Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
10 – 21 July 2023
19 February 2024
21- 22 February 2024

Virtual Hearing

Name of registrant:	Mary Frances Jamieson
NMC PIN:	99C0143S
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 13 September 2010
Relevant Location:	North Lanarkshire
Type of case:	Misconduct
Panel members:	Christina McKenzie (Chair, Registrant member) Linda Tapson (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Andrew Lewis
Hearings Coordinator:	Jumu Ahmed
Nursing and Midwifery Council:	Represented by Yusuf Segovia (10 – 21 July 2023), Case Presenter Represented by George Hugh-Jones (19, 21 and 22 February 2024), Case Presenter
Mrs Jamieson:	Not present and not represented
No case to answer:	Charges 1(a)(i) (in respect of 7 March 2020 at 04:10), 3
Facts proved:	Charges 1(b), 5
Facts not proved:	Charges 1(a)(i), 1(a)(ii), 1(c), 2(a), 2(b), 4
Fitness to practise:	Impaired

Sanction:	**Suspension order (4 months)**
Interim order:	**Interim suspension order (18 months)**

Preliminary and procedural matters

On day 1 of the hearing on Monday 10 July 2023, Mrs Jamieson did not attend the hearing and was not represented. The panel saw that she had responded to the Hearing Coordinators invitation email in an email dated 10 July 2023 at 09:37 as follows:

> *'Due to unforeseen circumstances I will be unable to attend this morning. I do though hope to be involved and as stated have a witness I would like involved also.'*

At the panel's direction, the Hearings Coordinator called Mrs Jamieson to find out what time she would be able to attend the hearing. She agreed to attend a pre-hearing meeting with the Legal Assessor and the Hearings Coordinator, which she did. In this meeting, Mrs Jamieson had significant technical difficulties. [PRIVATE]. She told the Legal Assessor and the Hearings Coordinator that she will join the Microsoft Teams Meeting link at 14:00 to have a conversation about what her next steps would be in the hearing.

The panel accepted this and adjourned the hearing for one day to allow Mrs Jamieson to return to the meeting for 14:00.

At 14:01, the Hearings Coordinator called Mrs Jamieson, but the call went to voicemail. A follow up email was sent to Mrs Jamieson at 14:16 which invited Mrs Jamieson to the Teams meeting link. There was a second phone call at 14:28 which went to voicemail again. A second email was sent to Mrs Jamieson at 14:33, which stated:

> *'Hi Mrs Jamieson,*
>
> *I hope you are well and having a good afternoon.*
>
> *I have tried to give you two calls, which went to voicemail.*

If you wish to join the hearing tomorrow, please join for 9am or please let me know as to a time that would be most suitable between 9:00-9:30.

If you do not, the panel may determine to proceed in your absence.

Please confirm that you have received this email. I look forward to hearing from you soon.'

Mrs Jamieson did not respond to either the phone calls or the emails.

Decision and reasons on service of Notice of Hearing

On Day 2 of the hearing, the panel was informed that Mrs Jamieson was not in attendance or represented. It saw that the Notice of Hearing letter had been sent to Mrs Jamieson's registered email address on 7 June 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and venue of the hearing and, amongst other things, information about Mrs Jamieson's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Jamieson on day two of the hearing

The panel next considered whether it should proceed in the absence of Mrs Jamieson. It had regard to Rule 21 and heard the submissions of Mr Segovia who invited the panel to continue in the absence of Mrs Jamieson.

Mr Segovia submitted that there had been some engagement by Mrs Jamieson as she joined the pre-hearing meeting on day one of the hearing. He submitted that in those circumstances he could not assert that Mrs Jamieson had voluntarily absented herself as she did not indicate that she would not be attending on day two. However, Mr Segovia submitted that efforts were made on day one of the hearing to secure Mrs Jamieson's attendance. She was told that if she was not to attend, then the hearing may proceed in her absence. Mrs Jamieson did not attend despite the emails that were sent to her to secure her attendance. Mr Segovia submitted that the short adjournment on day one, to allow Mrs Jamieson to attend, had inconvenienced the NMC witnesses as all four had to be warned for the day after the day they were due to give evidence. He submitted that there was no reason to believe that an adjournment would secure Mrs Jamieson's attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

The panel decided to proceed in the absence of Mrs Jamieson. In reaching this decision, the panel considered the submissions of Mr Segovia and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General*

Medical Council v Adeogba [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties.

The panel noted that no application for an adjournment has been made by Mrs Jamieson. Mrs Jamieson is aware of the hearing as she had expressed via email and in the pre-hearing meeting, in the morning, a wish to attend the hearing and that she also had a witness she wished to call to give evidence. Day one of the hearing was adjourned to allow Mrs Jamieson to have a pre-hearing meeting with the Legal Assessor and the Hearings Coordinator at 14:00.

Mrs Jamieson did not respond to any of the communications made to her, neither did she attend the pre-hearing meeting. The panel had no reason to suppose that adjourning would secure her attendance at some future date. The panel noted that two witnesses have attended today to give live evidence and two more are due to attend. All of the witnesses were rescheduled as a result of adjourning day one of the hearing. Therefore, not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services. Further delay may also have an adverse effect on the ability of witnesses accurately to recall events, or attend at all.

The charges relate to events that occurred in 2020. The panel noted that this hearing was first adjourned in January 2023 because the Fitness to Practice panel determined that service had not been effective. However, the panel noted that Mrs Jamieson had requested an adjournment in that hearing which meant that she appeared to know the process of requesting for an adjournment. She did not do this on day two of this hearing.

The panel was of the view that there is a strong public interest in the expeditious disposal of the case. As there was no independent evidence before the panel, it determined that there was no good reason to not proceed in Mrs Jamieson’s absence. The panel noted that there is some disadvantage to Mrs Jamieson in proceeding in her absence. Although

the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations.

Mrs Jamieson will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the panel concluded that any disadvantage to Mrs Jamieson is the consequence of her decision to absent herself from the hearing.

In these circumstances, the panel decided that it is fair, appropriate and proportionate to proceed in the absence of Mrs Jamieson. The panel will draw no adverse inference from Mrs Jamieson's absence in its findings of fact.

Mrs Jamieson's request for a short adjournment on day three of the hearing and further communication with Mrs Jamieson

On day two of the hearing, the Hearings Coordinator emailed Mrs Jamieson at 12:08. The email stated:

> *'Hi Mrs Jamieson,*
>
> *I hope you are well.*
>
> *I just wanted to let you know that your hearing has started as the panel proceeded in your absence. However, you are welcome to join at any time should you want to. If you need anything at all, let me know. I will do my best to help you.'*

On day three of the hearing, Mrs Jamieson emailed the Hearings Coordinator at 13:09:

> *'Good afternoon*

[PRIVATE].

I apologise again and wish I could take part.

I still wish to take part and have my witness take part also.'

Mr Segovia told the panel that it seems like Mrs Jamieson is taking some time to respond to the Hearing Coordinator's emails. He told the panel that there was no witness evidence to be heard on day three and that there should be a response to Mrs Jamieson's email.

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

The panel noted that Mrs Jamieson requested an adjournment in January 2023 and appeared to know how to do so. She did not request one at this time. [PRIVATE]. The panel was not clear as to what Mrs Jamieson was asking for.

The panel, therefore, had requested the NMC to respond to Mrs Jamieson's email with the following to seek clarification:

'Dear Ms Jamieson

Your email below of 12 July was passed to the hearing panel.

[PRIVATE].

If you want the Panel to adjourn, the Panel has said it needs you to say that you want the hearing adjourned.

[PRIVATE].

Please let the […] *Case Officer or* […] *the Hearings Coordinator* […] *know by 10.00am tomorrow morning (Thursday), so the panel can decide what to do.*

The Panel has said that if you do not reply by tomorrow it will continue to hear evidence from the NMC witnesses from 9:15am on Friday 14 July 2023, and you are free to attend at any time.

If the hearing continues, and you indicate that you would like to participate, the Panel has said it is prepared to wait until Monday to hear evidence from you and/or your witness.

Thank you.'

Mrs Jamieson responded on day three of the hearing, 12 July 2023, at 22:47:

'I would like my hearing adjourned but only for a short time as I do want it over with. I will try to obtain a letter to explain my absence.'

On day four, Mr Segovia informed the panel that Mrs Jamieson was requesting a short adjournment but had also expressed that she *'wants it over with'*. He submitted that he could not answer what a short time means. However, as the NMC had told her that if she did not reply, then the hearing will proceed. He submitted that as Mrs Jamieson had replied within the time limit that was set, the hearing could not proceed on day four of the hearing.

Mr Segovia submitted that it is clear that Mrs Jamieson wants to put her case forward and call a witness to give evidence on her behalf, rather than cross examine the NMC's witnesses. [PRIVATE].

The panel noted that Mrs Jamieson had requested a short adjournment but had also expressed that she *'wants it over with'*. The panel was of the view that Mrs Jamieson had expressed a desire to attend but given no indication when she would be able to do so. It bore in mind that it has a duty to be fair to both Mrs Jamieson and the NMC.

Witness 3 and Witness 4 were rescheduled to give evidence on day five of the hearing to allow Mrs Jamieson a short adjournment on day four as she requested.

On day four, an email was sent from the NMC to Mrs Jamieson with the following:

> *'Dear Ms Jamieson*
>
> *Your reply to the email of the 12th July has been passed on to the panel and they have asked us to write to you to convey their decision.*
>
> *The panel has a duty to balance fairness to both you and the NMC in reaching their decision.*
>
> *The panel considered your request very carefully and has tried to balance your request for more time, with also "getting it over with".*
>
> *The panel has agreed a short adjournment for today (13 July) in that it will not hear further witness evidence until 9.15am on the morning of Friday 14th July 2023. You are very welcome to attend to hear and question that evidence should you wish.*
>
> *You are not obliged to attend, however the panel will delay hearing any evidence from you and/or your witness until 9.15am on Monday 17th July 2023.*
> [PRIVATE]. *The letter should also indicate how long you would be unable to attend the hearing. This written confirmation must be available to the panel before 9am on Monday morning (17th July 2023).*
>
> [PRIVATE].

For your awareness, should you need a longer adjournment then it is unlikely that the hearing can resume for at least 6 – 12 months because of other workload at the NMC.

Thank you.'

Mr Segovia informed the panel that Mrs Jamieson had not responded to the NMC on day five.

On 16 July 2023 22:08, Mrs Jamieson sent an email to the NMC:

'[PRIVATE].

[PRIVATE].

[PRIVATE].*'*

On day six of the hearing, Mr Segovia submitted that it was very clear from Mrs Jamieson's response that she was not asking for an adjournment so that she can be present in her hearing. Therefore, the issue of adjournment is not relevant anymore. He told the panel that the panel was prepared to wait until 9:15 today, and that this time had passed. Mr Segovia also told the panel that he had no particular issue in waiting for a short amount of time to allow the witness to be heard. However, that the NMC would like this case to conclude in its scheduled time. He therefore submitted that it would be for the panel as to how much time should be given.

In response to the panel's question, he said that this witness is not known to the NMC, and it was Mrs Jamieson's responsibility to call her witness.

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

[PRIVATE]. Mrs Jamieson did not provide any evidence before the panel. The panel also noted that Mrs Jamieson was not asking for more time nor asking for a longer adjournment. In these circumstances, the panel determined to proceed. The panel also bore in mind that Mrs Jamieson had expressed a desire to get *'this over with'*.

The panel was of the view that Mrs Jamieson's witness should be given an opportunity to attend. However, the panel determined that the witness must attend by 14:00. Mrs Jamieson must provide the NMC Case Officer with the details of this witness by 13:30 today in order for the details of the hearing to be sent. If this is not done within the time and the witness does not attend for 14:00, the panel will move on and continue with the case.

Mrs Jamieson did not respond to the NMC within the time stated. The panel, therefore, decided to continue with the case.

Decision and reasons on application to amend Schedule A

The panel heard an application made by Mr Segovia, on behalf of the NMC, to amend the wording of the second schedule on Schedule A.

The proposed amendment was to accurately reflect the evidence. Mr Segovia referred the panel to Patient A's PAC dated 7 March 2020. He submitted that that starts 00:15 on 7 March and everything else on that is documented is on 7 March 2020. He told the panel that the schedule introduces an error when it refers to 2200 hours on 6 March, when the evidence of the relevant PAC shows that in fact it was actually 7 March 2020.

Mr Segovia submitted that there would be no unfairness to Mrs Jamieson as it was obvious from reading the evidence about the shifts of the 6, 7 and 8 March 2020 that the allegation relates to 2200 hours on 7 March 2020.

In light of the above, Mr Segovia submitted that the proposed amendment would more accurately reflect the evidence and could be made without the risk of injustice.

Original schedule

Schedule A

6 March 2020 at 2200 hours

Amended schedule

Schedule A

~~6~~ **7** March 2020 at 2200 hours

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that the proposed amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Jamieson and no injustice would be caused to either party by the proposed amendment being allowed. The panel determined that there would be no unfairness on Mrs Jamieson if it allowed this amendment. It, therefore, allowed the proposed amendment.

Decision and reasons on application to amend Charge 4

The panel heard an application made by Mr Segovia to amend Charge 4.

This application was made after the close of the NMC's case when the panel had ruled that there was no case to answer in respect of Charge 3 in the circumstances below.

Nevertheless, the panel deals with this application at this point in its decision so that all procedural matters are dealt within one place.

Original charge:

> 4) Your conduct at Charges 1(a)(ii) and/or 1(b) and/or 3(b) and/or 3(d) were dishonest in that you deliberately signed the Pressure Area Care and/or Bedrail Chart stating that the checks had been carried out when you knew they had not.

Amended charge:

> 4) Your conduct at Charges 1(a)(ii) and/or 1(b) ~~and/or 3(b) and/or 3(d) were~~ **was** dishonest in that you deliberately signed the Pressure Area Care ~~and/or Bedrail Chart~~ stating that the checks had been carried out when you knew they had not.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that the effect of the amendment was simply to remove reference to Charge 3, in respect of which there was no case to answer. The panel was satisfied that there would be no prejudice to Mrs Jamieson and no injustice would be caused by the proposed amendment being allowed. It, therefore, allowed the amendment.

Amendment of Charge 4 made by the panel of its own volition under Rule 27(7)(ii)

During its deliberations, the panel noted that charge 1(b) read as follows:

1) In respect of Patient A:

a) Between 25 February 2020 and 26 February 2020 recorded on Patient ’s Pressure Care Chart Colleague B’s initials to indicate that Colleague B had been present

during a Pressure Care Check when she had not.

Charge 4 reads as follows:

> 4) Your conduct at Charges 1(a)(ii) and/or 1(b) was dishonest in that you deliberately signed the Pressure Area Care stating that the checks had been carried out when you knew they had not.

The panel noted that Charge 1(b) alleged that Mrs Jamieson had recorded Colleague B's initials to indicate that Colleague B had been present during a PAC when she had not and that this was not expressly covered by Charge 4. The panel was concerned that this could result in under charging and in accordance with Rule 24(7) invited Mr Segovia to make submissions to the panel.

Mr Segovia submitted that Charge 4 was in relation to dishonesty in respect of charge 1(a)(ii) and 1(b). He appreciated that the charge was broadly worded and that it could be left alone as it refers to the charge sub charges. However, he told the panel that it could be better worded than what it currently is. He submitted that if the panel were minded to clarify Charge 4, then the wording should be changed and an additional charge 5 should be added. He invited the panel to take into account the wordings:

> '4) Your conduct at Charge 1(a)(ii) was dishonest in that you deliberately recorded on Patient A's Pressure Area Care Chart that you conducted a Pressure Area Care check when you knew you had not.
>
> 5) Your conduct at Charge 1(b) was dishonest in that you deliberately recorded on Patient A's Pressure Area Care Chart Colleague B's initials to indicate that Colleague B had been present during a Pressure Care Check when you knew Colleague B had not been present.'

Mr Segovia submitted that this does not change the charges in itself as the same dishonesty is being alleged. However, that it does make it clear as to which sub charges it relates to. He further submitted that in adding charge 5 as a new charge, it is simply making is clear and clarifying the dishonesty charge in relation to charge 1(b).

Mr Segovia submitted that no injustice would be caused as Mrs Jamieson had always been clear as to the wordings of the charges in their entirety and what they allege. He also submitted that Mrs Jamieson was also aware that the dishonesty charge was also in respect of both of these charges. However, he submitted that if the panel was to take a different view in that it would be of the view that serious injustice would be caused to Mrs Jamieson, then the only way to correct that is to adjourn the hearing, to allow Mrs Jamieson to receive the proposed amendments and for her to make a comment on it.

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

The panel noted that the proposed wordings of Charge 4 and 5 did not entail new information. The dishonesty in Charge 4 originally referred to Charge 1(a)(ii) and 1(b). The panel was of the view that as Mrs Jamieson was aware of the dishonesty allegation from the outset, and as the proposed charges do not entail new information, no injustice would be caused. Further, Mrs Jamieson absented herself and knew of the hearing taking place in her absence. Therefore, the panel determined that an adjournment was not required as no injustice would be caused by ensuring clarity of the charge.

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

Details of charge (as amended)

That you, a registered nurse:

1) In respect of Patient A:

   a) Between 25 February 2020 and 15 March 2020;

      i) On one or more occasions as set out in Schedule A failed to complete Pressure Area Care checks; **[NO CASE TO ANSWER for 7 March 2020 at 0410 hours in Schedule A] [NOT PROVED FOR 25 FEBRUARY 2020 AND 7 MARCH 2020 at 2200 hours]**

      ii) On one or more occasions as set out in Schedule A recorded on Patient A's Pressure Area Care Chart that you conducted a Pressure Area Care check when you had not. **[NOT PROVED]**

   b) Between 25 February 2020 and 26 February 2020 recorded on Patient A's Pressure Care Chart Colleague B's initials to indicate that Colleague B had been present during a Pressure Care Check when she had not. **[PROVED]**

   c) On 7 March 2020 failed to examine Patient A when carrying out a continence check. **[NOT PROVED]**

2) Between 26 February 2020 and 27 February 2020;

   a) Shouted at Patient B "sit on your bum, sit back down" or words to that effect and/or "what are you doing standing up? You are making me work tonight" or words to that effect. **[NOT PROVED]**

   b) Failed to administer to Patient B pro re nata ("PRN") medication when requested by Colleague A. **[NOT PROVED]**

3) On 7 March 2020 in respect of Patient C:

   a) On one or more occasions failed to carry out Pressure Area Care checks; **[NO CASE TO ANSWER]**
   b) On one or more occasions recorded on Patient C's Pressure Area Care Chart that you had conducted a Pressure Area Care check when you had not. **[NO CASE TO ANSWER]**

   c) On one or more occasions failed to carry out bedrail checks. **[NO CASE TO ANSWER]**

   d) On one or more occasions recorded on Patient C's bedrail chart that you had conducted bedrails checks when you had not. **[NO CASE TO ANSWER]**

4) Your conduct at Charge 1(a)(ii) was dishonest in that you deliberately recorded on Patient A's Pressure Area Care Chart that you conducted a Pressure Area Care check when you knew you had not. **[NOT PROVED]**

5) Your conduct at Charge 1(b) was dishonest in that you deliberately recorded on Patient A's Pressure Area Care Chart Colleague B's initials to indicate that Colleague B had been present during a Pressure Care Check when you knew Colleague B had not been present. **[PROVED]**

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

Schedule A

25 February 2020 at 2215 hours

7 March 2020 at 2200 hours

7 March 2020 at 0410 hours

Background

The NMC received a referral on 27 May 2020 from Murdostoun Brain Injury Rehabilitation Centre and Neurosurgical Care Centre ('the Centre'). The charges arose whilst Mrs Jamieson was employed as a staff nurse at Murdostoun Brain Injury Rehabilitation Centre ('the Unit') since August 2019. The Unit cares for patients with very complex needs.

The charges against Mrs Jamieson arise from her care of patients at the Unit and fall into three areas.

First, it is alleged that in respect of a severely disabled patient known throughout these proceedings as Patient A, Mrs Jamieson failed to complete necessary Pressure Area Care. This is documented in a Position Change Chart (referred to throughout these proceedings as 'PAC charts'). She initialled these records to show that she had completed

checks and also initialled to show that Colleague B had been with her during a PAC check, when she had not.

Secondly, it is alleged that Mrs Jamieson treated a second patient, known as Patient B, inappropriately in that she shouted at Patient B and failed to administer as required medication: Pro Re Nata (PRN) when requested by Colleague A.

Thirdly, it is alleged that Mrs Jamieson failed to carry out PAC checks and bed rail checks in respect of a third patient, known as Patient C, and falsely recorded that she had done so.

Evidence

The panel received documentary and witness evidence.

The documentary evidence included but was not limited to the following:

1) A redacted copy of an investigation report written by Witness 1 in March 2020;
2) PAC for Patients A and C dated 25 February, 7 March and 14 March 2020;
3) An undated and unsigned local statement taken from Colleague A;
4) Various interviews conducted by Witness 1 with care workers over the telephone;
5) A record of an interview with Mrs Jamieson conducted by Witness 1 over the telephone on 31 March 2020;
6) A written response dated 12 April 2020 submitted by Mrs Jamieson to the local disciplinary hearing; and
7) An un-headed, unsigned and undated document purporting to record viewing of CCTV relating to 6 and 7 March 2020.

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

- Witness 1: Consultant Clinical Neuropsychologist at the Centre;
- Witness 2: Unit Manager at the Unit;
- Colleague A: Support Worker.

The panel deals with the evidence in respect of each charge below. Nevertheless, the panel has decided that it would be useful to give an overview of the evidence at this stage.

Witness 1, who was appointed as the investigations manager, produced the documents set out above and told the panel something of the layout of the Unit based on her experience working there.

The panel had regard throughout to the advice of the Legal Assessor that it should put out of its mind any conclusions about the evidence that Witness 1 may have reached in her investigation.

Witness 2 told the panel about the duties of Mrs Jamieson when providing care to the patients on the Unit and drew the panels attention to the Unit's 'Pressure Area Care Management and Wound Management' policy which deals in particular with the need to carry out regular PAC checks.

Colleague A gave evidence to the panel regarding the events of 25 February 2020, her observations of Patient A and that she had been with Colleague B at the time when Mrs Jamieson had recorded that she was with her carrying out a PAC check. She also told the

panel about the events of the following night when she observed Mrs Jamieson's interaction with Patient B.

No case to answer in respect of Charge 3

Before hearing submissions and advice regarding the individual charges, the panel raised of its own volition the issue of whether 'sufficient evidence had been presented' for it to find Charge 3 proved.

The panel noted that the only evidence that Mrs Jamieson had not carried out PAC and bedrail checks in respect of Patient C was the un-headed, unsigned and undated document referred to above, which purported to record observations of CCTV recordings.

The panel invited Mr Segovia to make submissions whether there was a case to answer in respect of Charge 3, which alleged failings in respect of Patient C. Mr Segovia made this application under Rule 24(7).

Mr Segovia pointed out to the panel that there are three redactions of patients initials in the document. He informed the panel that he had checked the unredacted documents and found that the redacted initials were not those of Patient C but were those of Patient A.

Mr Segovia told the panel that Witness 1 confirmed to the panel that there was no interview conducted with Ms 3 nor were there any other notes beyond what was recorded on the CCTV notes. Mr Segovia also told the panel that Witness 2 said, in his oral evidence, that the CCTV was recording in real time.

Mr Segovia submitted that the charges that relate to the CCTV notes are Charge 3 in its entirety and Charge 1(a)(i) in relation to the 7 March 2020 04:10 entry (within Schedule A).

In relation to Charge 1(a)(i), Mr Segovia submitted that the only evidence for this charge is an entry in the same document. Mr Segovia acknowledged that this was a weakness in the NMC's case.

In respect to Charge 3, Mr Segovia submitted that the NMC only relies on the CCTV footage notes as Ms 3 was not called to give live evidence. Nor had Witness 1 spoken to Ms 3 as part of her investigation.

Mr Segovia submitted that Ms 3 was not in attendance to give oral evidence before the panel and there was no specific reason for this. In relation to Ms 3, he told the panel that the NMC had attempted to locate her by contacting her previous employer as to her location. However, he submitted that they were not successful. He informed the panel that the NMC had not had direct contact with Ms 3 at all, and that the last attempt the NMC had made to get in contact with her was in December 2020. As there were no details on her location, the NMC left it at that.

Mr Segovia accepted that the NMC had produced just the notes of the CCTV footage which somebody had told Witness 1 were made by Ms 3. He submitted that if the panel were to decide to accept this as evidence, then the panel may have an issue on the appropriate weight it can give to it. He accepted that on the point of fairness, the admissibility of these notes are an issue.

In relation to this application, Mr Segovia accepted there was an issue as to whether the purported schedule of the CCTV observations was admissible and accordingly whether there was a case to answer in respect of Charge 1(a)(i) and Charge 3 in its entirety.

The panel took account of the submissions of Mr Segovia and accepted the advice of the legal assessor in particular the panel had regard to Rule 24(7) of the Rules which states:

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

(i) either upon the application of the registrant, or

(ii) of its own volition,

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

In particular the panel had regard to the decisions of the High Court and Court of Appeal in the following cases. *Nursing and Midwifery Council* v *Ogbonna* [2010] EWCA Civ 1216, *Nursing and Midwifery Council* v *Ogbonna* [2010] EWCA Civ 1216 *El Karout* v *NMC* [2019] EWHC 28 (Admin) and *Thorneycroft* v *NMC* [2014] EWHC 1565 (Admin).

It reminded itself that:

- The issue of fairness relates to admissibility and not merely the weight that can be attached to evidence
- The admission of the evidence of an absent witness should not be regarded as a routine matter
- 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 there would be some means of testing its reliability.
- There is need for particular care where there is no signed statement from a witness whose evidence the regulator seeks to rely upon

The panel asked itself the following questions set out by the court in Thorneycroft (above):

‘(1) whether the statements were the sole or decisive evidence in support of the relevant allegations,

(2) the nature and extent of the appellant's challenge to the contents of the statements,

(3) whether there was any suggestion that the witnesses had reasons to fabricate their allegations,

4) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career,

(5) whether there was a good reason for the non-attendance of the witnesses,

(6) whether the Respondent had taken reasonable steps to secure their attendance, and

(7) the fact that the Appellant did not have prior notice that the witness statements were to be read.’

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 Mrs Jamieson had a case to answer.

The panel found that there was no dispute that the purported schedule of CCTV observations contained the sole evidence that Mrs Jamieson had not carried out the checks she should have in Charge 3 and Charge 1(a)(ii) on 7 March 2020 0410 hours.

Ms 3, the proposed author of the CCTV observations, was not called as an NMC witness, neither had she provided a witness statement for the panel. The panel noted that Witness

1, in her oral evidence, told the panel that this note relating to the CCTV was provided to her by someone she did not identify and she did not speak to Ms 3.

The panel did not have sight of any CCTV footage upon which the observations were supposedly made, as according to Witness 1 *'it had been lost on the system'*. There was no other evidence to demonstrate that the footage that was watched by Ms 3 was in the correct time and date, or that the CCTV system was calibrated and checked. There was no evidence before the panel to demonstrate the CCTV was watched and there was nothing on the face of the document to reassure the panel about the origin of the document. The panel noted the evidence of Witness 2 that the CCTV in the Unit was continuous but there was no evidence before the panel that either established or commented on the quality of this particular footage.

The panel reminded itself that the purported notes of the CCTV footage was the sole and decisive evidence in relation to Charge 3 and Charge 1(a)(ii) in relation to 7 March 2020 0410 hours.

Taking all of this into account, the panel determined that the undated and unsigned viewing notes that claimed to be of the CCTV footage as inadmissible evidence.

Consequently, the panel was of the view that there was no admissible evidence to support the two charges mentioned above.

Therefore, the panel determined that there was no case to answer for Charge 1(a)(i), in relation to 7 March 2020 0410 hours and Charge 3.

Decision and reasons on facts

The panel then considered Charges 1, 2, 4 and 5.

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

The panel also accepted the advice of the Legal Assessor. The panel accepted the advice that it must put out of its mind any conclusions reached by Witness 1 in the investigation she carried out. In particular, it reminded itself that burden of proving each allegation rested upon the NMC and drew no adverse inference from the non-attendance of Mrs Jamieson. It reminded itself that the standard of proof was the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

Charge 1(a)(i)

That you, a registered nurse:

1) In respect of Patient A:

a) Between 25 February 2020 and 15 March 2020;

i) On one or more occasions as set out in Schedule A failed to complete Pressure Area Care checks;

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient A's PAC record, Witness 1's NMC statement and Colleague A's local statement, NMC witness statement and oral evidence, Mrs Jamieson's job description, Patient A's care plan and Mrs Jamieson's written response dated 12 April 2020 to the local disciplinary hearing.

The panel first considered whether Mrs Jamieson had a duty to undertake comprehensive assessments including PAC. It noted that there was an ongoing process in which PAC keeps patients safe. It noted that Patient A's care plan highlights the need for PAC:

> '[…] *Due to Patient A lack of mobility she is at high risk of developing pressure area damage and requires pressure area care to be carried out 2 hourly by 2 staff members* […]'
>
> The panel took into account Witness 1's NMC statement:
>
> *'Patients on the Unit require PAC (Pressure Area Care) checks to be completed and their PAC charts to be signed to show that pressure area care has been completed every two hours. PAC checks involve moving a patient from lying on one area of their body to another, every two hours, so that the patient is not continuously putting pressure on one point of their body. This is particularly important with the type of patients we care for on the Unit as many of them are immobile and cannot move without assistance.'*

The panel therefore was of the view that there was a duty of care placed on Mrs Jamieson to complete PAC for Patient A.

The panel also took into account Colleague A's NMC witness statement:

> *'10.* [Colleague B] *and I started the night shift PAC check round at 20:00 and completed Patient A's PAC check at 20:15.* […] [Colleague B] *and I then continued the PAC check round on the other side of the Unit. When we returned to Patient A's room at 22:15, Patient A appeared to be in the same position as they had been following our 20:00 PAC check so they had not been moved. We checked Patient A's PAC chart and it said that they had received a PAC check at 22:15 by the Nurse and* [Colleague B].'

In her contemporaneous local statement, although undated and unsigned, she said:

> *'On close examination it appeared that the pillows had been removed but the client herself had not been repositioned or checked. It is not possible to physically carry out this task by 1 person due to the immobility of the patient involved.'*

The panel noted that this was contrary to the contemporaneous record of Patient A's PAC at 20.15 as it records that Colleague A and Colleague B put Patient A on their right side and that when they attended at 22.15 the patient had been turned onto her back. Further, this change of position was consistent with the pillows being removed, which is what Colleague A mentioned in her local statement and also during her oral evidence. Colleague A told the panel the only alterations she made to the chart was to cross out Mrs Jamieson's initials and substitute her own, and she amended Patient A's recording position from the back to the left.

Colleague A changed her oral evidence from saying the patient was in the exact same position at 22.15 conceding that if the pillows were removed then the patient would have been on her back when she went to check her at 22.15, which is consistent with what was recorded on the PAC.

The panel had sight of Patient A's PAC dated 25 February 2020. This showed that Patient A was on her back when Colleague A rechecked her at 22.15 hours so her position must have been changed from her right side.

Colleague A conceded that Patient A could have been moved.

The panel took into account Mrs Jamieson's written response to the local disciplinary hearing dated 12 April 2020:

> *'I can confirm that yes I did move this patient by myself from her side to her back after checking her incontinence pad, during my medication round* […] *It is safe to*

move the patient to their back from a tilt as she does not require to be lifted at any point during this manoeuvre.'

The panel considered that it would be possible for one person to roll a patient from her right side onto her back and that when the patient was rolled onto her back the patient could be checked for pressure marks and continence.

There was insufficient evidence before the panel to establish that Mrs Jamieson did not conduct a pressure area check on Patient A. Colleague A's witness statement was insufficient for the reasons set out above. The panel was of the view that Patient A's pillows were removed, the evidence demonstrated that Patient A was on her back when Colleague A checked her at 2215 which was a change of position from the record made at 2015.

Although Mrs Jamieson was not in attendance at the hearing, the panel could attach some weight to her response dated 12 April 2020 to the local investigation hearing. The panel found that her evidence was consistent with the entries on Patient A's PAC. Therefore, the panel determined that it could rely on it, and the panel had no direct evidence before it that contradicted Mrs Jamieson's response to the local hearing.

The only evidence that Mrs Jamieson may not have completed a pressure area check on the 25 February 2020 was contained in Colleague A's comments in her local statement. However, the panel noted that Colleague A was not physically in the room with Mrs Jamieson and Patient A at the time. Further, during her oral evidence, Colleague A conceded, when taken to her local statement that it did look like the pillows were removed. The panel noted that the charge was not questioning the quality of the pressure area check, but rather whether a check was completed.

In relation to the 7 March 2020, Witness 1 exhibited an unsigned and undated local interview record with Ms 5 on the 17 March 2020 that indicated that Ms 5 may have found

a 1cm by 1cm piece of dry faeces that she'd had to remove from Patient A's bottom with scissors.

Ms 5 has not provided a statement for the NMC and was not brought as a witness who could verify what she might have found or said in her interview. The panel has had no opportunity to hear from or question Ms 5 and therefore can place no weight on the notes arising from her local interview.

There was evidence on Patient A's PAC record that there had been a level of incontinence much earlier on the 7 March 2020 and that subsequently a number of staff including Mrs Jamieson had noted that patient A was continent. If the small piece of dry faeces was found and had been missed by all these staff then it's possible that Mrs Jamieson had too. This did not mean that she had not completed a pressure area check on the 7 March 2020.

The panel was therefore of the view that the NMC had not proved its case on the balance of probabilities. In light of this, the panel finds this charge not proved.

Charge 1(a)(ii)

That you, a registered nurse:

1) In respect of Patient A:

a) Between 25 February 2020 and 15 March 2020;

ii) On one or more occasions as set out in Schedule A recorded on Patient A's Pressure Area Care Chart that you conducted a Pressure Area Care check when you had not.

This charge is found NOT proved.

As the panel found that Mrs Jamieson had conducted and completed pressure area care checks for Patient A in Charge 1(a)(i), the panel determined that the recording of her initials on Patient A's PAC was made appropriately.

The panel finds this charge not proved.

Charge 1(b)

1) In respect of Patient A:

b) Between 25 February 2020 and 26 February 2020 recorded on Patient A's Pressure Care Chart Colleague B's initials to indicate that Colleague B had been present during a Pressure Care Check when she had not.

This charge is found proved.

In reaching this decision, the panel took into account Patient A's PAC record of 25 February 2020, Colleague A's witness statement and oral evidence, Witness 1's interview notes with Colleague B via telephone on 26 March 2020 and Mrs Jamieson's written response dated 12 April 2020 to the local disciplinary hearing.

The panel took into account Colleague A's witness statement:

> *'9. I recall that, during a night shift I worked on the Unit on 25/26 February 2020, the Nurse* […] *falsely recorded on Patient A's PAC chart that PAC checks had been completed by themselves and* [Colleague B] *when* [Colleague B] *had been working all evening with me.*
>
> *10.* [Colleague B] *and I started the night shift PAC check round at 20:00 and completed Patient A's PAC check at 20:15* […] [Colleague B] *and I then continued the PAC check round on the other side of the Unit. When we returned to Patient A's*

room at 22:15 […],*. We checked Patient A's PAC chart and it said that they had received a PAC check at 22:15 by the Nurse and* [Colleague B].

11. […] *The Nurse could not have completed the PC check on Patient A with* [Colleague B] *as they had been doing the PAC round with me on the other side of the Unit so were not with the Nurse.*

12. When I asked [Colleague B] *about the Nurse using her initials to sign PAC charts,* [Colleague B] *was concerned and we both made sure that the PAC checks were completed on Patient A. We amended the PAC chart entry and I signed it with my initials and crossed out the Nurse's initials as they had not completed the checks with* [Colleague B] *at 22:15.'*

The panel also took account of Witness 1's interview notes with Colleague B via telephone on 26 March 2020:

'[Witness 1] – *Has anyone ever filled in your initials on a PAC round when you have not carried it out? If so, who?*

[Colleague B] – *It happened a couple of weeks ago. My name was against a round when I didn't do it. IT was Rm 19.*

[Witness 1] – *Who put your initials on the sheet?*

[Colleague B] – *Mary Jamieson.'*

Colleague B was not called as a witness by the NMC and the record of her local telephone investigation meeting is unsigned and undated therefore little weight could be given to that evidence. However the panel found that the record of Colleague B's telephone interview on the 31 March 2020, was consistent with Colleague A's evidence that colleague B had

been with her in another part of the unit and had not been with Mrs Jamieson when attending Patient A.

The panel therefore accepted that Colleague A was working throughout the shift with Colleague B on 25 February 2020 and therefore could not have been with Mrs Jamieson when she made the entry on Patient A's PAC record at 22.15.

The panel also took into account Mrs Jamieson's written response dated 12 April 2020 to the local disciplinary hearing:

> *'I understand that this was wrong but since I started in Birc, every member of staff on night duty has done this and willingly put others initials down, this was common practice. I can only apologise for doing this but this was done by all staff to help.'*

In light of the above and the panel's findings in relation to charge 1(a), it determined that on the balance of probabilities, it is more likely than not that Mrs Jamieson recorded Colleague B's initials on Patient A's PAC to indicate that Colleague B had been present during a Pressure Care Check when she had not. It therefore finds charge 1(b) proved.

Charge 1(c)

1) In respect of Patient A:

c) On 7 March 2020 failed to examine Patient A when carrying out a continence check.

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient A's PAC record of 7 March 2023, Witness 1's witness statement and oral evidence, Witness 1's investigatory meeting

notes with Ms 5 on 17 March 2020 and Witness 1's investigatory telephone meeting with Mrs Jamieson on 31 March 2020.

The panel accepted that Mrs Jamieson had a duty to examine Patient A whilst carrying out continence checks.

Patient A's PAC recorded that there had been one episode of bowel incontinence at 08.45 on the 7 March whilst Patient A was being moved from the bed to a chair. A further note of an undefined incontinence was made at 14.00 hours when Patient A was being returned to bed. The four subsequent two hourly entries by several staff including Mrs Jamieson indicate that Patient A had remained continent until Ms 5's entry at 22.40. Ms 5 has entered that Patient A was incontinent at 22.40 but has not defined what type of incontinence that was.

Ms 5 then gave an opinion during a local telephone interview. This record is unsigned and undated. Ms 5 has not provided a statement to the NMC nor was she called as a witness. The panel can therefore place no weight on the content of the local interview record.

The panel first considered what 'examine' meant. There was no evidence before it as to what 'examining' Patient A entailed in the context of this charge.

The panel took into account Witness 1's investigatory telephone interview with Mrs Jamieson on 31 March 2020:

> *'LR – On 7th March when your colleague when to PAC room 19 they found dried faeces and to clean the patient they did not just have to use wipes but hot soapy water and scissors to cut the dried faeces off the patients pubic area. Why was this lady in this condition?*
>
> *MJ – I was pulled for this at the time. The pad was clean. What was on the patient was from the previous shift.*

LR – Are you saying you did not notice the dried faeces when checking the pad?

MJ – We looked at the pad not the patient. She had not had a bowel movement on our shift.'

The NMC rely on Mrs Jamieson's response '*We looked at the pad not the patient'* as an admission that she did not examine the patient. However, the panel took the view that this did not amount to an admission. The panel was of the view that the evidence placed before it in relation to this charge was inherently weak. The panel noted that Mrs Jamieson did not have Patient A's PCC record during this telephone interview. Further, it determined that the question about faecal matter put by Witness 1 to Mrs Jamieson during the telephone interview did not reflect the other evidence from her interview with Ms 5. She did not appear to ask any questions that would elicit specific details about what kind of examination is required during a continence check. It was of the view that there was no evidence before it that this interview note was ever seen or checked by Mrs Jamieson to verify its content. Therefore, having regard to all the evidence, the panel was not satisfied that Mrs Jamieson was making an admission to the charge before the panel.

In the absence of any other documentary evidence, the panel did not find this charge proved.

Charge 2(a)

2) Between 26 February 2020 and 27 February 2020;

   a) Shouted at Patient B "sit on your bum, sit back down" or words to that effect and/or "what are you doing standing up? You are making me work tonight" or words to that effect.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement and oral evidence, Colleague A's statement, Witness 1's investigation report, Witness 1's telephone interview with Mrs Jamieson on 31 March 2020 and Mrs Jamieson's response dated 12 April 2020 to the local disciplinary hearing.

The panel also took into account Colleague A's undated and unsigned local statement:

> *'MJ came over to the reception area here* [sic] *I was with the patient as he attempting to stand up with his wheelchair attached to him and was roaring at the patient.'*

The panel also had regard to Witness 1's telephone interview with Mrs Jamieson on 31 March 2020:

> [Witness 1] – *On 26.02.2020 between 8pm to 9pm a patient who is on a 1:1 was seemingly very argumentative and standing up in his wheelchair. Your colleague has stated they asked a total of 3 times and you refused to give.* [sic] *They have also accused you of shouting at the patient.*
>
> *MJ – I have never shouted at Patient B. He can be talked down readily. If he is reassured he can be calmed down and he did calm down. He did not need his PRN that night.'*

The panel noted from Mrs Jamieson's written response dated 12 April 2020 to the local disciplinary hearing:

> 'It was myself and [Colleague A] *who ran to stop him from falling, this should have been visible on CCTV. At no point did I shout at Patient A. I may have joked about him making me run but I certainly never shouted at him'*

The panel was of the view that Mrs Jamieson's responses have been consistent between her investigatory interview and written response. The panel noted her request for the local disciplinary panel to look at the CCTV system to clarify what had happened was not actioned by anybody at the Unit nor was it presented in evidence to the panel.

The panel was of the view that although words to that effect may have been used there was insufficient evidence that Mrs Jamison was shouting. It therefore finds this charge not proved.

Charge 2(b)

2) Between 26 February 2020 and 27 February 2020;

b) Failed to administer to Patient B pro re nata ("PRN") medication when requested by Colleague A.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's and Colleague A's witness statements and oral evidence. The panel also took into account Mrs Jamieson's job description and her responses to local investigations.

The panel took into account Witness 2's witness statement:

> *'23. By failing to administer Patient B with their PRN medication, the Nurse placed Patient B at risk of harm. Sometimes patients do not require their PRN medication straight away and it is common to see if they calm down themselves before administering this* […]'

Witness 2 explained to the panel that the first step would be to try and calm the patient down and that giving medication would be a last resort. It would be a nurses responsibility to assess the patient and not to give medication unless it was absolutely necessary
The panel accepted Witness 2's explanation that this was a rehabilitation centre which meant that the patients would have had a behavioural plan, which needed to be followed before any medication was given, which was a last resort.

The panel was of the view that Mrs Jamieson had a general duty to administer the PRN medication if it was required by Patient B. The panel accepted that it was the clinical decision of the nurse on duty to make a decision as to whether the PRN medication was necessary, after making a full assessment of the patient. Mrs Jamieson did not have a duty to administer the PRN medication to Patient B upon the request of Colleague A.

Whilst this was a distressing incident for Colleague A, there was no evidence before the panel that Mrs Jamieson did not exercise her clinical decision making properly.

The panel determined that Mrs Jamieson did not have a duty to administer to Patient B the PRN medication upon the request of Colleague A. It therefore finds this charge not proved.

Charge 4

4) Your conduct at Charge 1(a)(ii) was dishonest in that you deliberately recorded on Patient A's Pressure Area Care Chart that you conducted a Pressure Area Care check when you knew you had not.

This charge is found NOT proved.

As the panel found that Mrs Jamieson had conducted a Pressure Area Care check and had recorded appropriately on Patient A's PCC record in Charge 1(a)(ii), it finds this charge not proved.

Charge 5

5) Your conduct at Charge 1(b) was dishonest in that you deliberately recorded on Patient A's PAC Colleague B's initials to indicate that Colleague B had been present during a Pressure Care Check when you knew Colleague B had not been present.

This charge is found proved.

In reaching this decision, the panel took into account Patient A's PCC record of 25 Feb 2020, Colleague A's statement and oral evidence, Witness 1's telephone interview notes with Colleague B on 26 March 2020 and Mrs Jamieson's written response to the local disciplinary hearing dated 12 April 2020. The panel also noted the NMC Guidance document 'Making decisions on dishonesty charges.'

In considering whether Mrs Jamieson's action was dishonest, the panel had regard to the test as set out in the case of *Ivey v Genting Casinos* [2017] UKSC 67:

- What was Mrs Jamieson's actual state of knowledge or belief as to the facts; and
- Was her conduct dishonest by the standards of ordinary decent people?

Mrs Jamieson's written response dated 12 April 2020 to the local disciplinary hearing includes:

> *'I understand that this was wrong but since I started in Birc, every member of staff on night duty has done this and willingly put others initials down, this was common practice. I can only apologise for doing this but this was done by all staff to help.'*

In considering whether Mrs Jamieson's conduct would be regarded as dishonest by the standards of 'ordinary decent people', the panel bore in mind her state of mind at the time

of this incident. The panel considered that Mrs Jamieson was aware that Colleague B was not present with her when she signed colleague B's initials on Patient A's PCC chart. The panel determined that this behaviour would be regarded as dishonest by the standards of ordinary decent people because it gave a false impression as to how many staff had been present undertaking the check. The panel therefore found Mrs Jamieson's actions at charge 1(b) to be dishonest. This charge is therefore found proved.

The hearing went part-heard on 21 July 2023.

The hearing resumed on 19 February 2024.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Jamieson was not in attendance and that the Notice of Hearing letter had been sent to her registered email address on 22 January 2024.

Mr Hugh-Jones, on behalf of the NMC, submitted that it had complied with the requirements of Rules 32(3) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and venue of the hearing and, amongst other things, information about Mrs Jamieson's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Jamieson has been served with the Notice of Hearing in accordance with the requirements of Rules 11, 32 and 34.

Decision and reasons on proceeding in the absence of Mrs Jamieson

The panel next considered whether it should proceed in the absence of Mrs Jamieson. It had regard to Rule 21 and heard the submissions of Mr Hugh-Jones who invited the panel to continue in the absence of Mrs Jamieson.

Mr Hugh-Jones submitted that there had been no engagement at all by Mrs Jamieson with the NMC in relation to these proceedings since the adjournment and, that there was no evidence that there had been a change of circumstances since the hearing went part heard in July 2024.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Mrs Jamieson;
- Mrs Jamieson has not engaged with the NMC since the adjournment in July 2023 and has not responded to the email sent to her about this hearing;
- Mrs Jamieson did not attend the hearing in July 2023 and voluntarily absented herself from this hearing;
- There is no reason to suppose that adjourning this hearing would secure her attendance at some future date; and

- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Jamieson in proceeding in her absence. She will not be able to challenge the submissions made by the NMC and will not be able to give submissions or evidence on her own behalf. However the panel concluded that the disadvantage is the result of Mrs Jamieson's decision not to participate in the hearing.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mrs Jamieson.

Fitness to practise

Having reached its determination on the facts of this case, the panel then adopted a two-stage process in its consideration. First, the panel considered whether the facts found proved amount to serious misconduct. Secondly, if misconduct is found, whether Mrs Jamieson's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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 Hugh-Jones invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr Hugh-Jones referred the panel to the case of *Doughty v General Dental Council* [1987] 3 All ER 843 and the NMC's Code of Conduct. He submitted that Code 10.3 was engaged. He also referred the panel to NMC's guidance on 'How we determine seriousness' (Reference FTP-3) and 'Serious concerns which are more difficult to put right' (Reference: FTP-3a), which states:

> *'breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague or member of staff or patient who wants to raise a concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care'*

Mr Hugh-Jones invited the panel to find Mrs Jamison's covering up and falsifying records to be pertinent. He referred the panel to the NMC's guidance on 'Serious concerns which could result in harm to patients if not put right' (Reference: FTP-3b) and submitted that the evidence demonstrated that Mrs Jamieson had failed to *'uphold the reputation of the profession, by not acting with honesty and integrity …'*

Mr Hugh-Jones referred to the NMC's guidance on 'Making decisions on dishonesty charges' (Reference: DMA-7) and submitted that the falsification of records was serious and had implicated Colleague B. He said that there was a theoretical risk for the panel to consider and to determine whether that risk was being covered up by not having two people present.

Mr Hugh-Jones also referred to the case of *Calhaem, R (on the application of) v General Medical Council* [2007] EWHC 2606 (Admin) and submitted that it was serious to falsify and cover up records.

Submissions on impairment

Mr Hugh-Jones moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) which is set out in full and referred to in the panel's decision.

Mr Hugh-Jones submitted that all four limbs of the *Grant* test are engaged. He submitted that whilst there was an apology from Mrs Jamieson, she had sought to excuse her behaviour by saying that she falsified the records to 'help'. Mr Hugh-Jones stated that this does not demonstrate sufficient insight and that therefore, there is a risk of repetition of her conduct.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311and *Grant.*

Decision and reasons on misconduct

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

The panel was of the view that Mrs Jamieson's actions did fall short of the standards expected of a registered nurse, and that Mrs Jamieson's actions amounted to a breach of the Code. Specifically:

'10 - Keep clear and accurate records relevant to your practice

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

20 - Uphold the reputation of your profession at all times
To achieve this, you must:

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

The panel considered whether the facts found proved amounted to serious misconduct. It noted that breaches of the Code do not automatically result in a finding of misconduct.

At the fact finding stage, the panel found that Patient A's clinical care was appropriately and safely delivered. Mrs Jamieson knew that moving a patient on her own did not fulfil the requirements of Patient A's care plan. She tried to cover up that two members of staff had not been present by inserting Colleague B's initials into the care record. Although there is no evidence of harm resulting from this action, there was a risk that, had Patient A's care found to be substandard, the falsification of the record to show that Colleague B was present would have implicated Colleague B.

The public places high reliance on the integrity and trustworthiness of nurses and midwives, and the preservation of public trust in nurses and midwives is essential to ensure that the public can access healthcare without fear. While mindful that not all breaches of the Code would amount to misconduct, the panel was satisfied that Mrs Jamieson recording Colleague B's initials on Patient A's Pressure Area Care Chart to indicate that Colleague B had been present during a Pressure Area Care Check when she had not, amounted to serious professional misconduct.

Having considered the NMC guidance in respect of seriousness regarding Charge 1(b), the panel determined that Mrs Jamieson's actions did fall seriously short of the conduct and standards expected of a nurse and amounts to misconduct.

In relation to Charge 5, the panel was of the view that Mrs Jamieson knew that she was being dishonest when she deliberately recorded Colleague B's initials on Patient A's Pressure Area Care Chart when she knew Colleague B had not been present. She knew that two people must be present when providing this care. The panel took into account Mrs Jamieson's response to the local investigation in which she said that she understood that this was wrong and therefore implicitly accepted that she had done this. Mrs Jamieson sought to mitigate her conduct by alleging that it was common practice by all staff on night duty in the unit and this was done to help. The panel was of the view, through her actions she was condoning bad practice in record keeping and as a registered nurse, it was her duty to make sure records were accurate.

Although the false entry of Colleague B's initials into the care record was an isolated incident, the panel determined that Mrs Jamieson's dishonesty did fall short of the conduct and standards expected of a nurse and therefore amounted to serious misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel reminded itself that it had not found proved any allegations that Mrs Jamieson had provided substandard care, or put patients at unwarranted risk of harm. The panel therefore found that limb a of the *Grant* test is not engaged.

Nevertheless, the panel found that Mrs Jamieson had breached two provisions of the Code and was satisfied that her misconduct breached fundamental tenets of the nursing profession and brought the profession into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find Mrs Jamieson's fitness to practise to be impaired in light of its findings. The panel concluded that limbs b, c and d of the *Grant* test are engaged.

Aside from the evidence in Mrs Jamieson's local admissions, the panel did not have any documentation or other evidence before it addressing Mrs Jamieson's insight on the importance of honesty as a fundamental tenet of the nursing profession and of the impact her actions could have had on her patients, colleagues, the nursing profession and the wider public as a whole. Therefore, the panel was of the view that Mrs Jamieson had not demonstrated sufficient insight into her misconduct. The panel could not be satisfied, in the absence of any other evidence, testimonials or references that Mrs Jamieson understands and appreciates the seriousness of her conduct and the impact on public confidence in the nursing profession.

The panel noted that in the local investigation, Mrs Jamieson had apologised for her conduct, stating that she understood that her conduct was wrong. However, she sought to justify herself by alleging that other staff also do this in the unit. Mrs Jamieson has not provided evidence that she has strengthened her own practice. It was of the view that this demonstrated that Mrs Jamieson lacks sufficient insight into her conduct.

In considering whether Mrs Jamieson had remediated her nursing practice, the panel noted that it did not have any relevant information before it. It bore in mind that dishonesty is often more difficult to remediate than clinical concerns.

The panel has not seen evidence to demonstrate that Mrs Jamieson understands the potential and actual implications of her actions or that she has taken steps to strengthen her practice or remediate her dishonesty. In the absence of any evidence to the contrary, the panel considered that, although low, there remains a risk of repetition of Mrs Jamieson's dishonest record keeping. Therefore the panel decided that a finding of current impairment is necessary on the grounds of public interest.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. In light of Mrs Jamieson's past misconduct and the lack of evidence of insight and remediation from Mrs Jamieson, the panel considered that public confidence in the nursing profession would be undermined if a finding of current impairment was not made.

Having regard to all of the above, the panel was satisfied that Mrs Jamieson's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 4 months. The effect of this order is that the NMC register will show that Mrs Jamieson's registration has been suspended.

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

In the Notice of Hearing, dated 7 June 2023, the NMC had advised Mrs Jamieson that it would seek the imposition of a striking-off order if it found Mrs Jamieson's fitness to practise currently impaired.

In light of the panel's finding on Mrs Jamieson's current impairment, Mr Hugh-Jones invited the panel to impose a striking-off order. He submitted that there was no real or substantive evidence of any insight demonstrated by Mrs Jamieson and that there was a risk, albeit low, of a repeat of the dishonesty and a breach of fundamental tenets of the Code. Mr Hugh-Jones referred the panel to the NMC's Guidance on 'Striking-off order' (Reference: SAN-3e). He submitted that Mrs Jamieson's regulatory concerns raise fundamental questions about her professionalism and that public confidence in the nursing profession could not be maintained if Mrs Jamieson was not removed from the register. Further, he submitted that a striking-off order was the only sanction that would be sufficient to protect patients, members of the public and maintain professional standards.

The panel accepted the advice of the legal assessor who referred to the cases of *Bolton v Law Society* [1993] EWCA Civ 32, *General Medical Council v Bramhall* [2021] EWHC (2109) (Admin) and *General Medical Council v Khetyar* [2018] EWHC 813 (Admin).

Decision and reasons on sanction

Having found Mrs Jamieson's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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:

- Mrs Jamieson lacks insight into the seriousness of her misconduct;
- Misconduct which implicated Colleague B, when she was not involved.

The panel also took into account the following mitigating features:

- A single incident;
- No patient harm;
- Mrs Jamieson apologised to her employer at an early stage;
- No previous regulatory matters in an otherwise unblemished career;
- No personal gain.

The panel had regard to the passages in SG dealing with dishonesty which states:

> ‘Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:
>
> - deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients;
> - misuse of power;
> - vulnerable victims;
> - personal financial gain from a breach of trust;
> - direct risk to patients;
> - premeditated, systematic or longstanding deception.’

The panel found that Mrs Jameson’s misconduct did not fall into any of those categories. The panel also noted that the SG provided that, ‘Dishonest conduct will generally be less serious in cases’ of:

- one-off incidents;
- opportunistic or spontaneous conduct;

- no direct personal gain;
- incidents in private life of nurse, midwife or nursing associate.

The panel was satisfied that Mrs Jamieson's misconduct was a one off incident, and neither resulted in, nor had the possibility of resulting in personal gain to her. In those circumstances, the panel decided that, although dishonesty is always a serious matter, Mrs Jamieson's misconduct should be considered at the lower end of such misconduct.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the dishonesty involved in this case. The panel decided that it would be neither proportionate nor would it mark the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the dishonesty involved in this case this order would not sufficiently mark the public interest. 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.'* In light of the, albeit low risk of repeating the misconduct, the panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Jamieson's 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. It noted that there were identifiable areas of Mrs Jamieson's record keeping practice in need of assessment and/or retraining. However, as Mrs Jamieson has not engaged in the proceedings, the panel had no evidence before it and could not be assured that she had the potential and willingness to respond positively to any conditions. Therefore, the panel concluded that the placing of conditions on Mrs Jamieson's registration would not be the appropriate order.

In the absence of Mrs Jamieson's engagement, the panel went on to consider whether a suspension order would be an appropriate sanction. The panel had regard to NMC's guidance on 'Suspension order' (Reference: SAN-d3) which outlines the circumstances where a suspension order may be appropriate. The SG states that suspension order may be appropriate where the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems.*

The panel also had regard to the NMC's guidance on 'Considering sanctions for serious cases' (Reference: SAN-2), in particular on dishonesty. It was of the view that dishonesty will always be serious and a nurse who has acted dishonestly will always be at risk of being removed from the register. However, it also noted that not all dishonesty is equally serious. The panel determined, in the circumstances of the case, that Mrs Jamieson's dishonest conduct was at the lower end of seriousness as this was a one off incident involving one false entry of a colleague's initials in Patient A's Pressure Area Care Chart. It noted that there was no evidence that similar actions happened before the night shift of 24 February 2020 or since. The panel also noted that there was no harm to Patient A, nor was there a cover up of anything going wrong with Patient A's care because of this false entry and there had been no personal gain for Mrs Jamieson. There was no evidence of harmful deep-seated personality or attitudinal problems. The panel found that Mrs Jamieson was currently impaired on public interest grounds only.

In making this decision, the panel carefully considered the submissions of Mr Hugh-Jones in relation to the sanction that the NMC was seeking in this case. It considered whether a striking-off order would be proportionate. The panel reminded itself that it has already found that Mrs Jamieson's misconduct did not fall into any of the categories where the SG indicates that striking off is most likely. Mrs Jamieson's misconduct engages two of the matters indicating that the dishonesty is less serious. Therefore, the panel is satisfied that a striking off order is not consistent with the guidance given in the SG as set out above.

Taking account of all the information before it, and of the mitigation factors, the panel was of the view that a temporary removal would mark the public interest and allow Mrs Jamieson to take steps to strengthen her practice and to demonstrate what she had learned and provide evidence that this misconduct will not be repeated. It, therefore, concluded that a striking-off order would be disproportionate in light of the circumstances. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Jamieson's case to impose a striking-off order.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel noted the hardship such an order may cause Mrs Jamieson, however this is outweighed by the public interest in this case.

The panel determined that a suspension order for a period of 4 months was appropriate in this case to mark the seriousness of the misconduct and to allow Mrs Jamieson the opportunity to take steps to strengthen her practice, to develop and provide evidence that she has insight into her misconduct and the impact of her misconduct on her colleagues, patients and the public's confidence in the nursing profession.

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

Any future panel reviewing this case would be assisted by:

- Your attendance at any review of this order;
- A written reflective piece showing your understanding and insight into the impact of your misconduct on patients, colleagues and the nursing profession;
- Evidence of any steps you have taken to strengthen your practice to ensure that the misconduct would not repeated;
- Relevant training addressing the concerns raised in relation to record keeping and honesty;
- Any relevant up to date testimonials from any work undertaken, paid or voluntary; and
- Evidence of where you demonstrated good record keeping practice and honest behaviour.

This will be confirmed to Mrs Jamieson in writing.

Interim order

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

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

Submissions on interim order

The panel took account of the submissions made by Mr Hugh-Jones. He submitted that an interim suspension order should be imposed for a period of 18 months to cover the 28 day appeal period and the subsequent period should an appeal be lodged. He submitted that this is necessary for the same reasons as given by the panel regarding the substantive order.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary in the public interest. The panel had regard to the dishonesty and the risk of repetition and the reasoning set out in its decision for the substantive order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, because there has been a finding of dishonesty and the panel had no information that would assure it that Mrs Jamieson would comply with an interim conditions of practice order. The panel therefore imposed an interim suspension order for a period of 18 months due to allow sufficient time for any appeal to be heard. The panel is satisfied that this order and for this period is proportionate in the circumstances of this case.

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

That concludes this determination.