Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 29 January 2024 – Wednesday, 7 February 2024

Virtual Hearing

Name of Registrant:	Deborah Helen Douglas
NMC PIN	05I1660S
Part(s) of the register:	Registered Nurse Sub Part 1 RNA Adult Level 1 (24 November 2008)
Relevant Location:	Fife
Type of case:	Misconduct
Panel members:	Caroline Rollitt (Chair, lay member) Catherine Devonport (Registrant member) Shaun Donnellan (Lay member)
Legal Assessor:	Robin Leach (29 January – 2 February 2024) Fiona Moore (5 – 7 February 2024)
Hearings Coordinator:	Clara Federizo
Nursing and Midwifery Council:	Represented by Arthur Lo, Case Presenter
Mrs Douglas:	Present and represented by Sophie Walmsley, instructed by the Royal College of Nursing (RCN)
No case to answer:	Charges 1a, 1b, 1c, 2b, 2d and 2f
Facts proved by admission:	Charges 1d, 2a, 2c, 2e and 2g
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge

That you, a registered nurse at IC Beauty Aesthetics Ltd:

1. Between 21 October 2020 – 15 November 2020:

    a. Failed to ensure that a face-to-face consultation had taken place between Patient A and the prescriber prior to administering Botulinum Toxin; **[NO CASE TO ANSWER]**

    b. Failed to explore Patient A's medical conditions prior to administering Botulinum Toxin; **[NO CASE TO ANSWER]**

    c. Failed to provide Patient A with sufficient information about the risks/benefits of treatment prior to administering Botulinum Toxin; **[NO CASE TO ANSWER]**

    d. Reused a vial of Botulinum Toxin against the manufacturer's guidance when administering a 'top-up' treatment to Patient A. **[ADMITTED]**

2. Between 21 October 2020 – 22 November 2020, failed to record either properly or at all on Patient A's Care Record:

    a. your initial consultation with Patient A; **[ADMITTED]**

    b. Any consultation/conversation between Patient A and the prescriber; **[NO CASE TO ANSWER]**

    c. any conversation with Patient A regarding their medical conditions; **[ADMITTED]**

    d. That you had discussed with Patient A, the risks and benefits of treatment; **[NO CASE TO ANSWER]**

    e. The top-up Botulinum Toxin dose administered; **[ADMITTED]**

    f. Aftercare advice; **[NO CASE TO ANSWER]**

    g. Communications with Patient A seeking aftercare advice and support. **[ADMITTED]**

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

Background

The charges arose as you were referred to the Nursing and Midwifery Council (NMC) on 23 March 2021, by Witness 1, an inspector at NHS Healthcare Improvement Scotland (HIS). You were formerly the owner of IC Beauty Aesthetics Ltd, mainly providing treatments such as Botox and Derma fillers.

Witness 1 undertook a local investigation following a formal complaint made by Patient A, after the scarring she suffered on her face post-Botox treatment. There were concerns raised regarding your alleged failing to record the care you provided to Patient A and allegedly did not provide any after care advice. The other main concern was that you allegedly failed to conduct a face-to-face consultation with Patient A as required.

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

At the outset of the hearing, Ms Walmsley made a request on your behalf that this case be held partly in private on the basis that proper exploration of your case involves some references to your mental health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Lo, on behalf of the Nursing and Midwifery Council, did not object to the application.

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

The panel determined to go into private session in connection with any reference to your health as and when such matters are raised in order to protect your privacy in these proceedings.

Decision and reasons on application to admit hearsay evidence of Witness 2

The panel heard an application made by Mr Lo under Rule 31 to allow the exhibit pertaining to the witness statement of Witness 2 in as hearsay evidence.

Mr Lo submitted that the evidence is highly relevant as it concerns a telephone conversation between Witness 2, who was the NMC Senior Investigator in relation to the initial referral, and Patient A. He submitted that this may address whether you have taken accurate medical history of the patient and the nature of engagements with the prescriber, which are relevant to the charges alleged.

Mr Lo submitted that the contents of the exhibit is not sole or decisive evidence as it primarily corroborates what is set out in Witness 1's local investigation into the events, which is also otherwise supported by other documentary evidence.

Ms Lo also submitted that despite the NMC's efforts to secure the attendance of Patient A, they do not wish to engage further with proceedings, however, Witness 2 would be in attendance to provide evidence before the panel. He submitted that there is no reason for Witness 2 to fabricate evidence or allegations against you, Witness 2 simply recorded a note of a telephone conversation with Patient A. He also submitted that, on balance, any potential prejudice against you in allowing this evidence would be limited as a result of Patient A's non-attendance, and as Witness 2 can be cross-examined.

Mr Lo invited the panel to allow the telephone notes and emails of Witness 2 to be admitted into evidence as it is relevant and fair to do so.

Ms Walmsley opposed the application on your behalf. She submitted that the evidence would not be relevant as Witness 2 is not a direct witness as opposed to Patient A, to be able to provide evidence on the alleged charges. Further, she submitted that this evidence would be sole and decisive in relation to charges 1a, 1b and 1c, and would be *'multiple handed hearsay'*. She submitted that it would be unfair to admit the evidence of Witness 2 given Patient A's non-attendance and considering there is no witness statement produced or signed by them.

Ms Walmsley submitted that a significant period of time has passed between the alleged event in October/November 2020 and the telephone note being taken on 4 May 2022. Further, she submitted that the telephone note appeared to be a summary from Witness 2 of what was discussed and not a verbatim record of the call, so there is no certainty of its accuracy or if there is any fabrication of information. She also submitted that when the note was produced, it was not designed to be Patient A's witness statement. Finally, she submitted that this evidence would prejudice you as although Witness 2 is present, the content of the evidence is from Patient A, which cannot properly be challenged. She submitted that there is no information provided that constituted a good reason for Patient A's non-attendance. The response by Patient A suggested that they appeared to disengage later on in correspondence. She submitted the charges are so serious that it would adversely affect you if they were found to be proved on this basis.

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 provides that, so far as it is *'fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

In reaching this decision, the panel carefully considered the guidance provided by the NMC, Rule 31 and relevant case law referred to including *Thorneycroft v NMC* [2014] EWHC 1565 (Admin).

The panel was of the view that the evidence produced by Witness 2 was very relevant as it relates to charge 1. It noted that some of Witness 2's evidence was *'multiple hearsay'* as she was not a direct witness to the alleged events and was simply reporting on what Patient A had said on the phone. It accepted there is no reason for Witness 2 to fabricate evidence on this basis.

The panel was of the view that the evidence was not sole or decisive as this exhibit merely corroborates the evidence of the primary witness, Witness 1, who is capable of being

challenged, as well as other documentary evidence which speaks to the alleged charges before the panel.

The panel had regard to the principles in *Thorneycroft*, see paragraph 45, particularly:

> *"1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability."*

The panel had regard to the dates and recognised that the consultation took place on 29 October 2020 and the telephone note is dated 4 May 2022. Further, it acknowledged that the note was a summary by Witness 2's perception and not a transcript of the phone call. It also noted that what is written on the telephone note had not been verified by Patient A, it has not been signed and there is no information to suggest whether they agree that this is an accurate record of the phone call. Due to the concerns raised regarding the passage of time and the note's accuracy, the panel could not be satisfied that the evidence was demonstrably reliable.

Although Witness 2 is due to provide evidence before the panel and can be cross-examined, the panel recognised that in essence the evidence is that of Patient A. As the last correspondence was made in September 2023, it determined that the NMC could have made further efforts to secure Patient A's attendance or establish a reason for not being able to. The panel determined that there was limited information as to the reasons for Patient A's non-attendance and no good reason could be established on the information available. The panel noted that the witness could not be cross-examined properly and may result in unfairness towards you. It bore in mind the seriousness of the charges alleged and the adverse effect it would have on you if these were proven.

In these circumstances, the panel determined that although the evidence may be relevant, it would be unfair to admit the hearsay evidence. It therefore refused the application.

Witness evidence

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

- Witness 1: Inspector at NHS Healthcare Improvement Scotland.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Walmsley that there is no case to answer in respect of charges 1a, 1b, 1c, 2b, 2d and 2f. This application was made under Rule 24(7).

In relation to this application, Ms Walmsley made the following submissions orally and in writing:

1. *"[…]*

2. *At the time of these alleged events, the Registrant owned and operated an aesthetics business which was suitably and properly registered. The Registrant would arrange and provide aesthetic treatments which included Botox and filler. As the Registrant was not a nurse prescriber, and in order to comply with the requirements for registration, she retained a nurse prescriber.*

3. *In relation to the incident in question, regarding Patient A, it is alleged that there was a failure on the part of the Registrant to ensure there was a face-to-face consultation with Patient A. In response to the same, the following is submitted:*

    a. *The Registrant met with Patient A, face-to-face, in her clinic on 21st October 2020;*

    b. *The Registrant and Patient A discussed treatment options and thereafter the Registrant discussed the matter with the nurse prescriber;*

c. *Due to the incidence of the Covid-19 pandemic, it was agreed with the nurse prescriber that the consultation could take place remotely;*

d. *The nurse prescriber took Patient A's medical history, in which, no medical conditions were noted (p4 and 5 of the Exhibit bundle);*

e. *Patient A has denied ever speaking with the nurse prescriber, a matter which seems to be patently incorrect;*

f. *The Registrant neither was nor held herself out to be a nurse prescriber;*

g. *Any failure to arrange a face-to-face consultation between the prescriber and the patient was not the responsibility of the registrant;*

h. *It is not alleged nor set out in any sufficient detail in the evidence or charges how it is said this was the responsibility of the Registrant, nor how it was the Registrant's sole responsibility, nor what steps the Registrant should have otherwise taken;*

i. *The Registrant fundamentally objects to Charge 1(a) on the following grounds:*

    i. *It is improperly constituted;*
    ii. *It is not fully particularised;*
    iii. *The Registrant is unaware of the nature or extent of the charge she is being asked to respond to;*
    iv. *In any event, it is denied the same would amount to misconduct or impairment on the part of the Registrant;*
    v. *Charge 1(a) as formulated gives rise to fundamental and procedural unfairness in the circumstances;*
    vi. *No amendment should be permitted and, in any event, the same is beyond rectification by any amendment.*

4. *As for the submissions of no case to answer, the panel is respectfully referred to the following:*

    a. *DMA-6;*
    b. *R v Galbraith [1981] 1 WLR 1039.*

5. *The Registrant will contend that, following the evidence submitted on behalf of the NMC, there is insufficient evidence either for the facts to be found proved in relation*

to charges 1(a)-(c) and/or that the Registrant's fitness to practise could be found to be impaired.

6. *The Respondent will respectfully submit:*

    a. *Charges 1 (b) and (c) as drafted require the panel to find the very fact of whether the Registrant explored the patient's medical history and whether or not she gave sufficient information about the risks and benefits about Botox. The charge is not formulated by reference to the adequacy of documentation as compared with charge 2.*

    b. *The NMC is reminded that the burden of proof rests with the NMC.*

    c. *The fact of whether those matters were explored, and the information given cannot be commented on by the NMC's sole witness, [Witness 1], as she was not present in the consultation. She cannot therefore comment on what discussions took place nor the extent of those discussions, a fact which the witness reasonably accepts.*

    d. *The documentation provided and relied upon by the NMC simply cannot establish whether such matters were not, as a matter of fact, explored or provided.*

    e. *There is no evidence, from Patient A about the consultation which is capable of being tested by the Registrant or the panel or that would support these charges. Nor is there any formal evidence from the nurse prescriber about the extent of discussions that took place. The only evidence which can reasonably be put before the panel on the charges is from the Registrant herself, which at this time cannot be considered.*

    f. *The fundamental question is whether on the evidence provided by the NMC this would be sufficient, when taken at its highest, of resulting in those very facts being found proved. Quite plainly, they cannot.*

    g. *In any event, it is submitted that the same could not reasonably amount to a finding of misconduct in the same circumstances and for the reasons explained above.*

7. *As for charge 1(a) and the submission of no case to answer, it will be submitted as follows:*

a. *The NMC evidence as it stands is insufficient to establish that the same would amount to misconduct when taken at its highest.*

b. *The Registrant will draw the panel's attention to the relevant evidence provided by the witness for the NMC and exhibited.*

c. *In her oral evidence, [Witness 1] agreed that the regulations she referred to did not explicitly address the remote prescribing of medications. She inferred that Regulation 12(b) of the HIS Regulations would encompass the same. On further questioning she was unable to refer to any specific guidance about the same beyond that she believes the information may have been published online. She was unable to assist with whether she was aware of any changes in the guidance due to the prevailing pandemic.*

d. *It is not disputed, and has never been disputed, that there was no face-to-face consultation between the nurse prescriber and patient A. However, the Registrant will aver that this does not connote to or amount to misconduct on her part, or that she had a duty that was equivalent or more than that to which the nurse prescriber owed.*

e. *The applicable guidance put before the panel and discussed in evidence very carefully delineates between the duties and standards of prescribers and those who are administering medications.*

f. *In addition, the guidance referred to is contradictory, the NMC "useful information for prescribers" which is purported to have been on their website in September 2020 provided:*

   "This applies to all forms of prescribing, including remote prescribing; and to all medicinal products, including non-surgical medicinal products being used for cosmetic and aesthetic purposes, such as Botox… All prescribers must take individual responsibility for their prescribing decisions and should recognise that there are certain areas of practice where remote prescribing is unlikely to be suitable, for example when prescribing medicines likely to be subject to misuse or abuse, or injectable cosmetic treatments.

   We recommend that it is good practice for face-to-face consultations to take place before prescriptions are issued in the cosmetic context."

g. *Whereas the JCCP guidance indicates:*

   "The JCCP does not therefore endorse or permit the use of remote

prescribing of injectable, topical or oral prescription medication for non-surgical cosmetic treatments in any circumstances. Examples of this include the off-label use of adrenaline when applied topically, to enhance pain control and limit bleeding. The JCCP reminds all prescribers of the need to carry out a physical examination of patients before prescribing injectable prescription only cosmetic medicines. Prescribers must not therefore prescribe such medicines by telephone, video link, online or at the request of others for patients whom they have not examined personally." (emphasis added)

h. *The JCCP guidance refers to the same being shared with and by the GMC and the GDC but does not confirm the same was accepted/endorsed by the NMC at that time. It is unclear if, or when, this may have happened on the available evidence.*

i. *Much of the guidance, aside from the JCCP guidance, does not explicitly address the remote prescribing of non-surgical cosmetic treatments. The JCCP guidance refers to the prescriber and the role of prescribers. It is an accepted and incontrovertible fact that the Registrant was not a prescriber.*

j. *In the circumstances, it is averred that the failure to ensure there was a face-to-face consultation rested with the prescriber.*

k. *In the circumstances, it is submitted that the evidence when taking at its highest could not result in it being found that the registrant's fitness to practice is impaired.*

8. *In relation to the other applicable charges, the Registrant will aver as follows:*

a. *There is no case to answer in relation to charge 2(b), the Registrant held and has provided evidence of the documentation provided by the nurse prescriber. The Registrant also documented that there had been a discussion with the nurse prescriber as shown by the exhibit in the Registrant's bundle p8. The Registrant avers that the details of the discussion between the prescriber and the patient also rested with the prescriber.*

b. *There is also no case to answer in respect of charge 2(d), as evident from the evidence of [Witness 1] she is unable to confirm what information was orally relayed to the patient. It will be submitted that the tenet of [Witness 1]'s evidence was that the information booklets alongside verbal information was likely to be sufficient regarding the risks and benefits of the procedure. The risks and benefits are quite clearly set out in the documentation held.*

Booklets provided to the patient also explained the same, ancillary to that, there is no reliable evidence before this panel that the same was not relayed and/or provided to patient A.

c. *For the same reasons as set out above, there is no case to answer in respect of charge 2(f). The Registrant will rely on the evidence of the informative booklet and leaflet provided and confirmation in the available records that the same was provided to the patient. Again, the Registrant would submit that due to the absence of evidence from Patient A the evidence of the NMC is not sufficient to establish this charge or that the same would amount to impairment.*

9. *For the reasons stated above and to be expanded upon in oral submissions the Registrant invites the panel to find there is no case to answer on the above charges."*

In response, Mr Lo submitted the following submissions orally and in writing:

1. *"Where a registrant makes a submission of no case to answer at the close of the Council's case, the legal principles which the Panel should apply are those set out in R v Galbraith [1981] 1 WLR 1039 at 1042, as well as the Guidance DMA-6 within the Council's Fitness to Practice Library. In summary, there will be no case to answer for the registrant where there is:*

   (1) No evidence in support of an allegation; or

   (2) There is some evidence, but the evidence which, when taken at its highest, could not properly result in a fact being found proved against the registrant's fitness to practice being impaired.

2. *Where a submission of no case to answer is based on the second limb of the Galbraith test, the Panel may also consider the principles set out in GMC v Udoye [2021] EWHC 1511 (Admin) at paragraphs 93-103. Analysing the relevant past authorities, Mr Justice Holgate held that the correct test is whether there is evidence on which the factfinders, properly directed, could infer guilt. The focus is on what a reasonable factfinder could do when making her determination. If the situation is such that no reasonable jury could convict, the case should be stopped. As he states at paragraph 99, the key question is whether, "on one possible view of the evidence, there is evidence upon which a reasonable tribunal, not all reasonable tribunals, could find the matter proved when making the final adjudication. If the answer is yes, then there is a case to answer."*

3. It follows therefore that the threshold which the Registrant must meet in making this submission is a high one. In order to find no case to answer under limb 2, the Panel must satisfy itself that the evidence adduced by the Council is so inadequate that no reasonable Panel could find the facts to be proven.

CHARGE 1a

Failed to ensure that a face to face consultation had taken place between Patient A and the prescriber prior to administering Botulinum Toxin;

4. A part of the NMC's Prescribing Standards is a section titled 'Useful Information for Prescribers', which can be located on the NMC's website. As extant in September 2020, this guidance contains the following passage:

> *All prescribers must take individual responsibility for their prescribing decisions and should recognise that there are certain areas of practice where remote prescribing is unlikely to be suitable, for example when prescribing medicines likely to be subject to misuse or abuse, or injectable cosmetic treatments.*
>
> *We recommend that it is good practice for face to face consultations to take place before prescriptions are issued in the cosmetic context.*

5. Per the JCCP Guidance Statement – Responsible Prescribing for Cosmetic Procedures (Exhibit 6) at page 2 –

> *"Legislation does not provide a requirement to the legal enforcement of face to face consultation, however, in line with the guidance set down by several Professional Statutory Regulators (the General Medical Council and the General Dental Council and in accordance with guidance set down by the Royal Pharmaceutical Society), the JCCP and the CPSA (The Cosmetic Practice Standards Authority) have set down their decision not to endorse or permit the remote prescribing of any injectable prescription medicine and medical device when used for non-surgical cosmetic procedures. When the prescriber delegates the procedure to other practitioners, then the JCCP reminds the prescriber that the duty of care for the patient remains with the prescriber and the decision to prescribe must be compliant with the MHRA regulations and the Professional Statutory Regulatory Body guidance on remote prescribing. For the avoidance of doubt this guidance applies to the routine/planned administration of medicines or medical devices which are used for non-surgical cosmetic procedures, such as, but not limited to,*

botulinum toxins, injected local anaesthetic, dermal fillers…Prescribers must not therefore prescribe such injectable medicines and devices for non-surgical cosmetic use by telephone, video link, online, at the request of others, for patients whom they have not examined personally 'face-to-face'.

6. *In live evidence, when asked about whose responsibility it was to ensure that the prescribing standards were adhered to, [Witness 1] answered that this applied jointly to both the Registrant, as the primary service provider, as well as the prescriber. It is therefore misconceived to create an artificial division between the scope of their respective responsibilities, in this scenario. They both owed a duty of care to the patient.*

7. *It is common ground that the Registrant did not arrange for a face-to-face consultation between the Prescriber and Patient A.*

8. *In the circumstances, there is clearly sufficient evidence for the Panel to make a positive finding of fact in relation to charge 1a. The key issue in respect of this charge is whether, in light of the circumstances presented by COVID, the Registrant's deviation from best practice could give rise to a finding of misconduct or impairment. It is a matter for the next stage of these proceedings.*

CHARGE 1b

Failed to explore Patient A's medical conditions prior to administering Botulinum Toxin;

9. *In the Council's submission, the substance of this charge goes beyond a pro forma filling in of medical history forms. As part of the Registrant's duty of care and to act in Patient A's interest, the Registrant ought to have proactive taken steps to ensure that she had a good understanding of Patient A's medical history, prior to treatment being administered. Per [Witness 1] in live evidence, it is imperative that, before treatment is administered, the practitioner knows whether the patient is suffering from any pre-existing condition, contraindications and any medicine which she is already on.*

10. *It is common ground that, in the medical history form filled in by the prescriber on 21 October 2020, during the initial consultation, the boxes for asthma and depression were both circled 'no' [4]. According to Patient A, she mentioned the fact that she had asthma during the initial consultation [32].*

11. *However, in the medical consent form for Botox which the Registrant submitted on 29 October 2020, the day of the treatment, she ticked 'yes' for both asthma and depression [8].*

12. *The Registrant did not know until 25 November 2020 that Patient A has a history of asthma [14]. In other words, in spite of the medical consent form, the Registrant was unaware of this at the time of treatment.*

13. *Even if, and it is not agreed, that Patient A made no mention of asthma during the initial consultation of 21 October 2020, a prudent and diligent practitioner should have:*

    (a) Read the medical consent form dated 29 October 2020 carefully, prior to treatment being administered; and -

    (b) Upon discovering the discrepancy in the contents of the two medical history forms, asked further questions in order to ensure that she had an accurate medical history.

14. *As set out above, the substance of this allegation is not that the Registrant failed to fill in a medical history form; to 'explore' a patient's medical history goes further than that. It implies making sure that the practitioner has a good understanding of pre-existing conditions before administering treatment. This includes taking proactive steps to ensure that the medical history which one has on hand is correct, upon being apprised of a potential discrepancy between two medical history forms. Accordingly, there is sufficient evidence to a reasonable panel to find that the Registrant has failed to explore Patient A's medical conditions.*

CHARGE 1c

Failed to provide Patient A with sufficient information about the risks/benefits of treatment prior to administering Botulinum Toxin.

15. *It is acknowledged that Patient A was provided with a consent form, which she signed. This form contains information pertaining to the course of Botox treatment, and that above the signature line is an acknowledgment that she has been provided with sufficient information about the treatment detailed for her to make an informed decision [7].*

16. *However, it is submitted that the duty of the practitioner goes further than to simply presenting the patient with the information contained within the template booklet. As [Witness 1] emphasised, this was the first time Patient A received cosmetic treatment of this nature. Accordingly, it was incumbent upon the Registrant to proactively ensure that Patient A was fully aware of the risks.*

17. *Per [Witness 1]'s live evidence, when she interviewed Patient A, whilst the latter could remember receiving a booklet from the Registrant, she struggled to recall the information contained within. This suggests that the Registrant had not gone over the contents of the booklet with her at the time of the initial consultation, especially if, supposedly, she had to allow the prescriber to take her medical history on the same occasion. According to Patient A, this meeting lasted for a mere 10 minutes [62]. Per [Witness 1]'s witness statement at paragraph 16, there is no evidence that the Registrant had discussed the risks and benefits of treatment with the patient.*

18. *In the circumstances, the Council submits that a reasonable panel is capable of finding the charge to be proven, given the evidence which is available."*

Further, in respect of charge 2b, Mr Lo submitted that there are no comprehensive notes taken of the conversation between Patient A and the prescriber. He submitted there are only substantive documents which arose as a result of that discussion (the first medical history form), which appears to be erroneous. He submitted there is limited information about was discussed and this had not been properly documented by you, when it should have been, for you to understand Patient A's medical history before treatment and accurately reflect it in their patient records. Therefore, there is sufficient evidence to demonstrate a failure.

In respect of charge 2d, he submitted that you failed to record properly or at all whether you discussed the risks and benefits of treatment with Patient A. He submitted that the charge does not read that you failed to give her a treatment booklet, there has to be some effort on your part, as the practitioner, to proactively ensure that the patient understood the risks and benefits of treatment. He submitted that we have no information as to the scope of the discussion you may have had with Patient A in this regard, as you did not properly or at all record this, only that a booklet was given. Therefore, there is sufficient evidence to demonstrate a failure.

And finally, in respect of charge 2f, regarding aftercare advice, he submitted that Witness 1 states in her witness evidence that apart from an entry on the 31 October 2020, the day of treatment, there were no other entries in Patient A's care record, which means there was no record of aftercare advice. He submitted that 'after care contact' between you and Patient A was during conversations which took place by text messages and therefore,

these were not fully documented in accordance with your professional standards of practice and behaviour for nurses. It is not sufficient that you had screenshots of potential aftercare advice via social media platforms, further entries should have been properly recorded on Patient A's care records. Therefore, there is sufficient evidence to demonstrate a failure.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer in respect of the aforementioned charges. It considered the NMC guidance (DMA-6) and the relevant case law it was referred to, particularly *Galbraith*.

Charge 1 (a)

"That you, a registered nurse at IC Beauty Aesthetics Ltd:

1. *Between 21 October 2020 – 15 November 2020:*

   a. *Failed to ensure that a face to face consultation had taken place between Patient A and the prescriber prior to administering Botulinum Toxin;"*

The panel took into account the wording of the charge in that it alleges a *'failure'*. It noted that this meant there must be a duty on you to ensure that a face-to-face consultation had taken place between Patient A and the prescriber, between 21 October 2020 and 15 November 2020, prior to you administering Botulinum Toxin.

The panel heard oral evidence from Witness 1 that the duty to arrange a face-to-face consultation was a *'joint responsibility'* between the prescriber and you, as the main service provider.

The panel had regard to the policies, including NMC guidance on *'Standards for Prescribers - Useful Information for Prescribers'* and the *'JCCP Guidance Statement – Responsible Prescribing for Cosmetic Procedures'*. It acknowledged that these policies establish that it is good practice for face-to-face consultations. However, it noted that the documentary evidence indicates that this duty is on the prescriber and does not suggest a *'joint'* responsibility. There was no documentary evidence put before the panel that demonstrates there was a duty on you to arrange a face-to-face consultation between Patient A and the prescriber.

The panel determined that there was insufficient evidence put before the panel on this charge. Accordingly, the panel finds there is no case to answer on this charge.

Charge 1 (b)

1. *"Between 21 October 2020 – 15 November 2020:*

    b. *Failed to explore Patient A's medical conditions prior to administering Botulinum Toxin;"*

The panel took into account the wording of the charge in that it alleges a *'failure to explore'*. It had regard to Patient A's complaint email to HIS on 30 November 2020, the consent and medical history form, dated 29 October 2020 and Witness 1's 'Evaluation of Patient A's Patient Care Record', as well as the NMC and JCCP guidance.

The panel heard oral evidence from Witness 1 that you, as a practitioner, had a duty of care and were to act in Patient A's interest. It is important that prior to treatment, you, as the practitioner should ensure you have an understanding of whether the patient is suffering from any pre-existing condition, contraindications, and any medicine they may be taking.

The panel had regard to the text message correspondence between you and Patient A, as well as Patient A's email complaint to HIS. The panel noted that Witness 1 was unable to comment further on this evidence as she was not present at the time. The panel noted that

there was no witness statement from Patient A, and they were not present to provide oral evidence before the panel. Such crucial evidence may have assisted the panel in assessing the nature of any conversations that took place between you and Patient A.

The panel noted that the consent form, dated 29 October 2020, stated:

"I confirm that [Debbie Douglas] my treating practitioner has:

- *Provided me with sufficient information about the treatment detailed overleaf in order to make an informed decision*
- *Given me the opportunity to ask all remaining questions I may have about the treatment, and has answered them to the best of their ability*
- *Given me the time to consider the treatment detailed overleaf*
- *Received the relevant medical history information from me to the best of my knowledge*

I therefore consent to receiving the described treatment by my treating practitioner."

The panel noted that this was signed by Patient A.

The panel determined that the evidence which suggests there was a *'failure to explore'* was tenuous. It noted that the charge was not particularised and that the term *'explore'* was vague.

The panel determined that there was insufficient evidence put before the panel on this charge. Accordingly, the panel finds there is no case to answer on this charge.

Charge 1 (c)

1. *"Between 21 October 2020 – 15 November 2020:*

    c. *Failed to provide Patient A with sufficient information about the risks/benefits of treatment prior to administering Botulinum Toxin;"*

The panel took into account the wording of the charge in that it alleges a *'failure to provide sufficient information'*, it took into account the NMC and JCCP guidance as above.

The panel had regard to Patient A's complaint email to HIS on 30 November 2020 and the consent and medical history form, dated 29 October 2020. The panel noted that the consent form stated:

"I confirm that [Debbie Douglas] my treating practitioner has:

- *Provided me with sufficient information about the treatment detailed overleaf in order to make an informed decision*
- *Given me the opportunity to ask all remaining questions I may have about the treatment, and has answered them to the best of their ability*
- *Given me the time to consider the treatment detailed overleaf*
- *…*

I therefore consent to receiving the described treatment by my treating practitioner."

The panel noted that Patient A signed and dated the consent form above and therefore agreed that the statements were true. It determined that the evidence which suggests there was a failure was tenuous, and Patient A was not present to further expand on it.

The panel determined that there was insufficient evidence put before the panel on this charge. Accordingly, the panel finds there is no case to answer on this charge.

Charge 2 (b)

2. *"Between 21 October 2020 – 22 November 2020, failed to record either properly or at all on Patient A's Care Record:*

    b. *Any consultation/conversation between Patient A and the prescriber;"*

The panel recognised that the wording of the main limb of charges 2a-g concerned alleged failures to record activity on 'Patient A's Care Record'. This was referred to by Witness 1. However, the panel determined that there was no single document titled 'Patient A's Care Record' and so relied upon a number of other documents produced which did appear to document Patient A's treatment.

It noted there was no record of any consultation or conversation between Patient A and the prescriber.

As the charge alleges a *'failure to record'*, the panel had regard to the policies put before it, including NMC guidance on *'Standards for Prescribers - Useful Information for Prescribers',* the *'High level principles for good practice in remote consultations and prescribing'*, the 'HIS (Requirements as to Independence Health Care Services) Regulations 2011' and the *'JCCP Guidance Statement – Responsible Prescribing for Cosmetic Procedures'*. The panel accepted that these outline a duty on the prescriber to record any consultation/conversation between them and Patient A, but there is no explicit duty on you to record this.

The panel determined that there was insufficient evidence put before the panel on this charge. Accordingly, the panel finds there is no case to answer on this charge.

Charge 2 (d)

2. *"Between 21 October 2020 – 22 November 2020, failed to record either properly or at all on Patient A's Care Record:*

    d. *That you had discussed with Patient A, the risks and benefits of treatment;"*

The panel had sight of the consent and medical history form dated 29 October 2020. It noted that under 'Advised consent', it states: *"I confirm I have been informed that:"* and is followed by information including the temporary improvement of appearance by using Botox, adverse reactions, side-effects, allergic reactions and risks of frequent or excessive use of Botox. It noted that at the bottom of this page, Patient A had signed and dated the form.

The panel considered that the wording of the alleged charge pertains to whether you *'discussed'* the risks and benefits of treatment with Patient A. The panel heard evidence from Witness 1, where she confirms that there is a duty as such discussions should take place between a patient and a practitioner prior to treatment but accepted that she does

not know what the discussions were between you and Patient A as she was not present at the time.

Whilst the panel had regard to the text message correspondence between you and Patient A, it noted that Patient A's attendance at this hearing would have been of assistance to the panel to further explore the nature of any conversations that took place before treatment. It determined that the evidence in support of this charge was tenuous.

The panel determined that there was insufficient evidence put before it on this charge. Accordingly, the panel finds there is no case to answer on this charge.

Charge 2 (f)

2. *"Between 21 October 2020 – 22 November 2020, failed to record either properly or at all on Patient A's Care Record:*

    f. Aftercare advice;"

The panel had regard to all the documentary and witness evidence before it. The panel considered your notes on Patient A's care records, which included some aftercare advice (the manufacturer's treatment book – see page 13 of the registrant's bundle). The panel had sight of the message exchange on social media between you and Patient A regarding post-treatment issues. The panel concluded there was no evidence to show that the record keeping was not done at all.

The panel carefully considered the word *'properly'* in relation to this charge. The panel has been given no assistance as to the meaning or definition of the word *'properly'.* The panel has concluded therefore that, whilst the record keeping could have been improved upon, there is insufficient evidence to show that the record keeping was not done properly.

The panel determined that there was insufficient evidence put before it on this charge. Accordingly, the panel finds there is no case to answer on this charge.

In respect of charges 1a, 1b, 1c, 2b, 2d and 2f, where the panel has found no case to answer, it follows that there is no finding of misconduct or impairment.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Walmsley, who informed the panel that you made full admissions to charges 1d, 2a, 2e and 2g. Additionally, during the course of the hearing, Ms Walmsley informed that you also admitted to charge 2c.

The panel therefore finds charges 1d, 2a, 2c, 2e and 2g proved in their entirety, by way of your admissions.

The panel also heard live evidence from you, under affirmation, and from the following witness called on your behalf:

- Witness 3: Staff Nurse and former colleague at Spire Murrayfield Hospital.

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 ability to practise safely, kindly and professionally.

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, your 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.'*

Mr Lo invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified specific and relevant standards where your actions amounted to misconduct. Mr Lo made the following submissions orally and in writing (introduction omitted):

"MISCONDUCT

3. Article 22(1)(a) of the Nursing and Midwifery Order 2002 provides for misconduct as one of the potential grounds for a finding that a registrant's fitness to practice is impaired.

4. Per Roylance v General Medical Council (No. 2) [2000] 1 AC 311, 'misconduct' is defined as a "word of general effect, involving some act or omission which falls short of what would be properly in the circumstances".

5. The Panel is invited to find that the facts found proven amount to misconduct, in light of the relevant provisions of The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2015) ('the Code'). It is submitted that the following provisions apply:

(a) In relation to charge 1d, this is contrary to paragraph 18 of the Code, which requires the Registrant to "Advise on, prescribe, supply, dispense or

administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations."

(b) In respect to charge 2a, c, e and g, the Council submits that the Registrant's conduct was contrary to paragraph 10 of the Code, which requires the Registrant to keep clear and accurate records relevant to her practice.

6. Breaches of the Code do not necessarily amount to misconduct. However, in this instance, the Council submits that the Registrant's conduct had fallen short of professional standards in a significant way:

(a) In respect of charge 1d, it was incumbent upon the Registrant to ensure that the manufacturer's guidelines were adhered to, in order to avoid the maintain sterility and reduce the risk of contamination [1st WS of [Witness 1] at para 14]. Notwithstanding the fact that there appears to be some scientific evidence indicating that the reconstituted Botox remains safe in such circumstances, a prudent practitioner would adhere to existing guidelines until they were changed by the manufacturer. The Registrant's conduct had thus placed Patient A at an unwarranted risk of harm.

(b) In relation to charge 2a, c, e and g, the Registrant's conduct had likewise placed the patient at an unwarranted risk of harm. If, as per subsequent events, the patient suffered from an adverse reaction following treatment, the lack of complete records would render it more difficult to reconstruct events and identify what went wrong than would ordinarily have been the case. The failure to record the top-up dose was a particularly serious omission from the perspective of patient-safety."

Ms Walmsley opposed the NMC's position and made the following submissions orally and in writing:

1. *"The following submissions are made in support of the Registrant's case, namely, that the actions do not amount to misconduct and/or that the Registrant's fitness to practice is not currently impaired.*

THE LAW ON IMPAIRMENT/MISCONDUCT

2. *The meaning of misconduct as defined in Meadow v GMC [2007] 2 W.L.R 286 is nothing less than "serious professional misconduct". In Roylance v GMC (No. 2) [2000] 1 A.C. 311 the essential element of misconduct was defined as follows:*

"misconduct involved some act or omission, falling short of what would be proper in the circumstances, which was linked to the profession of medicine, though not necessarily occurring in the carrying out of medical practice, and serious..."

And further at p331:

"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which would qualify. The professional misconduct must be serious."

3. *As stated by the courts, misconduct must be "serious professional misconduct", there is no definitive list of what would constitute misconduct and each case warrants consideration on its own merits. Examples of misconduct have included previous convictions, drug abuse, sexual impropriety etc. The Registrant seeks to highlight that not only must there be misconduct but that such misconduct must also be serious.*

4. *Also of assistance is the NMC guidance (FTP-2a). Key elements of the same are quoted below:*

   Because fitness to practise is about keeping people safe, rather than punishing nurses, midwives and nursing associates for past mistakes, one-off clinical incidents won't usually be considered serious professional misconduct.

   Even where there has been serious harm to a patient or service-user, provided there is no longer a risk to patient safety, and the nurse, midwife or nursing associate has been open about what went wrong and can demonstrate that they have learned from it, we will not usually need to take action."

Submissions on impairment

Mr Lo 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. 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). He submitted the following in relation to impairment:

"IMPAIRMENT

1. *If the Panel holds that, as a result of the facts found proven, the Registrant's actions amounted to misconduct, it must then proceed to decide whether her fitness to practice is impaired.*

2. *'Impairment' is not defined in legislation. Per the guidance 'Impairment' (DMA-6) in the NMC's Fitness to Practice Library, the key question is whether the Registrant is currently able to practice 'kindly, safely and professionally'. It is not the aim of fitness to practice proceedings to punish the Registrant for past failings.*

3. *Mrs Justice Cox noted in CHRE v NMC and Grant [2011] EWHC 927 (Admin) at paragraph 74 that:*

   "In determining whether a practitioner's fitness to practice 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 professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."

   At paragraph 76, she set out the following test:

   "Do our findings of fact in respect of the doctor's misconduct, deficient professional performance…show that his/her fitness to practice 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.*

4. *In relation to charge 1d, the Council submits that the first three limbs of the Grant test are engaged. It is acknowledged that this was a one-off incident. It is however of significant concern that the Registrant had not read the manufacturer's guidance in relation to the use and storage of reconstituted Botox in the course of her long practice in the aesthetic field, instead following the common practice of her colleagues within the industry. It was not until after the incident with Patient A that she perused the relevant guidelines. In the Council's submission, this constituted a very serious breach her duty to administer medicine safely in accordance with paragraph 18 of the Code, as set out above. She is not currently in a clinical position, but has not precluded returning to such a role in the future. The Registrant set out her insight into the nature of her error in respect of this sub-charge in her Reflective Piece; she has also read into relevant scientific literature on the storage and use of reconstituted Botox [Updated Registrant's Bundle, p.72-73]. In the Council's submission, whilst the Registrant's insight is significant, the Registrant's misconduct is of a serious nature and, as set out above, had the potential to cause harm to the patient. Accordingly, a finding of impairment is necessary on the ground of public interest, in order to uphold and declare professional standards, as well as to maintain the public's confidence in the nursing profession and the Council its regulator.*

5. *In relation to the sub-charges connected with record keeping, the Council submits that all three limbs of the test per paragraph 76 of Grant are engaged, and that the Registrant's fitness to practice is impaired for the following reasons:*

    (a) *As set out above, the failure to record properly her initial consultation with Patient A, her enquiries into her medical conditions, the top-up dose and communications concerning aftercare had the potential to result in patient harm. The patient experienced adverse reactions after the treatment, and the incomplete records hampered the ability of [Witness 1] to reconstruct what went wrong. The failure to record the top-up dose of Botox was particularly concerning from the standpoint of clinical safety.*

    (b) *Prior to the incident involving Patient A, the Registrant had previously been inspected by Healthcare Improvement Scotland ('HiS') for poor record keeping [1st WS of [Witness 1], para. This is indicative of a risk of repetition.*

    (c) *In respect of charge 2c, relating to conversations with the patient regarding her medical conditions, it is concerning that she failed to fully read the patient's medical history as set out in the Botox consent form before administering that treatment. Instead, having read the consent form for the filler treatment, she assumed that the two forms would not conflict. This was*

despite the fact that the two forms were not identical in terms of content, and that the filler form contains no box for 'asthma' [Updated Registrant's bundle at p.11]. In doing so, she failed to note the discrepancy between the two forms and did not become alert to the possibility that Patient A's self-reporting of her medical history could have been erroneous or unreliable. In the Council's submission, this was a serious error which could have resulted in patient harm.

(d) *In respect of insight, the Registrant acknowledges that her documentation at the time was not adequate and should have been far more robust. She states that she had overly relied upon the pre-printed template consent forms provided by the manufacturer ('the Allergan Forms'). The Council submits that this assertion is questionable. The Allergan Forms in respect of both fillers and Botox are not restrictive and are relatively open-ended in respect of the information which one could record [Updated Registrant's bundle at p.13]. There was no reason why information concerning the initial consultation and aftercare communications could not be written down in greater detail on the Allergan Forms. The Registrant has provided no specific explanation as to why she failed to record the top-up dose, which, as set out above, could potentially have resulted in patient harm. For these reasons, it is submitted that the Registrant has not yet demonstrated complete insight.*

(e) *In relation to remediation, it is acknowledged that she has undertaken remedial reading and training connected with record keeping. However, she does not appear to have engaged in any further training, reading or reflection concerned specifically with aftercare, the use of social media in communications with patients, or the keeping of records relating to this area of practice. As [Witness 1] pointed out, a patient's journey from initial consultation, treatment plan, aftercare advice and support as well as follow up treatment constitutes a 'flow', a continuing process. It is therefore concerning that the Registrant does not appear to have placed greater focus on reinforcing this area of her practice.*

(f) *Whilst the Registrant has stated that she is not at present in a clinical position, she does not rule out returning to a clinical role in the future.*

(g) *In the premises, in spite of the insight and remediation as set out in the Registrant's Reflective Piece and in live evidence, there remains some risk of repetition. The Panel is invited to find that the Registrant's fitness to practice is impaired on the ground of public protection.*

In addition, if the Panel makes the finding that the Registrant's insight or remediation remains inadequate, it is also invited to hold that a finding of impairment is otherwise necessary in the public interest. In this scenario, a reasonable member of the public would be concerned that the Registrant is able to practice freely without restrictions. A finding of impairment would therefore be necessary in order to declare and uphold standards, as well as to maintain public confidence in the profession and the Council."

Ms Walmsley also referred the panel to the case of Grant, the judgement of Mrs Justice Cox and the test of Dame Janet Smith, as well as the NMC guidance on 'Impairment' (DMA-1). She submitted the following in relation to impairment:

"SUBMISSIONS ON IMPAIRMENT

8. *The panel has heard evidence from [Witness 1] and the Registrant. The Registrant seeks to highlight the following as relevant to any determination on misconduct and/or impairment:*

    a. *In [Witness 1]'s evidence in chief, when asked about the reuse of the Botulinum Toxin vial to administer a top-up dose, [Witness 1] said words to the effect of, "it is a recommendation not a requirement, we expect practitioners to follow the manufacturers guidance in this case it says to be used within 24 hours, it says how it is to be diluted, would expect practitioners to follow this and suggest that after 24 hours this could affect the medicine."*

    b. *As for the documentation, the Registrant confirmed in her evidence that she used the forms and documents that she had been provided from the manufacturer Allergan. This was consistent with the training she received, and she considered that these documents were, in some respects, more comprehensive in detail as they had been drafted by the manufacturer.*

    c. *The Registrant had been trained and had undergone further courses at many times throughout her lengthy career. She acted in accordance with the training she had been provided.*

    d. *The Registrant had made enquiries about an online application which would allow for more detailed record keeping. Unfortunately, due to the*

incidence of covid-19 she was unable to implement these prior to Patient A's consultation.

e. *The Registrant has ceased working in the aesthetics industry since this incident and has no intention to return.*

f. *The inadequate record keeping would not, in the circumstances, amount to misconduct which by its nature is serious. It will be submitted this was an isolated incident in the Registrant's long career as a nurse.*

9. *The Registrant has been candid throughout these proceedings, having readily admitted in the investigation at the outset that her record keeping in relation to patient A was substandard.*

10. *The panel is invited to consider the nature of the allegations which concern one patient over a short period of time. Of note, the panel is also invited to consider the impact of covid-19.*

11. *The panel may consider that in a previous investigation there had been some reference to recordkeeping. The Registrant will urge the panel to exercise an abundance of caution in respect of the same for the following reasons:*

    a. *Any prior investigation has not formed part of these proceedings and does not form part of the charges which have been found proved; and*

    b. *There is no evidence in relation to the previous investigation capable of being tested and/or sufficiently considered; and*

    c. *There is no evidence before the panel as to the context nor implication of any previous inspection nor any comments made.*

12. *The Registrant had operated her aesthetics business since around 2009. In evidence, the Registrant confirmed she had prided herself on not having any issues nor complaints in this time. There is no evidence before this panel of any concerns arising from the Registrant's aesthetics business prior to the events of October 2020.*

13. *In addition, the Registrant practised as a registered nurse for many years, having qualified in 2008. Her experience included working in a clinical setting at the Spire Hospital. She has enjoyed a long and unblemished career and has not had any concerns raised about her documentation during this time.*

14. *It will be submitted on behalf of the Registrant that:*

    a. *There are numerous testimonials from previous clients who have commended and praised the Registrant's service and professional approach. Examples include Caroline Fagan (Registrant's bundle p76), Fiona Thompson (p29 and p35), Louise Paterson (p33) and Gillian Maitland (p75).*

    b. *The panel has heard evidence from [Witness 3], a nurse, who had previously worked with the Registrant. [Witness 3] in her evidence confirmed that in her experience the Registrant was knowledgeable and professional. She had experience of the Registrant's record-keeping and did not have any concerns regarding the same.*

    c. *The testimonial from one of the Registrant's previous prescribers, Kathryn Johnston who states, "Debbie is a very knowledgeable and experienced Aesthetic Practitioner and Nurse."*

    d. *The Registrant has taken steps to strengthen her practise since the events of October-November 2020, including her record-keeping, and has completed additional training and reading (p37).*

    e. *The Registrant in her current role within the ambulance service is audited very regularly i.e. 3 times per month, these audits are also completed on the Registrant's record-keeping and documentation. The pass rate is set at 98%. In the Registrant's 2.5 years of working in her current role she has only failed twice. Examples of the audits can be found at p38 and p39 of the Registrant's bundle.*

    f. *The Registrant has had no further concerns raised about her documentation or record keeping in her present role which she has been working in for over 2 years and without any restriction on her practise.*

    g. *The Registrant has provided supportive testimonials from her current colleagues. Anna Miles, Clinical Auditor/Educator has praised the Registrant's demeanour, knowledge, professionalism and judgment as seen at p30. She is also supported by the positive testimonial from Mrs Teresa Hardy, Clinical Support Desk Practitioner as at p34.*

15. *It will be submitted that the Registrant has demonstrated considerable insight. The Registrant readily accepted the relevant charges, has complied*

with the investigation and accepted her shortcomings in her documentation throughout the investigation. She has candidly given evidence to the panel and provided a detailed reflective statement considering her actions and what she has learned from these events. The Registrant has taken time to reflect upon her actions, considering her practise at the relevant time and has questioned and rectified her own practise.

16. *In addition, the Registrant, undertaken considerable reading around the issues, has undertaken further training and has implemented this in her current role for which she is enjoying considerable success.*

17. *With regard to the guidance at DMA-1 the Registrant will respectfully rely on the following:*

    The Fitness to Practise Committee's role is to consider whether the professional's fitness to practise is currently impaired. It's not the aim of fitness to practise proceedings to punish a professional for past events. Fitness to practise proceedings are a way for us to establish whether the professional is able to practise kindly, safely and professionally. There might be many situations where something that the professional did in the past gave cause for concern, but the Committee is satisfied that those concerns have now been put right. If the professional's present way of working no longer raises concerns, such as those based on patient safety or in the public interest, then the likelihood is that they can practise kindly, safely and professionally. This will mean their fitness to practise is unlikely to be impaired

18. *It will be submitted that the Registrant can practise kindly, safely and professionally, as she has evidenced over the previous 2.5 years. She is not likely to put patients at risk of harm, nor bring the profession into disrepute, nor to breach any of the fundamental tenets of the profession. The Registrant will submit that any such concerns have now been put right and that is she is not currently impaired."*

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance*, *Grant*, *Meadow v General Medical Council* [2006] EWCA Civ 1390, *Nandi v General Medical Council [2004] EWHC 2317 (Admin)* and *Cohen v General Medical Council* [2008] EWHC 581.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to relevant case law, the terms of the Code and exercised its own professional judgement.

The panel acknowledged that although there might be a broad distinction between your nursing practice in a clinical environment and your practice as an aesthetic practitioner, you were still fulfilling the role of a nurse, particularly in the administration of medication. Therefore, you were bound by the Code, just as you would be if practising as a nurse in a clinical setting.

Charge 1 (d)

The panel determined that your actions in charge 1d fell significantly short of the standards expected of a registered nurse, and that such actions amounted to breaches of the Code. Specifically:

> *'**18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations***
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***
> *To achieve this, you must:*
> *19.3 keep to and promote recommended practice in relation to controlling and preventing infection*
> *19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public'*

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

The panel had regard to Witness 1's evidence:

> *"…The implication on sterility for re-using a vial of Botox is that, unless the method of reconstituting precludes the risks of microbial contamination, then the product should be used immediately within 24 hours. The manufacturer will only assure physical and chemical stability for 24 hours if stored in a drugs fridge. The special product characteristics (SPC) states that each vial is for single use only. These vials are not multi dose vials."*

It also considered the oral evidence of Witness 1, which expanded on the risks of contamination and importance of sterility. It noted that Witness 1 stated that *"it is a recommendation not a requirement, we expect practitioners to follow the manufacturers guidance".*

Whilst the panel noted that you said that you acted in accordance with the training you were provided, the panel determined that reusing a vial of Botulinum Toxin contrary to the manufacturer's guidance is a serious matter. Your actions put Patient A at risk of harm by deviating from and neglecting the recommended practices for controlling and preventing infection. Cross-infection was possible from reusing reconstituted medication which had been stored for longer than the manufacturer's guidance. The panel was of the view that fellow professionals would consider this to be a significant deviation from acceptable practice.

The panel noted that you accept in your evidence that you should have ultimately followed the manufacturer's guidance, despite the training you underwent, and that upon reflection, you now recognise the importance of adhering to those guidelines.

The panel determined that your actions were sufficiently serious to amount to misconduct as you put a patient at risk in failing to adhere to and administer medicines within the limits of the existing guidelines, in this case, the manufacturer's guidance.

Charges 2 (a), 2 (c), 2 (e) and 2 (g)

The panel considered each of the charges individually and collectively. It decided to deliberate on charges 2a, 2c, 2e and 2g cumulatively as they all relate to your professional responsibilities towards Patient A, specifically concerning your record keeping.

The panel determined that your actions fell significantly short of the standards expected of a registered nurse, and that such actions amounted to breaches of the Code. Specifically:

*'**4 Act in the best interests of people at all times***

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

4.2 make sure that you get properly informed consent and document it before carrying out any action

10 Keep clear and accurate records relevant to your 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

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

10.5 take all steps to make sure that all records are kept securely'

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

In respect of charge 2a, 2c and 2e, the panel had regard to sections 4.1 and 4.2 of the Code as outlined above. It considered your duty to act in the best interest of people at all times and concluded that, in your failure to record your initial consultation, any conversation with Patient A regarding her medical conditions and the top-up dose administered, you did not put the patient's interest first. In particular, after discovering that you had initially missed two key points in the patient's medical history (asthma and depression), you proceeded without documenting such events, which were fundamental to the process of obtaining properly informed consent prior to treatment.

Further, the panel noted that Patient A had to take antihistamine and prednisolone/prednisone medication following an inflammatory reaction to the treatment. The panel had regard to sections 10.1, 10.2 and 10.4 of the Code as above. It considered that if the patient had experienced a more serious adverse reaction post-treatment, the absence of comprehensive records would hamper the process of reconstructing events as there is no trail of evidence. Additionally, there would be only limited information accessible to share with other medical professionals if the need arose.

In respect of charge 2g, the panel took into account the same considerations as mentioned above, but it also had regard to section 10.5 of the Code. It noted that these incidents occurred during the Covid-19 pandemic, where some areas of work had adapted a more 'virtual' approach. It determined that whilst it may have been acceptable, in light of the pandemic, to communicate medical advice via social media platforms, social media messages are not an appropriate nor secure form of record keeping. You should have documented any communications with Patient A seeking aftercare advice and support in a formal manner on the patient's care record.

The panel determined that collectively the charges found proved relating to record keeping amounted to a serious falling short of the standards expected of a nurse. It considered that record keeping and updating documentation, such as a patient care record, is vital to enable you, colleagues, and/or other medical professionals to deliver safe and appropriate patient care. The panel determined that the failings in relation to documentation were sufficiently serious to amount to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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) …'

The panel determined that the limbs a), b) and c) of *Grant*, as outlined above, are engaged. The panel found that Patient A was put at risk of harm as a result of your misconduct. Your misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel took into account your detailed reflective pieces and your oral evidence under affirmation. It considered that you made admissions to your failings and have demonstrated an understanding of where you went wrong and how you would handle the situation differently in the future and apologised for your past actions.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you had taken steps to strengthen your practice. The panel took into account the additional training and reading you have undertaken. It also took into account that you completed six reflective accounts, between February and August 2023, as part of your continuing professional development (CPD) activity.

In assessing whether you had taken sufficient steps to strengthen your practise, the panel had regard to the NMC guidance on 'Has the concern been addressed?' (FTP-13b). Specifically:

*"**Sufficient steps to address the concern***
What is 'sufficient' to address the concern in a case will depend on the specific details, including the nature of the alleged failings or behaviour. The scale of the concerns will determine what steps are required. For example, the reassurance a decision maker will be looking for will be less for a single clinical incident in an otherwise unblemished career than it would be if a number of errors had taken place over a period of time, and they continued to happen after the nurse, midwife or nursing associate was made aware of the problem, or where other steps put in place to address the risks did not prevent problems from recurring.

Key considerations for decision makers in assessing the steps taken by a nurse, midwife or nursing associate to address concerns in their practice will be whether the steps taken are:

- *relevant, in that they are directly linked to the nature of the concerns*
- *measurable (for example, where the nurse, midwife or nursing associate says they have been on a training course, information should be provided to help the decision maker understand the scope of the course, the topics covered and the results of any assessments)*
- *effective, addressing the concerns and clearly demonstrating that past failings have been objectively understood, appreciated and tackled.*

Sufficient and appropriate steps may include the following:

- *Attending a training course. Decision makers should assess whether the course content is relevant to the concerns in the case and whether the course was sufficiently comprehensive, ideally including a practical element and some form of assessment, with results available.*
- *Reflection. Reflective work by the nurse, midwife or nursing associates will be of more weight where they are able to give examples not only of what they have learned following the concerns being raised, but also how they have applied this learning in their practice.*
- *Developing and successfully completing an action plan.*
- *Successfully completing a period of supervised practice targeted at the concerns arising from the alleged behaviour.*
- *Periods of employment during which the nurse, midwife or nursing associate has practised in similar clinical fields, or carried out similar procedures to those where the original failings or concerns arose. Decision makers should look for clear evidence that the employer was aware of the areas of concern within the nurse, midwife or nursing associate's practice and what has been observed or assessed regarding these.*
- *Periods of unemployment (whether in the past or present) or periods working without having had the opportunity to demonstrate that the problematic task or tasks can be successfully completed without difficulty, will usually be of limited relevance.*

Decision makers should only rely on the evidence that is actually available at the time they consider the case. They must not speculate about what other information might be available.

However, if a case is being considered before a final hearing or meeting, and the evidence of insight and the steps taken to address the concerns is insufficient, decision makers should consider whether further steps could be taken. For example, if a nurse, midwife or nursing associate has stated that they have attended a course or undertaken additional training, we could request evidence of this."

The panel recognised your demonstrable insight into your shortcomings and reflections on how you could do things differently. However, it had no *measurable* evidence before it that these reflections had been put into action. It noted that the training certificates you provided, while pertinent to cosmetology practice, are dated between 2009 and 2016. It noted that this training was undertaken prior to the concerns raised in 2020, and therefore, were not *relevant* in relation to steps to strengthen your practise. The panel had no information regarding any recent measurable training you pursued subsequent to the events in 2020 that led to this case, specifically training addressing the concerns related to your record-keeping.

The panel considered that the only measurable evidence before it, which is relevant to the nature of the concerns (record-keeping) are the audits of three phone calls you have documented in your current role. Whilst the panel acknowledged this was satisfactory work, the panel was not satisfied that these audits were *effective* in demonstrating that your past failings have been objectively understood, appreciated and tackled because only a limited number of audits were presented before it – one dated in June 2023 and two in August 2023 (on the same day). The panel determined that this only showed a glimpse of your work over a period of two and a half years, and therefore, it could not be satisfied that this demonstrated sufficient strengthening of practise.

The panel had regard to the testimonials you produced from former clients and colleagues which praise your positive character, service and professional approach. It noted the evidence provided by Witness 3, however, this related to your practice over a decade ago. The panel would have benefitted from an independent verification of your current practice, such as evidence from your current employer; someone in a managerial or supervisory capacity, who had overseen and could attest to your current record-keeping.

Further, the panel had regard to the NMC guidance 'Is it highly unlikely that the conduct will be repeated?' (FTP-13c):

> *"…Decision makers will consider whether the nurse, midwife or nursing associate is likely to repeat the conduct that caused the concerns. When doing this, they should take into account whether the nurse, midwife or nursing associate has been practising in a similar environment to where the conduct took place. If they have, and have therefore been exposed to occasions when there was a risk of past conduct being repeated, then the absence of repetition will be significant. If they have not been practising in a similar environment (whether because restrictions have been placed on their practice or for any other reason), the absence of repetition will be of little or no relevance."*

The panel took into account that in your oral evidence, you stated that your current role is highly structured, regulated and regularly supervised unlike the circumstances in your former aesthetic practise. It also considered that you no longer wish to return to the aesthetics field so you would not be exposed to similar occasions in aesthetic practise where there was a risk of past conduct being repeated.

Although your current employment is in a different context from that of where the concerns arose, the panel considered that the concerns focus on fundamental skills relevant to all areas relevant to nursing practise, as opposed to something specifically related to aesthetic practise. Therefore, the risk of past conduct being repeated remains relevant despite the different working environment.

Further, the panel considered that the guidance states:

> *"Decision makers can also take into account the full circumstances of the case. The likelihood of the conduct being repeated in the future may be reduced where:*
>
> - *The nurse, midwife or nursing associate has demonstrated sufficient insight and has taken appropriate steps to address any concerns arising from the allegations.*
> - *The behaviour in question arose in unique circumstances. While this may not excuse the nurse, midwife or nursing associate's behaviour, this may suggest that the risk of repetition in the future is reduced.*

- *The nurse, midwife or nursing associate has an otherwise positive professional record, including an absence of any other concerns from past or current employers and of any previous action by us or another regulatory body.*
- *The nurse, midwife or nursing associate has engaged with us throughout our processes."*

The panel acknowledged that you have had a 16-year career without any issues prior to the concerns and that the behaviour arose in unusual circumstances; considering the impact of Covid-19, your health conditions and private personal life matters at the time. It also recognised your efforts in engaging with the NMC throughout its process. However, it determined that a risk of repetition remains as you are yet to demonstrate that you have taken sufficient steps to strengthen your practise and address the concerns raised following the events in October 2020. Specifically, relating to the patient's journey from initial consultation through to aftercare, as well as follow-up treatment and the use of social media in communications with patients. 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; 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.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

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 your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC.

Submissions on sanction

Mr Lo referred the panel to the NMC guidance which states it should bear in mind proportionality. The panel should strike a fair balance between your rights as a nurse and the NMC's overarching objective of public protection, or otherwise public interest, to declare and uphold professional standards and maintain public confidence in the nursing profession. It should apply the right amount of regulatory force to deal with the *'target risk'*, but no more, and start at the lowest level in terms of severity, only escalating to increasingly higher ones if it deems that lower ones are inappropriate.

Mr Lo submitted that the panel may consider the following to be aggravating factors in this case:

- Failure to follow manufacturers guidance, which the panel deemed to be a significant deviation from acceptable practice
- Conduct which put Patient A at significant risk of harm, in respect of cross infection and more serious adverse reactions in proceeding with treatment without properly documenting medical history
- In respect of failures relating to record keeping, he outlined that the panel found that her actions had fallen significantly short of expected standards and failed to put the interests of the patient first
- The absence of comprehensive records could have greatly impeded the ability to reconstruct events and therefore hamper the ability to treat the adverse reaction by

other medical professionals, and as set out in his verbal submissions at the impairment stage, it was ‘pure luck’ that no such serious adverse reaction happened.

In terms of the mitigating factors, Mr Lo submitted the panel may consider:

- You have shown a fair level of insight, and are now resolved to always follow guidelines in the future
- Undertaken further training courses and reading in relation to record keeping and is working in an environment where your record keeping is constantly being audited and are working to a high standard.

In considering the available sanctions, Mr Lo submitted that as per the NMC guidance (SEN-3A) no further action is rarely appropriate where impairment is found and given the panel's findings that Patient A was placed at a significant risk of harm, no further action is clearly inappropriate.

In respect of caution order and NMC guidance (PSN-3B), this is only appropriate if the panel decides that there is no risk to the public or to patients requiring the nurses and practice to be restricted and the committee wants to mark the registrant’s conduct as unacceptable and should not be repeated. It is appropriate where the seriousness of the misconduct is at the lower end. However, given the panel's findings concerning the risk of patient safety, he submitted it would be insufficient to maintain public confidence due to the seriousness of the misconduct.

In respect of conditions of practice, he submitted that the regulatory concerns related to clinical practice, and they are remediable. However, he submitted that it has to be taken into account that you no longer work in the aesthetics industry nor are you in a patient facing clinical role at the moment. Accordingly, it can be difficult to formulate workable conditions which specifically tackle areas of concern.

Mr Lo submitted that the most appropriate sanction in the current circumstances of this particular case is a short suspension of 6 months. He referred the panel to guidance (SAN-3D), where suspension may be appropriate where the misconduct is not fundamentally incompatible with the nurse continuing to be a registered professional and the overarching objective can be satisfied by a lesser outcome than permanent removal.

Mr Lo submitted that this was a single instance of misconduct, there is no evidence of harmful, deep seated attitudinal problems and no evidence of repetition of behaviour since the incident. He highlighted that the panel is satisfied in its earlier findings that you have insight. Therefore, he submitted that a short period of suspension would mark the seriousness of the misconduct and the disapproval towards it and maintain public confidence and upholding standards.

The panel then considered Ms Walmsley's submissions. She emphasised that any sanction imposed does need to be proportionate, which means finding a fair balance between the nurse's rights and the overarching objective of public protection and must not go further than necessary. In addition, she submitted that there is a duty to make sure that any decision to restrict a nurse, midwife or nursing associates right to practice is justified.

Ms Walmsley invited the panel to consider that you have had 16 year unblemished career and that the charges that this matter relates to arose in quite unusual circumstances. She also highlighted that it is important to bear in mind that you no longer work within the aesthetics role that the charges relate to, and this explains why the training documentation was not dated beyond the events in 2020. She emphasised that you currently work within the ambulance service and you do not intend to return to aesthetics practice.

Ms Walmsley invited the panel to consider the context in which you are currently working as this may inform on what an appropriate sanction may be. She informed the panel that you do not administer medications in your current role and do not directly engage face to face with patients. She added that although you work remotely from home, you are still subject to regular reviews, audits and meetings with management.

Ms Walmsley referred the panel to your reflective statements and insight that you have developed. She submitted that both in oral evidence and in writing, you have shown considerable insight into what went wrong and have taken steps to reflect on your practice.

Ms Walmsley submitted that as for the strengthening of practice, one of the concerns was about the administering of medication. She referred the panel to your certificate of an online course on administering medication which you completed in April 2023. She submitted that this was a ‘catch 22’ because you are not in a role where you are administering medications, however you have completed this despite not being a requirement of your current role.

Ms Walmsley submitted the panel should consider aggravating and mitigating factors. She submitted that most aggravating factors listed on the guidance are not applicable as you have no previous regulatory or disciplinary findings, abuse of a position of trust nor a pattern of misconduct over time. She outlined that the panel considered that Patient A may have been put at risk of harm had she had a more adverse reaction. However, she submitted there is insufficient evidence to support this as there are no medical records and it is not entirely clear what went wrong or why. There was a risk, but not a significant risk, as indicated by Mr Lo in his submissions.

In terms of mitigation, Ms Walmsley submitted that you have read and completed a variety of different courses, made numerous reflections and even though some of this, such as the administration of medications, are not relevant to your current role but still have taken steps to put those matters right. She highlighted that you have shown considerable insight into failings and are remorseful as to what happened. The panel may consider that these events concern one very confined and quite unusual period of time due to the pandemic. She also submitted that a mitigation may include early admissions of the facts and engagement in these proceedings.

Ms Walmsley submitted that although panel have found that these were insufficient at this time to establish that you are not currently impaired, you have shown evidence that you

can adhere to and follow the principles of good practice. This is evidenced by way of the testimonials that have been provided, including with people that currently work with you, and by keeping up to date with your areas of practice, as seen in your reflective statements and independent learning.

Ms Walmsley highlighted that the panel may take into consideration your personal mitigations, including matters in relation to your health. Other factors, which may be relevant to the appropriateness of the sanction, particularly in light of the proposed 6-month suspension order, is that this would have a profoundly difficult effect on you and your personal circumstances, [PRIVATE].

Ms Walmsley submitted that your misconduct would fall toward the lower end of seriousness and is unlikely to be repeated, therefore, the panel may consider taking no further action despite the finding of current impairment. She submitted that should the panel wish to mark the seriousness of the misconduct; a caution order is appropriate and is the least restrictive. She submitted that there is no risk to the public should your practice not be restricted as you have not fallen into a pattern of repetition, and have taken sufficient steps to strengthen your practice, in light of your current role. She submitted this would be the most appropriate way to mark the disapproval of what had happened in terms of the behaviour at that time and sufficient in terms of maintaining and promoting the public confidence within the nursing and midwifery professionals.

Ms Walmsley submitted that should the panel not agree that a caution order is appropriate at this time, the alternative would be a conditions of practise order to protect the public and uphold the confidence in the profession, but that a suspension or strike off order would be wholly disproportionate as the seriousness of this case is not toward the higher end of the spectrum to warrant any period of removal from the Register.

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

Decision and reasons on sanction

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 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:

- Multiple incidents pertinent to Patient A
- Conduct which put Patient A at risk of suffering harm
- Lack of measurable evidence in relation to steps taken to strengthen practice

The panel also took into account the following mitigating features:

- Admissions at the outset
- Evidence of demonstrable insight and reflection
- Previous good character and no concerns raised following the events
- Self-directed learning and reading
- Personal mitigation including health and personal life matters, at the time of events, and potential financial hardship

The panel first considered whether to take no action but concluded that this 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 take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG 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 considered that your misconduct was at the lesser end of the spectrum. However, it determined that a caution order would be inappropriate in view of the issues and public protection risks identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order, as you are yet to demonstrate and satisfy the panel that you have addressed all the concerns raised and can practise safely, kindly and professionally.

The panel next considered whether placing conditions of practice on your 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 the following points:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's 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 and satisfy the necessity for public protection whilst you strengthen your practice. There is no evidence that you have any harmful deep-seated personality or attitudinal problems. It noted that the concerns relate to your clinical practice but, in the specific set of circumstances, there is no evidence of general incompetence, and you have a potential to respond positively to retraining.

The panel accepted Ms Walmsley's submission that you would be willing to comply with conditions of practice. It was mindful that you no longer practise and have said you do not intend to practise in the aesthetics industry in the future. However, as highlighted in its earlier findings, the panel identified that the areas which require improvement relate to fundamental nursing skills, which you still apply in your current role or are likely to apply in a different nursing role should you change employment. The panel was mindful that your current stated intention not to practise in the field of aesthetics may change in the future.

The panel had regard to the fact that these incidents happened three and a half years ago and that, other than these incidents, you have had a reputable career of 16 years as a nurse. It accepted that no further concerns were raised after the events in October 2020. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to continue 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 circumstances of your case because the misconduct was not sufficiently serious to require permanent nor temporary removal from the Register. The panel carefully considered the submissions of Mr Lo in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a period of suspension would not provide you with the opportunity to strengthen your practice, which is the only concern that is yet to be addressed.

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. It will also serve to protect the public pending satisfactory fulfilment of the conditions.

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 limit your practice to one single substantive employer, which must not be an agency.

2. You must undertake online or in person participatory learning. It should include self-reflection around medicines management, which must be endorsed by another nurse or paramedic in a supervisory or mentoring role as addressing the risks identified. You must also demonstrate to a reviewing panel that you have met the required standard.

3. You must work with your line manager, mentor, or supervisor, to create a personal development plan (PDP). You PDP must include:
    - Independent verification/assessment of three audits each month
    - Self-reflection every three months on your record keeping, to be endorsed by your manager, mentor or supervisor as meeting the required standard.

    You must send your case officer a copy of your PDP prior to any review hearing.

4. You must keep the NMC informed about any change in role and/or employment by:
    a) Telling your case officer within seven days of accepting or leaving any role/employment.

b) Giving your case officer your employer's contact details.

5. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any employers you apply to for work (at the time of application).

6. 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.

7. 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 other person(s) involved in your retraining and/or supervision required by these conditions'

The period of this order is for 12 months. The panel determined that this would allow you sufficient time to arrange and satisfy the conditions with your employer to demonstrate that you have sufficiently strengthened your practise in the areas of concern.

Before the order expires, a panel will hold a review hearing to see how well you have 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.

This will be confirmed to you in writing.

Submissions on interim order

The panel took account of the submissions made by Mr Lo. He referred the panel to the relevant NMC guidance (SAN-5) and outlined that this decision was not automatic. However, he submitted that considering the panel's earlier findings of current impairment and having identified a risk to patients, an interim conditions of practice order on the same terms as the substantive order is necessary on the grounds of public protection and otherwise in the public interest.

The panel also took into account the submissions of Ms Walmsley. She submitted that the decision is a matter for the panel, however, she echoed Mr Lo's submission that such a decision is not automatic. She invited the panel to give careful consideration as to whether it is necessary in the specific circumstances of the case, as well as the period of length.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest, as a member of the public would be concerned if this was not implemented. The panel had regard to the seriousness of the misconduct, its finding of current impairment 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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to allow for the appeal process to be completed and address the public protection risks during the interim period.

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 you are sent the decision of this hearing in writing.

That concludes this determination.