Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 26 June 2023 – Friday 30 June 2023

Virtual Hearing

Name of Registrant:	Marie Catherine Mortley
NMC PIN	02B1370O
Part(s) of the register:	Nurses part of the register Sub part 1 RN1: Adult nurse, level 1 (30 January 2002)
Relevant Location:	East Sussex
Type of case:	Misconduct
Panel members:	Dale Simon (Chair, lay member) Jim Blair (Registrant member) Nicola Jackson (Lay member)
Legal Assessor:	Juliet Gibbon
Hearings Coordinator:	Debbie Olawore
Nursing and Midwifery Council:	Represented by Rebecca Paterson, Case Presenter
Ms Mortley:	Not present and not represented at the hearing
Facts proved:	Charges 1, 2, 3, 4a
Facts not proved:	Charges 4b, 4c, 5, 6, 7a, 7b, 7c, 8
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Mortley was not in attendance and that the Notice of Hearing letter had been sent to Ms Mortley's registered email address by secure email on 25 May 2023.

Ms Paterson on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Mortley's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Ms Mortley.

The panel next considered whether it should proceed in the absence of Ms Mortley. It had regard to Rule 21 and heard the submissions of Ms Paterson who invited the panel to continue in the absence of Ms Mortley.

Ms Paterson submitted that there has been very little engagement directly from Ms Mortley. She submitted that the last phone call from Ms Mortley appears to have been on 25 February 2021 when she gave consent for the Royal College of Nursing (RCN) to represent her.

Ms Paterson submitted that the NMC had some contact with Ms Mortley's representative in 2021. However, there has been no substantive responses provided in that time. She told the panel that the RCN responded to the NMC through an email, stating that they are no longer instructed to act for Ms Morley. Ms Paterson then submitted that the NMC has not heard anything from Ms Mortley since then, despite making efforts to contact her by email and telephone.

Ms Paterson therefore submitted that Ms Mortley had voluntarily absented herself from these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Ms Mortley. In reaching this decision, the panel has considered the submissions of Ms Paterson, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Mortley;
- Ms Mortley has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date in light of her limited engagement;
- Three witnesses are due to give live evidence and not proceeding may inconvenience the witnesses, their employer(s) and, for those

involved in clinical practice, the clients who need their professional services;

- The charges relate to events that occurred in 2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Mortley in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Mortley's decisions to absent herself from the hearing, to waive her right to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

The panel subsequently received an email from Ms Mortley confirming that she was still happy for the hearing to proceed in her absence and that she had moved away from the UK. At the panel's request, the NMC contacted Ms Mortley to reiterate that she could appear for part of the hearing as the panel considered that it would be assisted by her attendance. Ms Mortley did not contact the NMC within the suggested deadline the following day, therefore the case again proceeded in her absence.

Decision and reasons on application to amend the charge

The panel invited Ms Paterson to make an application to amend the wording of charge 2. Ms Paterson accepted the invitation and agreed that the stem of charge 2 required minor amendments to correct the grammar. It was submitted by Ms Paterson that the proposed amendment would provide clarity and more accurately reflect the evidence.

The proposed amendment was as follows:

2) On 09 November 2020, incorrectly administered one, or more, items **of** medication to Patient A at, or around, 06:00, including:

    a) […] Quetiapine 150mg;
    b) Lamotrigine 100mg;
    c) Senna 15mg;
    d) Lithium Carbonate 300mg;
    e) Mirtazapine 30mg;

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 Ms Mortley 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 ensure clarity and accuracy.

Decision and reasons on application to amend the charge

Ms Paterson further made an application to amend charges 1d, 2d, 4b and 8d of the charges under Rule 28. Charge 1d and 2d relates to the medication dosage. She submitted that Lithium Carbonate at 300mg dosage should be amended to 800mg.

Ms Paterson submitted that the reason for the application to amend 1d and 2d at this stage is because having reviewed the evidence, it appears that there is a typographical error in the charges as it reflects the dosage recorded in Witness 2's statement which states, 'Lithium Carbonate 300mg'. Ms Paterson then referred the panel to Witness 1's statement and the Prescription and Administration Record of Patient A which both state that the dosage was 800mg.

Ms Paterson therefore submitted that in relation to the discrepancy, it can be reasonably inferred that it was a typographical error made in the witness statement.

Ms Paterson also invited the panel to amend charges 4b and 8b as they required minor amendment to correct the grammar.

The panel accepted the legal assessor's advice.

The panel considered Ms Paterson's application. The panel considered that there was no unfairness in amending the dosage of the medication from 300mg to 800mg because it made no material difference to the charge and the dosage is not an issue of dispute. The panel also noted that the doctor's assessment of a lack of likely harm was made on the basis of the higher and correct dose of 800mg. It determined that there is clear evidence from Witness 1 and the Prescription and Administration Record referring to the dosage as 800mg. It therefore determined that the reference to 300mg in the charges was an error as it appears to have been taken from the statement of Witness 2 which was clearly wrong.

The panel was of the view that amending charges 1d and 2d will cause no injustice to Ms Mortley and therefore accepted the amendments.

In relation to charges 4b and 8b, the panel was of the view that these were grammatical errors which do not change the substance of the charges, and as such the amendments would cause no injustice to Ms Mortley. It therefore allowed the application.

The proposed amendments were as follows:

That you, a registered nurse:

1) On 08 November 2020, failed to administer one, or more, items of medication to Patient A which were intended to be administered at 22:00, including:

    a) Quetiapine 150mg;
    b) Lamotrigine 100mg;
    c) Senna 15mg;
    d) Lithium Carbonate ~~300mg;~~ **800mg**
    e) Mirtazapine 30mg;

2) On 09 November 2020, incorrectly administered one, or more, items of medication to Patient A at, or around, 06:00, including:

    f) […] Quetiapine 150mg;
    g) Lamotrigine 100mg;
    h) Senna 15mg;
    i) Lithium Carbonate ~~300mg;~~ **800mg**
    j) Mirtazapine 30mg;

3) […]

4) Your conduct at any, and/or all, of charge 3 above was dishonest in that you:

    a) […]

    b) ~~Intend~~ **Intended** to conceal that you had not administered any and/or all of the items of medication referred to at 22:00;

    c) […]

5) […]

6) […]

7) […]

   a) […]
   b) […]
   c) […]
   d)

8) Your conduct at any and/or all of charge 7 above was dishonest in that you:

   a) […]

   b) ~~Intend~~ **Intended** to conceal that you had not administered any and/or all of the items of medication referred to at 22:00;

   c) […]

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

Details of charge (as amended)

That you, a registered nurse:

1) On 08 November 2020, failed to administer one, or more, items of medication to Patient A which were intended to be administered at 22:00, including:

   a) Quetiapine 150mg;
   b) Lamotrigine 100mg;
   c) Senna 15mg;

d) Lithium Carbonate 800mg;
e) Mirtazapine 30mg;

2) On 09 November 2020, incorrectly administered one, or more, items of medication to Patient A at, or around, 06:00, including:

a) Quetiapine 150mg;
b) Lamotrigine 100mg;
c) Senna 15mg;
d) Lithium Carbonate 800mg;
e) Mirtazapine 30mg;

3) Inaccurately recorded that you had administered one, or more, items of medication to Patient A as set out in charges 1 and/or 2 above at 22:00;

4) Your conduct at any, and/or all, of charge 3 above was dishonest in that you:

a) Knew that you had not administered any and/or all of the items of medication referred to at 22:00;

b) Intended to conceal that you had not administered any and/or all of the items of medication referred to at 22:00;

c) Intended to create the misleading impression that you had administered any and/or all of the items of medication referred to at 22:00;

5) On 09 November 2020, having been asked by Colleague 1, the time that you administered the medication referred to in charges 1 and/or 2 above, failed to disclose that you had administered the medication at, or around, 06:00;

6) Your conduct at any, and/or all, of charge 5 above was dishonest in that you intended to conceal that you had administered and/or recorded the administration of the medication at the incorrect time;

7) Failed to report that you had administered any and/or all of the medication referred to in charges 1 and/or 2 above at 06:00 instead of 22:00 in:

    a) Patient A's daily handover notes;

    b) The verbal handover;

    c) An incident report form;

8) Your conduct at any and/or all of charge 7 above was dishonest in that you:

    a) Knew that you had not administered any and/or all of the items of medication referred to at 22:00;

    b) Intended to conceal that you had not administered any and/or all of the items of medication referred to at 22:00;

    c) Intended to create the misleading impression that you had administered any and/or all of the items of medication referred to at 22:00;

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Paterson under Rule 31 to allow the hearsay evidence of Patient A, as set out in Witness 1's witness statement, into evidence. She submitted that the evidence relates to what Witness 1 was told by Patient A, in relation to the circumstances in which the incident came to light and invited the panel to allow this evidence to be considered.

The panel accepted the advice of the legal assessor.

The panel considered that the evidence is relevant in that it sets out the circumstances in which the incident arose. The panel considered fairness in this regard and noted that the evidence had been put before Ms Mortley at her local interview, and that she had not challenged any of the evidence. The panel considered that there was a good reason for Patient A not to be called as a witness as they were a vulnerable service user at the relevant time. It was also of the view that there would not be significant challenge if Patient A's version of events were to be admitted in evidence. It also noted that the hearsay evidence was not the sole and decisive evidence in this case, and indeed it appeared that Ms Mortley had accepted Patient A's version of events in the local disciplinary meeting.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Patient A but would consider what weight to attach to it once it had heard and evaluated all the evidence before it.

Background

The NMC received a referral from Bramley Health ('the Company'), in respect of Ms Mortley on 11 February 2021. Ms Mortley was first entered onto the NMC's register in January 2022. In addition to this, Ms Mortley is a Registered Nurse in St Lucia.

The allegations in this case arose whilst Ms Mortley was employed as a Registered Nurse at Langford Centre, which was part of the Company. The regulatory concerns identified are a failure to administer medication at the correct time, dishonesty, and failure to preserve safety by not providing a complete handover to colleagues.

It is alleged that on 08 November 2020, Ms Mortley failed to administer one, or more items of medication to Patient A which were intended to be administered at 22:00. It is also alleged that on 09 November 2020, Ms Mortley incorrectly administered one, or more, items of medication to Patient A at, or around, 06:00 which included; Quetiapine 150mg, Lamotrigine 100mg, Senna 15mg, Lithium Carbonate 300mg and Mirtazapine 300mg.

It is alleged that Ms Mortley incorrectly recorded that she had administered one or more items of medication to Patient A at 22:00, and was dishonest in that:

- Ms Mortley knew that she had not administered any/or all of the items of medication referred to at 22:00,
- Ms Mortley intended to conceal that she had not administered any and/or all of the items of medication referred to at 22:00, and
- Ms Mortley intended to create the misleading impression that she had administered any and/or all of the items of medication referred to at 22:00.

It is alleged that on 09 November 2020, having been asked by colleague 1, the time that Ms Mortley administered the medication, she failed to disclose that she had administered the medication at, or around, 06:00.

It is also alleged that Ms Mortley failed to report that she had administered any and/or all of the medication referred to at 06:00 instead of 22:00 in Patient A's daily handover notes, the verbal handover and an incident report form.

Decision and reasons on facts

The panel has drawn no adverse inference from the non-attendance of Ms Mortley.

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: A nurse on the Pevensey Ward, at the Langford Centre

- Witness 2: Ward Manager on the Pevensey Ward, at the Langford Centre at the relevant time;

- Witness 3: Company director of both Bramley Health limited, and Langford Clinic Limited.

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 the NMC.

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

Charge 1

On 08 November 2020, failed to administer one, or more, items of medication to Patient A which were intended to be administered at 22:00, including:

a) Quetiapine 150mg;
b) Lamotrigine 100mg;
c) Senna 15mg;
d) Lithium Carbonate 800mg;
e) Mirtazapine 30mg;

This charge is found proved in its entirety.

The panel considered each of the sub charges separately but as evidence in relation to each is similar. It dealt with them under one heading. In reaching its decision, the

panel took into account the evidence of Witness 1, Witness 2 and Witness 3 and all of the documentary evidence.

The panel accepted the hearsay evidence of Patient A. The panel noted that there was corroborative evidence to support their version of events. The panel also noted Witness 1's description of Patient A:

> *'Patient A is very anxious and can get very worried if something out of the ordinary happens with his care and routine. Patient A will often complain if there is something amiss with his care and therefore 1 knew he was being truthful about what had happened. …*
>
> *'Patient A is a T2 Patient' therefore he takes his medication willingly and he is aware of the medications he is Prescribed'*

In light of this evidence, the panel gave full weight to Patient A's version of events as provided by Witness 1 is as follows:

> *'On the day shift on 9 November, a patient ("Patient A"), reported to me whilst we were walking together along the corridor, that he had been given his medication, which was due to be administered at 22:00pm on 8 November, on or around 6:00am on 9 November.'*

The panel also noted Witness 2's statement where Ms Mortley said she admitted to not giving Patient A the medications at 22:00.

The panel the considered the admission made by Ms Mortley during a meeting with Witness 2 held on 12 November 2020 at 09:40, in terms of failing to administer the medications.

> *'SS- We are here to discuss the issue with neds. [SIC]*
> *MM - I gave it to him after the time I should.*
> *Patient*
> *SS- reports it was 6am*

MM - It was after midnight
S5 - It was signed for by you at 10pm
MM - I had tried to wake him up. I have taken the blame and cannot go through an Interview.
Patient A
SS- states he received his medication at 6am.
MM - I cannot give an exact time. I am just saying I gave it after I should have'.

The panel also considered Witness 3's oral evidence:

'The Registrant apologised and stated that she knew the medication should have been given at 10pm and she did not administer the medication late out of malice'.

The panel also bore in mind it is the responsibility of a registered nurse to administer medication at the right time.

In the light of the above the panel concluded that on the balance of probabilities the charge is found proved in its entirety.

Charge 2

On 09 November 2020, incorrectly administered one, or more, items medication to Patient A at, or around, 06:00, including:

a) Quetiapine 150mg;
b) Lamotrigine 100mg;
c) Senna 15mg;
d) Lithium Carbonate 800mg;
e) Mirtazapine 30mg;

The charge is found proved in its entirety.

In reaching its decision the panel again took into account Patient A's version of events in Witness1's statement:

> *'Patient A was anxious because he thought it was his fault that he had not received his medication at 22:00pm on 8 November. Patient A reported to me that he was asleep before 22:00pm. Patient A did not mention whether the Registrant had attempted to give him his 22:00pm medication. Patient A is very anxious and can get very worried if something out of the ordinary happens with his care and routine.*
> *Patient A will often complain if there is something amiss with his care and therefore 1 knew he was being truthful about what had happened.'*

The panel had regard to the evidence of Witness 1's statement:

> *'On the day shift on 9 November, a patient ("Patient A"), reported to me whilst we were walking together along the corridor, that he had been given his medication, which was due to be administered at 22:00pm on 8 November, on or around 6:00am on 9 November.'*

It also noted the reference made by the NMC in the CCTV footage, however, it placed very little weight on this footage because the actual footage was not produced as evidence. It was also informed that the footage no longer exists. The panel noted that the only account of the footage was provided by Witness 2 in her statement:

> *'As part of my investigation report, I reviewed the CCTV which was available from 09 November 2020. The CCTV showed the Registrant going into the clinic room at 06:10am, the time the patient said they had received their 22:00pm medication.*
> *I could also see the patient waiting outside the door of the clinic room. A recording of the CCTV is no longer available'.*

It also noted that the CCTV did not show Ms Mortley administering the medication, it only showed her going into the clinic room at 06:10. The panel also noted that there was no evidence produced of any earlier footage.

The panel took into account all of the evidence and determined that on the balance of probabilities the charge was proved in its entirety.

Charge 3

Inaccurately recorded that you had administered one, or more, items of medication to Patient A as set out in charges 1 and/or 2 above at 22:00;

This charge is found proved.

In reaching this decision, the panel took into account Patient A's Prescription and Drug Administration Record, the Management of Medicines in Hospitals Policy, and all of the oral and documentary evidence.

The panel considered the Prescription and Drug Administration Record, it noted that Ms Mortley had signed it at 22:00. However, there was no indication on it, either by way of an O or S in accordance with the medication policy or by any other mark showing an alteration in the time of drug administration as detailed in Witness 2's evidence. It noted that there was nothing to indicate that the medication had not been administered at 22:00. The panel also noted Ms Mortley's admission during the local disciplinary meeting:

> *'I know I signed the time at 22:00 and I am not saying you are wrong. I accept I was wrong and I am apologising and I am saying I am sorry.'*

The panel noted that the Management of Medicines in Hospitals Policy which states what should be done if medication is missed:

> *'If medicines is not administered the prescription card should be endorsed with:*

R refused
S if the service user is asleep
A if the service user is absent and cannot be found
O/L if the service user is on leave from the ward
W if the medicine is withheld at the nurse's discretion
O If medication has been omitted for reasons such as- patient is absent, asleep etc.
TTA If patient has gone on leave and has a supply of medication with them

An entry must be made in the clinical notes and on the back of the medicine chart to justify the reason for withholding/ omitting prescribed medicines'.

In light of this evidence, the panel found this charge proved on the balance of probabilities.

Charge 4a

Your conduct at any, and/or all, of charge 3 above was dishonest in that you:

a) Knew that you had not administered any and/or all of the items of medication referred to at 22:00;

This charge is found proved.

In reaching this decision, the panel took into account the findings it made in respect of charge 3 and the legal advice on dishonesty including the test set out in Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67.

The panel applied the test by first considering Ms Mortley's state of mind and concluded that she knew what she was doing was wrong because accurate recording is an essential basic tenet of nursing practice. The panel was satisfied that Ms Mortley's inaccurate recording that Patient A's medications had been given at

22:00 would be considered dishonest by the standards of ordinary decent people. The panel therefore found charge 4a proved on the balance of probabilities.

Charge 4b

Your conduct at any, and/or all, of charge 3 above was dishonest in that you:

b) Intended to conceal that you had not administered any and/or all of the items of medication referred to at 22:00;

This charge is found NOT proved.

The panel had regard to Ms Mortley's Staff Competency Assessment for the Management of Medicines, dated 22 May 2020. This recorded, against the statement *'can the member of staff describe the correct process for what to do if they make an error?'* the answer was circled *'No'.* There was no evidence before the panel that Ms Mortley had received any ongoing training or support to address this concern. In this circumstances, the panel considered that Ms Mortley may not have been aware of what she should have done after making a medication error. The panel considered that Ms Mortley's lack of competency was relevant to this decision. The panel also noted Ms Mortley's full and immediate admissions which it considered went against the concept of concealment.

It was therefore not satisfied that the evidence before it supported an intention by Ms Mortley to conceal that she had not administered the medication at 22:00.

The panel therefore found this charge not proved.

Charge 4C

Your conduct at any, and/or all, of charge 3 above was dishonest in that you:

c) Intended to create the misleading impression that you had administered any and/or all of the items of medication referred to at 22:00;

This charge is found NOT proved.

In reaching this decision, the panel considered that by signing the record inaccurately, anyone reading the record may have been misled as to what happened. However, it was not satisfied that the evidence provided supports an intention to mislead, considering Ms Mortley's lack of competence referred to above at charge 4b, and her full and immediate admissions and remorse during the local investigations.

In light of this evidence, the panel found this charge not proved.

Charge 5

On 09 November 2020, having been asked by Colleague 1, the time that you administered the medication referred to in charges 1 and/or 2 above, failed to disclose that you had administered the medication at, or around, 06:00;

This charge is found NOT proved.

In reaching this decision, the panel carefully considered the evidence of Witness 1 and noted that Ms Mortley was unable to give her a definite answer regarding the time of administration of the medications:

> *'The registrant did not give me a definite answer, she said that she had given the medication after midnight. I cannot recall the rest of the conversation, if any.'*

It also took into account Witness 2's evidence:

‘I saw the Registrant in person on 12 November 2020 in the Ward's visitor's room. I asked the Registrant about what had happened with the patient's medication; she was vague and did not give any details. The Registrant said she knew she had given the medication late but she did not say that she had not given it until 6am’.

The panel also noted Ms Mortley’s meeting with Witness 2:

‘ ….
MM - I gave it to him after the time I should.
Patient
SS- reports it was 6am
MM - It was after midnight …

MM - I cannot give an exact time. I am just saying I gave it after I should have.
SS - But you don't know when?...’

The panel reminded itself that it is for the NMC to prove its case. It appears to the panel that the NMC rely solely on the evidence of Witness 2. However, the panel was not satisfied that this was sufficient evidence to prove this charge as there was no duty for Ms Mortley to disclose that the medication was given at 06:00 if she was unable to remember the exact time, she administered it.

On the basis of this evidence, the panel found this charge not proved.

Charge 6

Your conduct at any, and/or all, of charge 5 above was dishonest in that you intended to conceal that you had administered and/or recorded the administration of the medication at the incorrect time;

This charge is found NOT proved.

Having found charge 5 not proved, charge 6 falls away.

Charge 7a

Failed to report that you had administered any and/or all of the medication referred to in charges 1 and/or 2 above at 06:00 instead of 22:00 in:

a) Patient A's daily handover notes;

This charge is found NOT proved.

The panel considered the minutes of the meeting on 12 November:

> ' ….
> *MM - I gave it to him after the time I should.*
> *Patient*
> *SS- reports it was 6am*
> *MM - It was after midnight …*
>
> *MM - I cannot give an exact time. I am just saying I gave it after I should have.*
> *SS - But you don't know when?...'*

The panel also had regard to Witness 1's statement:

> *'[...] also asked me to phone the Registrant to confirm whether Patient A had received his 22:00pm medication on or around 6:00aam on 9 November. I rang the Registrant's mobile number and told her that Patient A had said she had given the medication on or around 6:00am. The Registrant did not give me a tefinite [SIC] answer, she said that she had given the medication after midnight.'*

The panel took into account its previous finding that Ms Mortley could not identify the exact time at which she had given the medications. It therefore considered that there was no duty on Ms Mortley to hand over an administration time of 06:00.

It therefore found this charge not proved.

Charge 7b

Failed to report that you had administered any and/or all of the medication referred to in charges 1 and/or 2 above at 06:00 instead of 22:00 in:

b) The verbal handover;

This charge is found NOT proved.

For the reasons set out above the panel found that Ms Mortley did not have a duty to verbally handover the administration of the medication as 06:00. In addition, the panel noted that Witness 1 was not present at the verbal handover. And as such, her evidence in this regard was inadmissible hearsay.

The panel had no direct evidence of what was said at the verbal handover. Ms Mortley also was not questioned about the verbal handover during the local investigation.

For these reasons the panel found this charge not proved.

Charge 7c

Failed to report that you had administered any and/or all of the medication referred to in charges 1 and/or 2 above at 06:00 instead of 22:00 in:

c) An incident report form;

This charge is found NOT proved.

For the reasons set out above the panel found that Ms Mortley did not have a duty to complete an incident form concerning the administration of the medication as 06:00.

In addition, the panel took into account Management of Medicines in Hospitals Policy and noted that it was silent on the issue of whether an incident form is required to be completed. The panel also noted Witness 1's evidence in respect of the completion of an incident report:

> *'I can not say if the Registrant should have filled this in when she gave the medication at 06:00'.*

The panel also noted that there were no admissions or questions put to Ms Mortley in either of the local interviews about the completion of the incident form.

It therefore concluded that this charge is found not proved.

Charge 8

Your conduct at any and/or all of charge 7 above was dishonest in that you:

a) Knew that you had not administered any and/or all of the items of medication referred to at 22:00;

b) Intend to conceal that you had not administered any and/or all of the items of medication referred to at 22:00;

c) Intended to create the misleading impression that you had administered any and/or all of the items of medication referred to at 22:00;

This charge is found NOT proved.

Because the panel found the entirety of charge 7 not proved, charge 8 falls away.

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 Ms Mortley's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Paterson invited the panel to take the view that the facts found proved amount to misconduct.

Ms Paterson invited the panel to take the view that the facts found proved were sufficiently serious to amount to misconduct. She identified the specific, relevant standards where Ms Mortley's actions amounted to misconduct and submitted that the following paragraphs of the Code were the most relevant: 1.2, 8.2, 8.5, 8.6, 10.1, 10.2, 10.3, 13.3, 14.1, 14.3, 20.1, and 20.2.

Ms Paterson submitted that the facts proved are linked to Ms Mortley's practice and are serious. She submitted that the panel has made a finding of dishonesty and for all professionals, a finding of dishonesty lies at the top end of the spectrum of gravity of misconduct. She submitted that the context of the dishonesty in this case is particularly serious because it amounts to a breach of the professional duty of candour. She further submitted that the misconduct is also serious because it relates to failings in fundamental areas of nursing practice.

Ms Paterson submitted that the panel should give consideration to what Ms Mortley's state of knowledge was because this will have a bearing on its consideration of breaches of the code. She submitted that the panel has found that Ms Mortley did not administer medication due at 22:00, did administer medication that was not due at around 06:00, but that she did not know that it was 06:00 when she administered it. She submitted that the panel has also found a number of the charges not proved on the basis that Ms Mortley did not know it was 06:00 when the medications were administered and that the panel should not go behind its findings of fact.

Ms Paterson then submitted that the panel's consideration of Ms Mortley's actual state of knowledge as to the time is still an important consideration at this stage because it will have a bearing on its consideration of misconduct. This is because the mischief in the allegations is not whether she knew that it was 06:00 specifically, but whether Ms Mortley knew she was giving the medications significantly later than they were due, and therefore taking unreasonable risks.

Submissions on impairment

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

Ms Paterson submitted that the NMC considers Ms Mortley's Fitness to Practice is impaired on grounds of public protection and the wider public interest. She submitted that when considering the question of impairment, the panel may wish to look to the guidance set out by Dame Janet Smith in her fifth shipman report. Ms Paterson then submitted that all of the limbs are engaged.

Ms Paterson submitted that Ms Mortley's actions had the potential to put patients at unwarranted risk of harm. Whether or not the patient came to any actual harm is largely immaterial. Ms Paterson then submitted that the facts demonstrate that Ms Mortley created a risk of overdose by administering potentially toxic medication significantly later than she should have done. This was not reflected in the records to ensure colleagues were kept informed.

Ms Paterson submitted that Ms Mortley's actions as found proved have brought the nursing profession into disrepute and breached fundamental tenets of the nursing profession. The public has a right to expect that nurses will provide safe and effective care and the facts in this case demonstrate unsafe and ineffective care. She then submitted that failings in very basic areas do undermine nursing standards and public confidence in the profession.

Ms Paterson further submitted that through her dishonesty Ms Mortley has acted in a way which demonstrates that her integrity cannot be relied upon.

Ms Paterson submitted that when considering whether Ms Mortley is liable to act in such a way in the future, the panel may consider factors such as insight and remediation. She submitted that there is evidence in the local investigation documents that Ms Mortley has expressed remorse for her actions, and the panel

has found that she made full and immediate admissions at local level. However, there is no evidence before the panel which demonstrates that Ms Mortley has a good understanding of the seriousness of her misconduct, nor the risks associated and the impact that it has on the profession as a whole. Ms Paterson then submitted that there is no evidence of any strengthened practice nor steps taken to address the concerns in this case.

Ms Paterson submitted that NMC guidance sets out that dishonesty and breaching professional duty of candour is conduct that is more difficult to put right. She submitted that without proper engagement with the process, and without evidence of reflection and insight, there is a significant risk that similar conduct will be repeated in the future.

Ms Paterson submitted that when answering the question laid out in the NMC's guidance on impairment:

> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

She submitted that the panel cannot be satisfied that Ms Mortley can.

Ms Paterson submitted that Ms Mortley's Fitness to Practice is currently impaired on public protection grounds because she poses an ongoing risk to patient safety. She submitted that in the circumstances, members of the public would be very concerned if a finding of impairment were not made where a nurse who has made an error and acted dishonestly in circumstances which carry serious risks to a vulnerable patient. Ms Paterson then submitted that finding of current impairment is required to maintain public confidence in the profession and to uphold proper professional standards and conduct.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *General Medical Council v Meadow*

[2007] QB 462 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin), *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, and *CHRE v NMC and Grant.*

Decision and reasons on misconduct

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 Ms Mortley's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Mortley's actions amounted to a breach of the Code. Specifically:

> ***'1.2 make sure you deliver the fundamentals of care effectively***
>
> ***10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need***
>
> ***10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements***
>
> ***20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.'***

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

In this case, the panel took into account the context surrounding Ms Mortley's conduct. It considered the facts proved, in terms of inaccurate record keeping and dishonesty. It determined that the facts found proved concerned one episode of a failure of duty to administer medications at a given time. The panel took into account

Ms Mortley's admissions to what she had done and her apology at the local disciplinary meeting. However, it noted that the dishonesty in this case is a matter of concern, and this amounted to misconduct.

The panel determined that the concern in this case is at the lower end of the spectrum, and noted the evidence of Witness 2:

> *'I [SIC] was decided in conjunction with the Hospital Director, …. that the Registrant should not administer medication until her medication competency assessment had been re-done and should come off night shift to receive supervision.'*

The panel was of the view that Ms Mortley should have been given an opportunity of learning and training to remediate her actions.

The panel considered that charges 1 and 2 did not amount to misconduct because it was an isolated incident albeit that it involved 5 medications, which arose because Patient A was asleep when the medications should have been administered.

The panel noted that the facts found proved in charges 3 and 4a amounted to misconduct because of the dishonest nature of the incident, in terms of incorrect record keeping. The panel therefore determined that Ms Mortley's actions did fall short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Mortley's 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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *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 determined that the four limbs were engaged in this case. It found that Ms Mortley's misconduct had breached the fundamental tenets of the nursing profession by recording that she had administered medications at a time when she had not. It noted that Ms Mortley did not comply with a system of regulation designed to promote public confidence in nursing and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Ms Mortley made admissions to some of the concerns raised and has shown some level of insight and remorse. However, in the absence of a reflective piece, it was of the view that her insight is currently limited.

The panel was satisfied that the misconduct in this case is capable of being addressed. It carefully considered the evidence before it and determined that it had no evidence that Ms Mortley had taken steps to strengthen her practice. It noted that she has not evidenced an understanding of how her actions could potentially put patients at a risk of harm, and how she would handle the situation differently in the future should it arise again. In light of this, the panel is of the view that there is a risk of repetition as there was only evidence of limited insight before it, and no reflective piece has been submitted by Ms Mortley. It, therefore, decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overreaching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This 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 determined that a finding of impairment on public interest grounds is not required because Ms Mortley's misconduct is at the lower end of the spectrum

because the matter which arose in relation to dishonesty was an isolated incident linked to her lack of competence. It noted that this was a clinical error which can be remediated by undergoing suitable training. It also noted that the doctor informed Witness 1 that there was no harm caused to Patient A as a result of this incident. It therefore concluded that the public interest is not engaged at this stage.

Having regard to all of the above, the panel was satisfied that Ms Mortley's fitness to practise is currently impaired on public protection grounds only.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Ms Mortley's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

Submissions on sanction

In the Notice of Hearing, dated 25 May 2023, the NMC had advised Ms Mortley that it would seek the imposition of a striking off order if it found Ms Mortley's fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submitted that a suspension order is more appropriate in light of the panel's findings.

Ms Paterson submitted that a sanction is for the panel's independent professional judgement and that in this case the only appropriate sanction is a 6 month suspension order with review. She referred to the SG and reminded the panel that the purpose of a sanction is not to be punitive but to protect the public, although sanctions may have a punitive effect on registrants.

Ms Paterson reminded the panel that any sanction imposed should be proportionate and balance Ms Mortley's rights with the public interest. However, she submitted that

as set out in *Bolton v The Law Society* [1994] WLR 512 the reputation of the profession is more important than the fortunes of any individual member.

Ms Paterson submitted that there were mitigating factors in the case. This was a one-off and isolated incident that may have been opportunistic or spontaneous. She also submitted that Ms Mortley had made admissions and expressed remorse at a local level. In terms of aggravating features, she submitted that the dishonesty was linked to her clinical practice, that her actions put a vulnerable patient at unwarranted risk of harm and that Ms Mortley had shown limited insight.

Ms Paterson submitted that the options of taking no further action or imposing a caution order are not suitable where the nurse presents a continuing risk to patients. She submitted that this would not protect the public or uphold the public interest. Ms Paterson submitted that whilst the panel found that the misconduct in this case was at the lower end of the spectrum, in considering the NMC's guidance on sanctions for serious cases involving dishonesty, it says that not all dishonesty is equally serious but because of the importance of honesty to a nurse's practice, it will always be serious.

Ms Paterson submitted that the panel should not only consider that the incident was a *'one-off incident',* but also the panel needs to consider that there is a risk to vulnerable patients involved in this case.

Ms Paterson submitted that conditions may have been appropriate if there was evidence that Ms Mortley would be willing to engage with support and conditions. She submitted that as a result of the very limited engagement from Ms Mortley in these proceedings, there is nothing to demonstrate a willingness to comply and therefore conditions would not be workable in these circumstances.

Ms Paterson submitted that a striking-off order would be disproportionate in light of the panel's findings, and that Ms Mortley's misconduct was not fundamentally incompatible with remaining on the register.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Ms Mortley exposed a vulnerable patient to an unwarranted risk of harm

In relation to mitigating factors, the panel has considered the following as relevant:

- Ms Mortley's conduct was an isolated incident
- Ms Mortley made admissions to the regulatory concerns during the local investigation and also expressed remorse for her behaviour.
- Ms Mortley's lack of competence was known to her employer, but there was no evidence that she had been provided with any additional support or training.

The panel first considered whether to take no action but concluded that this would be wholly inappropriate in view of the circumstances of the case. The panel decided that it would be inconsistent with its earlier findings at the impairment stage of these proceedings to take no further action. It determined that it would not be appropriate or proportionate to take no further action having regard to the public protection 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 decided that it would not be

appropriate or proportionate to impose a caution order, taking account of the outstanding public protection concerns.

The panel next considered whether placing a conditions of practice order on Ms Mortley's 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 took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel considered, having regard to Ms Mortley's comments at the local disciplinary meeting and her recent email to the NMC, that she would be willing to comply with conditions of practice.

The panel had regard to the fact that it had no evidence of repetition identified. The panel was of the view that it was in the public interest that, with appropriate safeguards, Ms Mortley should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the particular circumstances of Ms Mortley's case, given that this was a clinical concern that can be addressed through training.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> 'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must undertake training in the following areas of practice:
   a) Medicine administration
   b) Management and escalation of any medication error or queries, and
   c) Record keeping.

2. You must ensure that you are supervised by a registered nurse when administering and recording medication any time you are working as a registered nurse, until such time as you are assessed by another registered nurse as being competent.

3. You must send the NMC a report seven days in advance of the next NMC hearing or meeting from either:

   - Your line manager.

- Mentor or supervisor

Containing details of your compliance with these conditions.

4. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

5. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

6. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).
   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
   e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

7. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months to allow sufficient time for Ms Mortley to secure employment and undertake the required training and reflection.

Before the order expires, a panel will hold a review hearing to see how well Ms Mortley has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Engagement with the NMC and attendance at the review hearing
- Evidence of training in the relevant areas
- Testimonials from Ms Mortley's employer and work colleagues
- A detailed reflective piece covering the impact of her behaviour on patients, colleagues and the wider public.

This will be confirmed to Ms Mortley in writing.

Interim order

As the conditions of practice 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. It 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 conditions of practice order takes effect.

Submissions on interim order

Ms Paterson invited the panel to impose an interim conditions of practice order for a period of 18 months. She submitted that this interim order is necessary on the grounds of public protection.

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 on the sole ground of public protection. The panel had regard to the seriousness of Ms Mortley's conduct, 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 be appropriate and proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. Owing to the seriousness of the misconduct in this case, it determined that Ms Mortley's actions were sufficiently serious to justify the imposition of an interim conditions of practice order until the substantive conditions of practice order take effect.

The panel concluded that the only suitable interim order would be that of an interim conditions of practice order, in the same terms, as to do otherwise would be incompatible with its earlier findings.

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

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order, 28 days after Ms Mortley is sent the decision of this hearing in writing.

That concludes this determination.