teams I have worked with over the years.

I can now see how harmful my actions were and would never do anything like this ever again…".

In taking account of the above, the panel was satisfied that you have developing insight in relation to your dishonesty. It considered there to be a level of understanding present which could be used to further develop your insight. You have shown some remorse, and recognised the impact your actions had on colleagues and the nursing profession as a whole, as well as how your behaviour could have impacted on the public's perception of how registered nurses should conduct themselves.

However, in relation to the clinical concerns identified, the panel considered you to have only demonstrated limited insight. The two reflective pieces you provided to address this largely provided a background narrative and did not sufficiently explore particular circumstances of this case. Your second reflective piece was provided after the panel's findings on facts had been handed down, but it did not consider you to have taken those findings into account in this document, or in your subsequent oral evidence.

The panel found you to have been evasive during cross-examination at stage two. It found you to have been inconsistent in places and it was unclear whether you do actually accept the panel's findings in respect of charges 1, 2, 4 and 5. Whilst you appear to recognise that you could have done more for the patients involved, the panel considered you to have attempted to minimise your acts and omissions, and to deflect blame away from yourself.

From the limited account you provided in your oral evidence, the panel determined that you had not fully understood or appreciated the extent of the clinical concerns, nor had you reflected on the impact your acts and omissions could have had on patients, colleagues, the nursing profession or the wider public as a whole. Due to your inconsistencies, you were unable to articulate to the panel with any real clarity, what it is that you would do differently in future if faced with a similar set of circumstances.

The panel did not consider you to have taken any real steps to remediate your nursing practice. You have not undertaken any training courses in attempt to rectify the clinical concerns identified. The panel acknowledged that you have been focusing on improving [PRIVATE]. You also told the panel that you were unaware that you could perform a carer role in a healthcare environment as you thought this was prohibited due to the restrictions currently imposed on you.

The panel did have sight of a number of references which attested positively to your clinical nursing practice. However, it noted that only three of these references were recent, with the majority being dated from 2020.

The panel determined that there is little evidence before it to demonstrate that you have fully remediated your misconduct, or developed a significant amount of insight into the concerns identified.

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. It considered there remained a risk of repetition of the incidents found proved and a risk of harm to patients in your care, should adequate safeguards not be imposed on your nursing practice. Therefore, 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 seriously concerned by the findings at the facts and misconduct stages of proceedings, with particular regard to your dishonesty. It concluded that public confidence in the nursing profession 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 12 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

Ms Dyas invited the panel to impose a striking-off order. She took the panel through aggravating features which, in the NMC's view, were present in this case.

Ms Dyas submitted that, in the round, you have demonstrated very little insight, and you have not remediated your misconduct. She submitted that your dishonesty was motivated by personal gain, and you have not provided an in-depth explanation for why you were dishonest at the interview for the role with HFH. Ms Dyas submitted that the mitigation offered by you, that personal matters were impacting on your thought-process, was not sufficiently addressed by you. She reminded the panel that you were untruthful to both HFH and the NMC, and submitted that you had opportunities between March 2020 and August 2020 to speak to someone about your dishonest behaviour, but you did not do so. Ms Dyas said that your dishonesty was serious and goes '*to the heart*' of good nursing practice.

Furthermore, in respect of the clinical concerns, Ms Dyas submitted that you have demonstrated a pattern of misconduct which exposed patients in your care to a risk of serious harm. She stated that some of these patients were vulnerable children with complex and multi-faceted care needs.

Ms Dyas submitted that you have only demonstrated limited insight in respect of the clinical concerns, and developing insight in relation to your dishonesty. She submitted that there is little evidence to demonstrate that you fully appreciate the severity of your misconduct, as you sought to minimise your acts and omissions and deflect blame away from yourself.

Ms Dyas referred the panel to the case of *Nicholas-Pillai v General Medical Council [2009] EWHC 1048 (Admin)* and submitted that the attitude shown by a registrant during regulatory proceedings can become a relevant factor for the panel's consideration at sanction. Ms Dyas stated that the panel had found you to have been evasive when giving your oral evidence, and it considered you to have attempted to '*row back*' from earlier admissions you have made. Ms Dyas also referred the panel to the case of *Sawati v General Medical Council [2022] EWHC 283 (Admin), 2022 WL 00413969*.

Ms Dyas submitted that there is a lamentable lack of remediation in this case. She submitted that whilst you have been subject to an interim suspension order, you have not taken the opportunity to undertake any training courses relating to the clinical concerns, nor have you made any attempts to keep your nursing practice up to date, despite a myriad of available resources.

Ms Dyas submitted that your conduct and behaviour raises fundamental questions about your professionalism. She submitted that public confidence in the NMC can only be maintained through the imposition of a striking-off order, and that temporary removal from the NMC Register by way of a suspension order will not be sufficient in the particular circumstances of this case. Ms Dyas submitted that the panel could not be satisfied that your conduct and behaviour would not be repeated, so she concluded by saying that a

striking-off order is the only sanction that is sufficient to protect the public and satisfy the public interest elements of the case.

Mr Turner told the panel that you accept the panel's determination regarding misconduct and impairment. He submitted that you accept the outstanding public protection concerns regarding your clinical nursing practice, and the public interest concerns in respect of your dishonesty.

Mr Turner submitted that a striking-off order is wholly disproportionate in the particular circumstances of this case. He submitted that a lesser sanction such as a conditions of practice order or a suspension order would be more appropriate and proportionate.

Mr Turner submitted there are not significant aggravating features, but there are some mitigating factors involved in this case. He submitted that the concerns arose within a relatively short period of time, and that prior to this you have had a very lengthy nursing career.

Mr Turner reminded the panel that you were suffering from [PRIVATE] at the time of the interview with HFH. He said that you felt ashamed to confide in people, you were not thinking straight and you were finding it difficult to get out of bed each day.

Mr Turner informed the panel that you have been subject to an interim suspension order for approximately 18 months so you have been unable to demonstrate remediation in a clinical setting. He submitted that the panel should be realistic about what would have been possible for you to achieve in respect of retraining over the past two years. Mr Turner stated that you were trying to '*make ends meet*' during the covid-19 pandemic.

Mr Turner submitted that the panel has not made a finding of a complete lack of insight; it has found limited insight in respect of the clinical concerns, and developing insight in respect of your dishonesty. He submitted that this is an important distinction to make as dishonesty is harder to remediate than clinical concerns, so it is to your credit that you

have made some progress in reflecting on why your behaviour was inappropriate. Therefore, Mr Turner submitted that you deserve a period of time to further develop your insight and demonstrate remediation. He reminded the panel that you had initially denied the clinical concerns identified, and this is not to your detriment. You should now be afforded a further opportunity to reflect on what has been found proved against you, and a conditions of practice order or suspension order would allow that. Mr Turner said that there is no reason why, with time, you cannot demonstrate the requisite level of insight into the outstanding concerns.

Mr Turner submitted that you are a good registered nurse, as shown by the references provided on your behalf. He reminded the panel that Ms 5 had also stated during her oral evidence that Patient A's mother was very complimentary about the care you delivered to her son, and went as far as saying that you were one of the best registered nurses that had attended to him.

Mr Turner concluded by stating that your acts and omissions are not so fundamentally flawed or so irredeemable to warrant permanent removal from the NMC Register. He submitted that this outcome would go much further than is needed to protect the public and would be inconsistent with the panel's previous findings, especially when you are willing to address the outstanding concerns.

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 ("the SG") and the guidance issued by the NMC on dishonesty.

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 motivated by personal gain, and directly related to your nursing practice.
- Your conduct and behaviour has put patients in your care at a risk of harm.
- Overall, you have demonstrated a lack of insight and remediation in relation to the concerns.

The panel did not identify any mitigating factors involved in this case.

The panel noted that you have engaged with the NMC process and it was informed that there are no previous regulatory findings against you.

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. Further, it would not address the public interest concerns identified.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel was of the view that 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. The panel decided that it would be neither proportionate nor 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 clinical deficiencies were capable of remediation, it was not satisfied that a conditions of practice order was sufficient to address your dishonest conduct, having regard to the public protection and public interest elements of this case. The panel had found you to be lacking insight in respect of your misconduct in the round, but considered you to have only had a limited opportunity to reflect on the panel's findings at this hearing. You have only just begun to reflect on the clinical concerns identified in charges 1, 2, 4 and 5 having previously denied these charges. Currently, there is limited evidence that you appreciate the serious ramifications your acts and omissions could have had on patients and their families, colleagues, the nursing profession and the wider public in this respect.

In taking account of the above, the panel determined that placing a conditions of practice order on your nursing registration would not adequately address the seriousness of this case, nor would it satisfy the public interest considerations.

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 a fundamental tenet of the nursing profession and a departure from the standards of the Code, the panel had determined your misconduct is capable of remediation, in principle. Notwithstanding the fact that two to three years has lapsed since these incidents, the panel considered you to be at a very early stage in understanding and reflecting on your misconduct overall, and it concluded that, in the absence of sufficient evidence to the contrary, you do not yet fully appreciate the impact of your acts and omissions.

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 remediated the concerns and failed to demonstrate an understanding of how and why your nursing practice fell significantly below the standards expected of a registered nurse.

The panel determined that, albeit 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 did consider this to be a finely balanced decision, but it reminded itself that the purposes of a sanction is not to be punitive, and it decided that you should be afforded the opportunity to demonstrate insight, remorse and remediation for your misconduct, having regard to your previous good character and lengthy nursing career which has spanned for a period of 30 years.

The panel determined that a striking-off order was not necessary in your case. It concluded that this would be disproportionate in having regard to the totality of the evidence before it. Whilst the panel had no recent evidence of safe and effective nursing practice due to your interim suspension order, the panel noted that you have a wealth of nursing experience and that there are no previous adverse findings against you in the

regulatory sphere. Your dishonesty was motivated by personal gain, but you have shown the beginnings of insight and have attempted to reflect on your behaviour. The panel was satisfied that these proceedings had acted as a salutary lesson for you. 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 12 months, subject to a review. The panel determined that this was the appropriate length of time for you to address the outstanding concerns through developing your insight, demonstrating remorse and remediation.

The panel had no specific information before it relating to your current employment status. It 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 and your attendance at the review hearing.
- A further reflective piece, using a recognised model (E.g. Gibbs), demonstrating any insight, remorse and remediation.

- Any evidence of training undertaken by you, and any other evidence of you having kept your nursing skills up to date.
- Any recent 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

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

Mr Turner did not oppose the application for an interim 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 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.