Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 7 March 2023 – Wednesday, 15 March 2023,
Monday, 11 December 2023 – Friday 15 December 2023

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

Virtual Hearing (Friday 15 December 2023, Tuesday 9 January 2024 – Thursday 11 January 2024)

Physical & Virtual hearing

Name of Registrant:	Kerry Louise Wragg
NMC PIN	06B0503E
Part(s) of the register:	RNA: Adult Nurse – 4 May 2006
Relevant Location:	Wakefield
Type of case:	Misconduct
Panel members:	Paul Grant (Chair, Lay member) Shorai Dzirambe (Registrant member) Karen Shubert (Registrant member)
Legal Assessor:	Gareth Jones (7 March 2023 – 15 December 2023) Fiona Moore (9 January 2024 – 11 January 2024)
Hearings Coordinator:	Max Buadi (7 – 15 March 2023) Daisy Sims (11 – 15 December 2023, 9 January 2024 – 11 January 2024)
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter (7 March 2023 – 15 December 2023) Represented by Holly Girven, Case Presenter (9 January 2024 – 11 January 2024)

Ms Wragg:	Present and represented by Laura Bayley, (instructed by the Royal College of Nursing (RCN))
No case to answer:	Charges 1a, 1b, 1c, 2a, 2b, 2c, 5, 6a(i), 6a(ii), 6b 7a, 7b, 8a, 11 and 12
Facts proved:	Charges 8b, 9a, 10a, 10b, 13a, 14a and 14b
Facts not proved:	Charges 3, 4a, 4b, 4c, 9b, 13b, 15a, 15b, 16a, 16b and 16c
Fitness to practise:	Impaired
Sanction:	**Suspension order (4 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge (not amended)

That you, registered nurse working for the Ossett Surgery:

1) On or around 27 February 2020 in relation to Patient I:
   a) Started them on Dapgliflozon when the medication was contraindicated
   b) Ignored the specialist advice not to start them on Dapgliflozon
   c) Did not document a) and / or b) above in their notes

2) At the beginning of November 2020 in relation to Patient G:
   a) Assessed their symptoms when this was outside your scope of competence
   b) Did not assess the severity of their symptoms correctly
   c) Did not book them in for a same day appointment

3) On 4 November 2020 in relation to Patient F:
   a) Did not escalate chest pain concerns appropriately

4) On or around 18 November 2020 in relation to Patient B:
   a) Did not follow recommendation from Colleague A that their contraceptive medication be changed
   b) Did not discuss with Colleague A why you had not followed their advice
   c) Did not document why the recommendation was not followed

5) On or around 18 November 2020 in relation to Patient C:
   a) Undertook a DOAC review when you had been told previously not to

6) On or around 18 November 2020 in relation to Patient D:
   a) When assessing renal issues did not:
      i) Review their medication
      ii) Request a kidney function test
   b) Did not document the consultation adequately or at all

7) On or around 18 November 2020 in relation to Patient E:
   a) Did not use the correct template form
   b) Did not record a risk assessment

8) On or around 18 November 2020 in relation to Patient K:
   a) Did not use a template for the consultation
   b) Did not provide adequate clinical information

9) Held out to the Practice that you had you had ARTP in Spirometry by:
   a) Stating you had completed the course
   b) Stating you were a 4 on the skills matrix for the practice

10) Your actions in charge 9 above were dishonest in that:
   a) You had failed the ARTP in spirometry
   b) They were intended to induce others to believe you are qualified in this area when you were not

11) Stated to Colleague A you had only failed the ARTP because you had not put patient names on the spirometry when you had also failed in other areas

12) Your actions in charge 11 above were dishonest in that:
   a) You sought to avoid and / or minimise the reasons for your failure

13) Held out to the Practice that you had you had a diabetes diploma by:
   a) Stating you had completed the course
   b) Stating you were a 4 on the skills matrix for the practice

14) Your actions in charge 13 above were dishonest in that:
   a) You were aware you had not completed the diploma
   b) They were intended to induce others to believe you had passed the diploma

15) Held out to the Practice that you were competent in asthma treatment by:

a) stating you had completed training in the ATRP course

b) Stating you were a 3 on the skills matrix for the practice

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

Background

The NMC received a referral from Ossett GP Surgery ("the Surgery") on 22 January 2021 relating to when you were employed as a practice nurse at the Surgery.

The Surgery was formed by the merging of two former practices namely, Church Street and Prospect Road Surgery. You were originally employed at Prospect Road Surgery and were an employee for just over a year before the merger.

When you applied for this new role in the combined surgery, you relied upon a Curriculum Vitae (CV) that stated that you had completed a diploma in diabetes and completed the Association for Respiratory Technology & Physiology ("ARTP") in spirometry qualification. This was repeated in your application form.

After the surgeries merged it was alleged that poor clinical performance by you was recognised in a number of clinical areas, including but not limited to asthma reviews/ chronic obstructive pulmonary disease ("COPD") reviews and diabetes reviews. The specific issues that were flagged up in terms of performance were described by your GP manager, Colleague A, as being "numerous and wide ranging".

The alleged concerns relate to acting outside of your competence, dishonesty and misrepresenting qualifications, record keeping concerns and medication administration and

prescribing incorrectly. These concerns are alleged to have occurred between February 2019 and January 2021.

It is alleged that asthma/COPD reviews were being done incorrectly with no care planning or emergency care plans provided to the patient. Further, patients were not being advised properly with regards to their inhalers and information was not being recorded properly in the patient notes.

It is also alleged that diabetes care was also an issue. You had allegedly been initiating medication for diabetes, namely Dapagliflozin in several patients with poor renal function which it is alleged is contraindicated. It is alleged that you were initiating medication outside your competency.

As a consequence of the above, the GP Practice Manager had to audit patients' records to try to locate all the patients medicated in this way. The practice found four patients affected. It is alleged that one of these patients was started on Dapagliflozin against the specific recommendation of an endocrine consultant who allegedly told you in an email not to give this drug. Despite this the drug was still given. The other three times this drug was allegedly given without any evidence that you had asked anyone qualified whether this was the right thing to do.

It is further alleged that on another occasion you ignored the advice of Colleague A who specialises in contraception. A patient had been on Depo-Provera for 23 years and you allegedly asked for advice as to whether the patient required a bone density DEXA scan. You were advised by Colleague A to change the patient to a different method of contraception, as the patient was peri-menopausal and her bone mineral density potentially needed time to recover before menopause. It is alleged that you disregarded this direction and booked the patient for a further depo without further consultation or discussion. This action was then picked from the notes during an audit carried out on your record keeping.

There were also allegedly specific clinical issues relating to hormone replacement therapy ("HRT"), contraception and direct oral anticoagulants ("DOAC") reviews.

Colleague A also found a problem with your record keeping. It is alleged that you had asked a doctor for advice regarding a patient with poor renal function, however this had not been recorded, nor if you had followed this advice.

It is also alleged that you did not have the qualifications that you had stated you had on your CV/application form to the Surgery. This included the diabetes diploma and Asthma training. A further meeting was convened with you where you were asked for copies of your qualifications.

It is alleged that when applying for the job at Prospect Road Surgery you stated on your CV and your application form that you had a diploma in Diabetes/COPD and an ARTP in spirometry.

This claim was repeated on a skills matrix filled in by you when the practices merged in October 2020. You also allegedly claimed to have been on a course in asthma on the skills matrix and claimed competency to perform HRT and DOAC reviews. It is alleged that you had been conducting consultations with COPD/asthma patients and also diabetes patients and initiating and changing medications in these areas. However, it is alleged that you do not hold these qualifications and have had no training in asthma, HRT or DOACs.

Decision and reasons on application to admit information regarding Dapagliflozin from the British National Formulary (BNF).

The panel heard an application made by Ms Bayley, on your behalf, under Rule 31 to allow information regarding Dapagliflozin from the British National Formulary (BNF) into evidence. Ms Bayley reminded the panel that in response to its questions, Colleague A referred to the BNF regarding the Dapagliflozin and said that it was contraindicated in the presence of reduced renal function.

Ms Bayley invited the panel to exhibit the information regarding Dapagliflozin from the BNF.

Mr Radley, on behalf of the Nursing and Midwifery Council (NMC), indicated that he did not oppose the application.

The panel heard and accepted the advice of the legal assessor. It took as its starting point Rule 31. This explains that evidence is only admissible in NMC proceedings if it is both (a) relevant and (b) fair.

The panel was satisfied that the information regarding Dapagliflozin from the BNF was relevant.

With regards to fairness, the panel bore in mind that both Ms Bayley and Mr Radley were in agreement that the evidence should be admitted.

In light of the above, the panel decided that it would be fair and relevant to admit the information regarding Dapagliflozin from the BNF. In due course the panel will determine what weight, if any, to attach to it.

Decision and reasons on application to admit Patient G's medical records.

The panel heard an application made by Ms Bayley under Rule 31 to allow Patient G's medical records into evidence. She submitted that these were provided by the NMC, are clearly relevant, and their admission into evidence would not be unfair.

Ms Bayley submitted that she planned to cross-examine Ms 2 and Dr 3 in respect of Patient G's records. She also reminded the panel that there is only one page of Patient

G's records available to the panel within the NMC bundle, whereas other patient records are available in their entirety.

Mr Radley submitted that he has no objection to this.

The panel heard and accepted the advice of the legal assessor. It took as its starting point Rule 31. This explains that evidence is only admissible in NMC proceedings if it is both (a) relevant and (b) fair.

The panel was satisfied that Patient G's records are relevant to charge 2.

With regards to fairness, the panel bore in mind that both Ms Bayley and Mr Radley were in agreement with that the records should be admitted.

In light of the above, the panel decided that it would be fair and relevant to admit the medical records of Patient G. In due course the panel will determine what weight, if any, to attach to it.

Decision and reasons to admit the witness statement of Ms 6

Mr Radley informed the panel that, on 10 March 2023, he had made enquires with regards to the availability of Ms 6, Lead Nurse at the Surgery and your Line Manager at the time. He submitted that he had contacted the NMC case officer and the NMC Case Lawyer to ask why Ms 6 was not part of the proceedings.

Mr Radley informed the panel that he had received no response from either but was aware that the NMC had prepared a witness statement with Ms 6. Mr Radley also submitted that he followed up his enquiry with the NMC Case Lawyer on 12 March 2023, but the Case Lawyer was on annual leave. He submitted that he emailed the Case Lawyer's supervisor, went through the case and explained potential evidence that could be given by Ms 6. He

submitted that the Case Lawyer's supervisor agreed that Ms 6's evidence should be heard.

Ms Bayley indicated that she had sight of a statement from Ms 6 in the NMC Case Examiners report, but Ms 6 did not appear on the NMC witness list. She further indicated that whilst she had no opposition to the witness statement of Ms 6 being admitted into evidence or Ms 6 being called as a witness, she nevertheless need time to take instructions.

The panel heard and accepted the advice of the legal assessor. It took as its starting point Rule 31. This explains that evidence is only admissible in NMC proceedings if it is both (a) relevant and (b) fair.

The panel was of the view that Ms 6 is an important witness given that she was your line manager and was integral to the production of the skills matrix. In the light of this, and the fact that there was no opposition to the application, the panel determined that the evidence was relevant and that it would be fair to admit it.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Radley to amend the preamble to all the charges and the wording of charges 1a, 3, 5, 7b, 11, 12 and 15.

The proposed amendments were to fix typographical errors which would provide clarity and more accurately reflect the evidence.

Proposed amendments:

That you, registered nurse ~~working for the Ossett Surgery~~:

1) *On or around 27 February 2020 in relation to Patient I:*

a) *started them on Dapgliflozin when the medication was contraindicated*
b) *Ignored the specialist advice not to start them on Dapgliflozin*

3) *On 4 November 2020 in relation to Patient F ~~a)~~ did not escalate chest pain concerns appropriately*

5) *On or around 18 November 2020 in relation to Patient C ~~a)~~ undertook a DOAC review when you had been told previously not to*

7) *On or around 18 November 2020 in relation to Patient E:*
   a) *…*
   b) *Did not record a **VTE** risk assessment*

11) *Stated to colleague A you had only failed the ARTP because you had ~~not~~ put patient names on the spirometry when you had also failed in other areas*

12) *Your actions in charge 11 above were dishonest in that ~~a)~~ you sought to avoid and / or minimise the reasons for your failure*

15) *Held out to the Practice that you were competent in asthma treatment by:*
   a) *stating you had completed training in the ~~ATRP~~ **ARTP** course*

Ms Bayley did not oppose the amendments as she was in agreement with them.

The panel then heard an application made by Mr Radley to add an additional charge. He submitted that this matter was raised with the panel at the beginning of this hearing. He submitted that the NMC wanted to give context and meaning to charge 15 and express in more specific terms the nature of the allegation against you.

Mr Radley reminded the panel that it had the power to add an additional charge where it is right to do so and where you are not “taken by surprise” or are unable to prepare an opposition to the charge.

Proposed additional charge:

16) Your actions in charge 15 above were dishonest in that:

a) you were aware that you had not completed the training in the ARTP

b) you were aware that you were not a level 3 on the skills matrix

c) they were intended to induce others to believe you had completed the training and / or were competent to carry out asthma treatment

Ms Bayley opposed the application to add an additional charge on the basis that it would result in an injustice. She highlighted that this case is now incredibly old dating back at least three years.

Ms Bayley informed the panel that the Case Management Form (CMF) never included a further allegation of dishonesty in relation to your competency in providing asthma treatment. She also submitted that the NMC have had plenty of opportunity prior to the charges becoming final and before notice of hearing was sent out to amend the charges.

Ms Bayley accepted that she was informed of the proposed amendment near the beginning of these proceedings. She submitted however, that this case has been through the NMC case examiners, it has been considered by an NMC Senior Lawyer, charges have been drafted and a CMF has been sent and there has never been an allegation of dishonesty. She reminded the panel that allegations of dishonesty are always very serious and submitted that it is right and proper that you are given 28 days notice before the start of the hearing as per Rule 28 of ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

Ms Bayley submitted that this amendment has never been a part of the NMC case, and it would be unfair at this late stage to add a very serious charge of dishonesty.

Ms Bayley submitted that this is not a case of correcting undercharging as per the case of *PSA v NMC & Jozi [2015] EWHC 764 (Admin).* This is because with regards to charge 9, 11 and 13, there is no such evidence in this case that you held out that you had a diploma in asthma and that is not what charge 15 says. Ms Bayley also reminded the panel of the evidence of Ms 6 and the skills matrix demonstrating that you have not held out having a particular qualification or diploma in administering asthma treatment.

Ms Bayley submitted that there has been very limited evidence about asthma treatment or competence, and it does not necessarily follow that this allegation amounts to dishonesty. She submitted that it has been apparent that the NMC case was “ill prepared”. She submitted that the fact that the allegation does not make sense could not be “cured” by the additional dishonesty charge.

Ms Bayley submitted that it is too late in the proceedings and unfair to make such an amendment to the charge.

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

With regards to the proposed amendments to charges 1a, 3, 5, 7b, 11, 12 and 15, the panel was of the view that such amendments, as applied for, properly reflected the evidence presented and could be made without injustice. It bore in mind that Mr Radley and Ms Bayley agreed with the amendments and was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It also noted that the panel had already identified some of these amendments already. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

The panel then considered the proposed amendment to add an additional charge. It bore in mind the submission of Ms Bayley pertaining to how it was too late in the proceedings to add an additional charge. However, the panel reminded itself of Rule 28 which states:

> *'**28.**— (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—*
>
> *(a) the charge set out in the notice of hearing; or*
>
> *(b) the facts set out in the charge, on which the allegation is based,*
>
> *unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.*
>
> *(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.'*

In light of the above, the panel was of the view that there would be no injustice in accepting the proposed amendment to add an additional charge. It considered that you would have had notice of this additional charge from the information that has been disclosed, namely from the witness statements you would have had sight of prior to the hearing. It noted that the NMC witness statements have alleged that you have undertaken asthma treatment when you were not qualified to do so, whilst leading others to believe you were qualified. It was of the view that this is amounts to an allegation of dishonesty. The panel also considered that the proposed additional charge followed the same pattern as the other allegations of dishonesty such that you could have reasonably anticipated that charge 15 was to be framed as an allegation of dishonesty.

The panel noted that while the application to amend the charge is late, it considered there to be no injustice in accepting the application and was of the view that this case would be undercharged if the addition was not made.

The panel also considered there to be a public interest in adding this charge and was of the view that you have sufficient evidence to robustly defend yourself. It was not suggested by Ms Bayley that the proposed additional charge would in anyway hinder you in the preparation and presentation of your defence.

Details of charge (as amended)

That you, a registered nurse:

1) On or around 27 February 2020 in relation to Patient I:
   a) Started them on Dapagliflozin when the medication was contraindicated
   b) Ignored the specialist advice not to start them on Dapagliflozin
   c) Did not document a) and / or b) above in their notes

2) At the beginning of November 2020 in relation to Patient G:
   a) Assessed their symptoms when this was outside your scope of competence
   b) Did not assess the severity of their symptoms correctly
   c) Did not book them in for a same day appointment

3) On 4 November 2020, in relation to Patient F, did not escalate chest pain concerns appropriately

4) On or around 18 November 2020 in relation to Patient B:
   a) Did not follow recommendation from Colleague A that their contraceptive medication be changed
   b) Did not discuss with Colleague A why you had not followed their advice
   c) Did not document why the recommendation was not followed

5) On or around 18 November 2020, in relation to Patient C, undertook a DOAC review when you had been told previously not to

6) On or around 18 November 2020 in relation to Patient D:

    a) When assessing renal issues did not:
        i) Review their medication
        ii) Request a kidney function test
    b) Did not document the consultation adequately or at all

7) On or around 18 November 2020 in relation to Patient E:
    a) Did not use the correct template form
    b) Did not record a VTE risk assessment

8) On or around 18 November 2020 in relation to Patient K:
    a) Did not use a template for the consultation
    b) Did not provide adequate clinical information

9) Held out to the Practice that you had you had ARTP in Spirometry by:
    a) Stating you had completed the course
    b) Stating you were a 4 on the skills matrix for the practice

10) Your actions in charge 9 above were dishonest in that:
    a) You had failed the ARTP in spirometry
    b) They were intended to induce others to believe you are qualified in this area when you were not

11) Stated to Colleague A you had only failed the ARTP because you had put patient names on the spirometry when you had also failed in other areas

12) Your actions in charge 11 above were dishonest in that you sought to avoid and / or minimise the reasons for your failure

13) Held out to the Practice that you had you had a diabetes diploma by:

a) Stating you had completed the course

b) Stating you were a 4 on the skills matrix for the practice

14) Your actions in charge 13 above were dishonest in that:

a) You were aware you had not completed the diploma

b) They were intended to induce others to believe you had passed the diploma

15) Held out to the Practice that you were competent in asthma treatment by:

a) Stating you had completed training in the ARTP course

b) Stating you were a 3 on the skills matrix for the practice

16) Your actions in charge 15 above were dishonest in that:

a) You were aware that you had not completed the training in the ARTP

b) You were aware that you were not a level 3 on the skills matrix

c) They were intended to induce others to believe you had completed the training and / or were competent to carry out asthma treatment

Decision and reasons on application to admit email from Ms 2 dated 17 November 2020 into evidence

The panel heard an application made by Ms Bayley under Rule 31 to admit an email from Ms 2 sent to you dated 17 November 2020 into evidence. Ms Bayley submitted that the email is evidence that Prospect Surgery Partners were aware of your diabetes qualification.

Ms Bayley submitted that the email from Ms 2 is in relation to allegations 13 and 14. She further submitted that this is something that Ms 6 could speak to given that she was the Lead Nurse and she was at the meeting where there was some discussion about the diabetes diploma.

Ms Bayley submitted that admitting this evidence is not unfair and is relevant to charges 13 and 14.

Mr Radley informed the panel that he did not oppose the application.

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

The panel decided to admit the email from Ms 2 dated 17 November 2020 into evidence. The panel determined to admit the email with a degree of hesitation because Ms 2 had not given evidence in relation to its content but recognised that another witness may be in a position to do so.

Decision and reasons on application to admit the unredacted Skills Matrix into evidence.

The panel heard an application made by Ms Bayley under Rule 31 to admit the unredacted Skills Matrix referenced by Ms 6 in her witness statement into evidence.

This document was not contested by Mr Radley.

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

The panel noted that there was no objection to the relevance of the unredacted Skills Matrix or the fairness of admitting it into evidence by either party. On that basis the panel was content to grant the application.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Bayley who provided the panel with written submissions which stated:

> ***"Introduction***
>
> *1. The Nursing and Midwifery Council ("NMC") brings this case and the burden of proof rests with the NMC at all times. Mrs Wragg is not required to prove anything. At the close of the NMC's case, it is submitted that the NMC has failed to discharge the persuasive and evidential burden and that there is no case for Mrs Wragg to answer in relation to the following charges:*
>
> *"That you, a registered nurse:*
>
> *1) On or around 27 February 2020 in relation to Patient I:*
> *a) started them on Dapagliflozin when the medication was contraindicated*
> *b) Ignored the specialist advice not to start them on Dapagliflozin*
> *c) Did not document a) and / or b) above in their notes*
>
> *2) At the beginning of November 2020 in relation to Patient G:*
> *a) Assessed their symptoms when this was outside your scope of competence*
> *b) Did not assess the severity of their symptoms correctly*
> *c) Did not book them in for a same day appointment*
>
> *4) On or around 18 November 2020 in relation to Patient B:*
> *a) Did not follow recommendation from Colleague A that their contraceptive medication be changed*
> *b) Did not discuss with Colleague A why you had not followed their advice*
> *c) Did not document why the recommendation was not followed*

5) On or around 18 November 2020, in relation to Patient C, undertook a DOAC review when you had been told previously not to

6) On or around 18 November 2020 in relation to Patient D:
a) When assessing renal issues did not:
i) Review their medication
ii) Request a kidney function test

7) On or around 18 November 2020 in relation to Patient E:
a) Did not use the correct template form
b) Did not record a VTE risk assessment

8) On or around 18 November 2020, in relation to Patient K:
a) Did not use a template for the consultation

11) Stated to colleague A you had only failed the ARTP because you had put patient names on the spirometry when you had also failed in other areas

12) Your actions in charge 11 above were dishonest in that you sought to avoid and / or minimise the reasons for your failure"

Legal Framework

2. *Application in relation to the facts is made under Rule 24(7) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended:*

"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…"

3. *In accordance with the principles set out in the criminal case of R v Galbraith [1981] 1 W.L.R. 1039, when considering whether there is a case to answer, the Panel should first determine whether there is any evidence upon which a Panel could properly find the charges proved. Where there is none, the Panel should find no case to answer. Where there is some evidence presented, the Panel should consider the nature and strength of that evidence and decide whether it can properly be relied upon to find the facts proved. Evidence which is inherently weak and vague, or inconsistent with the remaining evidence in the case, ought not be relied upon.*

4. *Application is made that no reasonable panel, properly directed could find the above charges proved. This is a legal application related to the sufficiency of the evidence in this case. The panel must decide whether the allegation could be made out, not whether it would be made out, on the balance of probabilities, taking the NMC case at its highest. The panel is reminded of the principle in the case of Shippey [1988] Crim LR 767 that "'taking a prosecution case at its highest' did not mean picking out the plums and leaving the duff behind."*

5. *Charge 5 relies upon multiple and, in some instances, anonymous hearsay. The principles concerning the admissibility of hearsay evidence in professional disciplinary proceedings are well established in case law. In the case of White v Nursing and Midwifery Council [2014] EWHC 520 (Admin) the High Court found that, as a general rule, it would be unfair to admit anonymous hearsay evidence in professional disciplinary cases. Mitting, J stated:*

   "13. In the context of disciplinary proceedings, it is difficult to conceive of circumstances in which the admission of potentially significant evidence about the attitude and conduct of a registrant which is both anonymous and hearsay will not infringe the

requirement of fairness. This is not because the rule in criminal cases applies without more, but because of the underlying principle which it applies and illustrates. It cannot normally be fair for significant evidence about the attitude and conduct of a registrant to be admitted against her which she has no opportunity to test or meet by anything beyond a bare denial."

6. *Reference was also made in that judgment to the leading case of Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin), which was decided at a similar time and summarised the relevant principles in respect of hearsay generally (as opposed to anonymous hearsay specifically), at para 45, per Mr Andrew Thomas QC sitting as a deputy judge of the High Court as follows:*

"45. For the purposes of this appeal, the relevant principles which emerge from the authorities are these:

1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.

1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.

1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.

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."

7. *The case of El Karout v Nursing and Midwifery Council [2019] EWHC 28 (Admin) makes clear that, as set out in the earlier authorities, admissibility should be considered as a primary application, before consideration is give to what, if any weight should be placed upon the evidence.*

8. *Where the NMC charges a failure, the NMC is obliged to prove that there exists a duty AND an unreasonable failure on the part of the Registrant to fulfil that duty (Daly v NMC [2018] CSIH 51). Where a charge of "did not" appears in a schedule of NMC allegations, the panel ought to interpret that as "failed to".*

9. *The NMC produces guidance on "no case to answer" applications, as well as taking account of context.*

1) On or around 27 February 2020 in relation to Patient I:
a) started them on Dapagliflozin when the medication was contraindicated
b) Ignored the specialist advice not to start them on Dapagliflozin
c) Did not document a) and / or b) above in their notes

10. *Mrs Wragg is not a prescriber. She has no power to start someone on medication. That is the role of a prescriber. In this case, the patient was started on Dapagloflozin by [Dr 7] [Ex7], not Mrs Wragg.*

11. *The BNF does not include low eGFR as a contraindication [Ex13 and Ex17].*

12. *[Ms 6] told the panel, in answer to questions arising, that if the prescription was signed by a GP, it was the GP who "started" the medication.*

13. *[Dr 1] agreed (in cross-examination) that the responsibility for a prescription lies with whomever signed and issued the prescription. He told the panel that it would be a GP who raised the prescription.*

14. *The prescription [Ex7] was issued by [Dr 7] prior to the advice coming back from eConsult [Ex11]. It would appear from Patient I's records that the alert was sent back to [Dr 7] the day after his medication had been started. There is no evidence that Mrs Wragg would have been made aware of the eConsult response.*

15. *Patient G was seen by a number of clinicians after his appointment with Mrs Wragg, none of whom noted there to be a problem with the prescription.*

16. *As there is no evidence to support parts a) or b) of the charge, c) must also fail.*

2) At the beginning of November 2020 in relation to Patient G:

a) Assessed their symptoms when this was outside your scope of competence

b) Did not assess the severity of their symptoms correctly

c) Did not book them in for a same day appointment

17. *It transpired, during the evidence of [Dr 3] in cross-examination, that the "Patient G" she discussed at paragraph 22 of her statement [Ex1, p25-26] is not the same patient as appears in Patient G's notes [Ex 10], or the evidence of [Ms 6] [Ex14, para 19, Ex2, SB/02] and [Mr 5] [Ex1, para 22]. No information has been provided about this unknown patient. The panel is invited, in the circumstances, to disregard para 22 of [Dr 3]'s statement.*

18. *There is no evidence that it was outside the scope of Mrs Wragg's practice to assess Patient G's symptoms. There is no evidence about what the severity of Patient G's symptoms were and nothing to suggest they were more severe than noted by Mrs Wragg in the patient's notes. The patient was spoken to by [Dr 9] on the same day in a telephone appointment.*

19. *The NMC witnesses gave hearsay evidence that [Dr 9] was critical that Mrs Wragg sent the patient home before asking for a GP review of her ECG [Ms 6] or that the ECG was abnormal [Mr 5]. This is not charged. The ECG has not been provided. Neither Mrs Wragg nor [Dr 9] note that the ECG was abnormal. This hearsay evidence is inconsistent and insufficient such that any panel, properly directed, could find the allegation proved on this basis.*

20. *In any event, the evidence matrix indicates that the NMC relies on the evidence of [Dr 3] in relation to this charge. The panel is invited to find no case to answer.*

4) On or around 18 November 2020 in relation to Patient B:

a) Did not follow recommendation from Colleague A that their contraceptive medication be changed

b) Did not discuss with Colleague A why you had not followed their advice

c) Did not document why the recommendation was not followed

21. *The advice from [Colleague A] was received by "task" the day after the contraceptive depot had been administered to the patient and the repeat appointment created [Ex 9 and Ex2, CJ/02], on 19 November 2020.*

22. *On 18 December 2020, there is a note from Mrs Wragg that the patient must be reviewed prior to her next appointment [Ex2, CJ/02, Ex9 and Ex2, CJ/05]. There was a discussion on task about the merits of stopping the depo [Ex2, CJ/02]. This clearly demonstrates that Mrs Wragg had a "discussion" with [Dr 3], after putting in a request for Patient B to make a GP appointment, and that her advice was followed.*

5) On or around 18 November 2020, in relation to Patient C, undertook a DOAC review when you had been told previously not to

23. *The appointment was not a DOAC review. Medication may have been reviewed as part of the AF (Atrial Fibrillation) review but this was not a specific DOAC review. The Code for DOAC review was not used by Mrs Wragg.*

24. *The DOAC review was undertaken by [Pharmacist 10] (Pharmacist) on 14 December 2020 [Ex3, p155 of 384 and Ex12].*

25. *Further, there is insufficient evidence that Mrs Wragg was told not to undertake DOAC reviews. None of the witnesses were present when Mrs Wragg was allegedly told not to, nor were they sure who was said to have given the instruction. [Dr 3]'s evidence was that she was told by someone that it was [Ms 8] who gave the instruction. This evidence therefore amounts to multiple hearsay and is inherently unreliable. The panel is invited to exclude the multiple and/or anonymous hearsay evidence that someone, possibly [Ms 8], told Mrs Wragg that she ought not to be carrying out DOAC reviews.*

6) On or around 18 November 2020 in relation to Patient D:

a) When assessing renal issues did not:

i) Review their medication

ii) Request a kidney function test

b) Did not document the consultation adequately or at all

26. *[Dr 1]'s evidence confirmed that Patient D did not require a kidney function test at that appointment and that Mrs Wragg was not qualified or required to review Patient D's medication during the appointment.*

27. *[Colleague A] resiled from the evidence in her statement and stated that she had been unduly critical of Mrs Wragg having later considered the patient notes. She did not stand by the evidence given in relation to this patient (Words to the effect, "my statement of this patient is not correct", cross examination around 12:10pm).*

7) On or around 18 November 2020 in relation to Patient E:

a) Did not use the correct template form

b) Did not record a VTE risk assessment

28. *There is no evidence that it was a requirement to use a specific template for an appointment. [Colleague A] gave evidence that a template was not necessary, as long as all the appropriate information is recorded. In answer to panel questions, [Colleague A] said that using a template was "optional".*

29. *A risk assessment is recorded [Ex5, Ex17]. [Dr 1] told the panel that the SystemOne code for a VTE risk assessment outcome would be automatically generated once complete. There is no evidence that the VTE risk assessment was not completed by Mrs Wragg.*

8) On or around 18 November 2020 in relation to Patient K:

a) Did not use a template for the consultation

30. *There is no evidence that it was a requirement to use a specific template for an appointment (as above).*

11) Stated to colleague A you had only failed the ARTP because you had put patient names on the spirometry when you had also failed in other areas

12) Your actions in charge 11 above were dishonest in that:

a) You sought to avoid and / or minimise the reasons for your failure

31. *The evidence makes clear that Mrs Wragg failed the ARTP because she had included patient names in the notes [Ex2, CJ/03]. She did not fail in other areas. It is right to say that the exhibit suggests there were "faults with your testing (No VCs) and your interpretations which make it unlikely you would have passed". Such comment does not equate to failing the spirometry portfolio assessment in other areas.*

32. *As there is no evidence to support charge 11, charge 12 must fail.*

Conclusion

33. *The NMC has not produced any, or any sufficient evidence such that a reasonable panel, properly advised, could find the above charges proved. The*

panel is invited to find that Mrs Wragg has no case to answer in relation to those charges, in accordance with Rule 24(7).”

In response, Mr Radley submitted that it is the case of the NMC that in your application to Prospect Road Surgery and in your CV, you provided information that was incorrect. He submitted that effectively what follows from the initial application is a failure to be transparent on the position of your qualifications and skill set to the Surgery, during the merger, and the other professionals you worked with.

Mr Radley submitted that the Skills Matrix provided by Ms 6 relates to the skill set her nurses would possess. He submitted that the crucial aspect of this is the skill set directly impacted on the colleagues and patients attending the practice. He submitted that if you had deliberately provided incorrect information regarding your skill level then this would be dishonest.

With regards to charge 11, he submitted that it is fair to say that the aspect identified in the failure is one element, but it is not the complete picture with regards to the spirometry test results exhibited. He submitted that this is because the letter goes on to say that there are further issues and a likelihood that you would not have passed anyway in the circumstances.

Mr Radley submitted that this could be identified as minimising the reason for failure and supports the contention that there was a lack of best practice in relation to the completion of records and reports you filed in relation to patients and communication between nurses and GP colleagues.

Mr Radley submitted that it is accepted by the NMC that the computer system was not an obligatory method of recording information. He submitted however that if the patient management system is put into practice, then the system should be used unless there are grounds for it not to be used. He submitted that this would lead to far less chance of error.

Regarding charge 1, Mr Radley submitted that Dr 4 gave evidence that Dapagliflozin was contraindicated and expressed caution with its use. Dr 4 said that when there was going to be a change in medication or a new medication was being suggested there should have been a consultation between the nursing team and the doctors, which was a practice Ms 6 said was in place at the time.

Mr Radley submitted that he agrees with paragraph 17 of Ms Bayley's written representations.

With regards to paragraph 19, Mr Radley asked the panel to consider whether you had acted outside the scope of your competence in these circumstances and effectively you had acted against the practice's convention explained by Ms 6.

Mr Radley submitted that he agrees with paragraph 21 of Ms Bayley's written representations. He submitted however that in relation to charge 4c, Colleague A did go on to say that your record keeping was inadequate.

Mr Radley submitted that effectively this is the culmination of issues that have arisen from a lack of competence and lack of qualifications that have led to the concerns being considered today.

In response to a question from the legal assessor, Mr Radley agreed with paragraph 8 of Ms Bayley's written representations. He submitted that where a charge of "did not" appears, the panel's approach should be that there was a recognised procedure that you failed to follow. Mr Radley further clarified that by procedure he meant duty.

Ms Bayley submitted that the specific allegation in charge 11 is that you failed the spirometry assessment in many areas. She submitted that this is not correct because Prospect Road Surgery and Colleague A were fully aware of the reason why you had failed the spirometry assessment as you had provided the relevant document to the

Surgery and it did not make a difference to them. She submitted that you had been honest in this regard and invited the panel to find no case to answer.

With regards to charge 1, Ms Bayley submitted that it was the usual practice for nurses to have a discussion with the prescribing doctor. She submitted that there is no evidence that you had not had a discussion with the prescribing doctor. She further noted that the prescribing doctor, Dr 7, had not been called to give evidence.

Ms Bayley submitted that the charge falls on the basis that you were not a prescriber, did not start the medication and specialist advice was not ignored.

Ms Bayley also submitted that as you did not start Patient I on Dapagliflozin, there is no duty to document it.

Panel Decision

The panel took account of the submissions made and heard and accepted the advice of the legal assessor who directed the panel to the tests in *Galbraith*.

In reaching its decisions, the panel made an initial assessment of all the evidence that had been presented to it at this stage. It considered the evidence at its highest, taking into account its strength and its weaknesses. The panel was solely considering whether sufficient evidence had been presented, such that a properly directed panel could find the charge proved and therefore whether you had a case to answer.

The panel also reminded itself that Mr Radley conceded that where a charge of “did not” appears, that this implies that you had a duty. Further, if the panel are of the view that there is no possibility of finding that such a duty existed, then it follows that you have no case to answer in respect of that charge.

Charge 1a

1) On or around 27 February 2020 in relation to Patient I:
a) started them on Dapagliflozin when the medication was contraindicated

The NMC evidence matrix identifies the evidence in support of this charge as Patient I's records and paragraphs 12 onwards of Dr 1's witness statement. Dr 1 stated "Patient I was a diabetic and was seen by the Registrant on 27 February 2020. The notes indicated that a discussion had taken place between Patient I and the Registrant about starting medication, called Dapgliflozin. However, his Glomerula Filtration rate ('eGFR'), which is a marker regarding kidney function was too low. Therefore, starting him on the proposed medication was a contraindication."

The panel considered that it had to establish the meaning of "starting" a patient on medication. It noted that the NMC witnesses provided conflicting evidence on what constituted starting a patient on medication to the extent that the panel found the evidence overall inherently weak and vague.

The panel considered that there is evidence that "starting" could be interpreted as a nurse making a suggestion of what medication would be appropriate and that a doctor would check this and sign the prescription if they were in agreement.

The panel took account of an extract from the BNF relating to Dapagliflozin, dated September 2019 to March 2020. This stated *"Renal Impairment: Manufacturer advises avoid initiation if eGFR less than 60ml"*. This indicated that Dapagliflozin can be used under certain circumstances, namely if the eGFR is less than 60ml however this would require monitoring of the patient.

The panel then took account of Patient I's medical records. In an entry, dated 27 February 2020 you have entered *"EGFr satisfactory, agreed to start dapa and make app for bloods*

in 3./12". However, the panel considered that it is not clear what Patient I's eGFR was on 27 February 2020. As a result, it was of the view that the evidence is unclear as to whether the Dapagliflozin was contraindicated when you saw Patient I on 27 February 2020.

Therefore, while there is evidence that you may have "started" Patient I on Dapagliflozin, when applying the test in *Galbraith*, the panel concluded that no reasonable panel, properly directed, could find that you started Patient I on Dapagliflozin when the medication was contraindicated due to the evidence being contradictory and weak.

Therefore, you have no case to answer in respect of this charge.

Charge 1b

1) On or around 27 February 2020 in relation to Patient I:
b) Ignored the specialist advice not to start them on Dapagliflozin

The NMC evidence matrix identifies the evidence in support of this charge as being Patient I's medical records and paragraphs 12 onwards of Dr 1's witness statement. Dr 1 stated "The notes indicated that the Registrant asked a diabetic specialist at the Hospital for advice by way of an 'eConsultation' regarding starting [Patient I] on the medication. A recommendation was received advising not to start Patient I on Dapagliflozin because of his kidney function. However, the Registrant ignored the recommendation as she started the medication for Patient I."

The panel then took account of Patient I's medical records. In an entry, dated 28 February 2020 where Dr 7 has entered "e-Consult Refferal for Advice and Support updated: Awaiting Intervention". The panel noted that the specialist advice came after Patient I was started on Dapagliflozin.

The panel concluded that there was no evidence to support the charge that on 27 February 2020, you ignored the specialist advice not to start Patient I on Dapagliflozin.

Therefore, you have no case to answer in respect of this charge.

Charge 1c

1) On or around 27 February 2020 in relation to Patient I:
c) Did not document a) and / or b) above in their notes

The panel was of the view that as it has found you have no case to answer in respect of charge 1a and 1b, there cannot be a case for you to answer in respect of charge 1c.

Charge 2a, 2b and 2c

2) At the beginning of November 2020 in relation to Patient G:
a) Assessed their symptoms when this was outside your scope of competence
b) Did not assess the severity of their symptoms correctly
c) Did not book them in for a same day appointment

The NMC evidence matrix identifies the evidence in support of this charge as being Patient G's medical records and paragraphs 22 onwards of Dr 3's witness statement. Dr 3 stated "From my recollection, the Registrant did a review of asthma amongst other things for Patient G. She did note Patient G to have acute issues with a wheeze and shortness of breath… However, Patient G had to be rebooked for that same day to receive the treatment. She received steroids to treat the wheeze. The potential outcome for Patient G was that had we not got her back in the same day, it could have resulted in a hospital admission. This is because Patient G required acute treatment for her wheeze. The problem with the Registrant's actions was that she made a decision as a clinician to diagnose the issue, but she was not qualified to do so and she did not appreciate the need for a sooner appointment."

Dr 3 in her oral evidence stated that the patient described in paragraph 22 is not the same patient that appears in Patient G's medical records.

The panel also noted that the allegation is too broad, too vague and non-specific. It does not specify what exactly the symptoms were that you assessed that were outside your scope of competence or which ones were severe. The panel was also of the view that the issue pertaining to the ECG was introduced very late into the proceedings. Additionally, if the alleged failings in the charge were in relation to the ECG, then this should have been specified in the charge.

The panel was of the view that the evidence to support charges 2a and 2b was too vague and lacking in specificity and concluded that no reasonable panel, properly directed, could find that you have a case to answer in respect of charges 2a, 2b and 2c.

Therefore, you have no case to answer in respect of these charges.

Charge 4a, 4b and 4c

4) On or around 18 November 2020 in relation to Patient B:
a) Did not follow recommendation from Colleague A that their contraceptive medication be changed
b) Did not discuss with Colleague A why you had not followed their advice
c) Did not document why the recommendation was not followed

The NMC evidence matrix identifies the evidence in support of this charge as being Patient B's medical records and paragraphs 20 of Colleague A's witness statement. Colleague A stated "Patient B had been on a drug called depo-provera ('depo') for 23 years. This is a contraceptive injection; it works by inhibiting ovulation and due to this stops the body producing oestrogen which is requires for bone mineral density. She checked UKMEC guidelines but asked me for advice due to my specialism in

contraception and it being unusual for someone like Patient B to be on depo for 23 years. I gave the advice that the patient should be switched to an alternative method of contraception as I was concerned that Patient B was approaching menopause and due to being on the injection for such a long time needed to have time for her bone mineral density to recover…She completely ignored my suggestion to take Patient B off the drug and carried Patient B on the injection before…"

Colleague A, in her oral evidence, stated that there was a process in place for nurses to review changes in medication with GPs.

The panel took account of Patient B's medical records where you have made an entry on 18 November 2020 at 10:24 which stated: "*Examination: came for depo, has been on for 23 yuears ? needs Dexa scan?? task sent to gps"*

It appears to the panel that you recognised risk areas for Patient B as they had been on depo for 23 years and you sought advice from Colleague A who is a specialist. It appears that a recommendation was given a few hours after you had administered the injection. However, the panel was of the view that there could be a duty on you to follow the recommendation of a senior colleague so as to act in the best interest of a patient. The panel noted that it appears you acted on this advice on 18 December 2020 however this was only after the meeting on 15 December 2020 when this issue was highlighted to you.

In these circumstances, a charge based on such a duty could be made out and you have a case to answer in respect of charge 4a.

As it appears a duty could be established, the panel noted that if you did not follow the advice, you arguably should have discussed this with Colleague A and documented why you did not follow the advice. As a result, the panel was of the view that you have a case to answer in respect of charges 4b and 4c.

Charge 5

5) On or around 18 November 2020, in relation to Patient C, undertook a DOAC review when you had been told previously not to

The NMC evidence matrix identifies the evidence in support of this charge as being Patient C's medical records and paragraph 21 of Colleague A's witness statement. Colleague A stated, "…it was noted that the Registrant undertook an asthma review at 10.25am. She did DOAC monitoring of Patient C a DOAC is an anticoagulant medication for thinning the blood. The Registrant had already been previously told not to undertake DOAC reviews as she had not had the training for this. She was not filling in templates nor documenting things properly. This was a concern as it was very difficult to see from her notes what had happened during the consultation thus it was very difficult to tell whether the patient had received adequate care or not. The DOAC review looks at renal function/age/indication etc to decide what dose of DOAC a patient should be on. The Registrant was not doing this properly and this could have meant patients were put on the wrong dose of anticoagulants which could have meant that they were at bleeding risk if the dose was too high or clotting risk if the dose was too low. She said that she felt qualified to do this as she had been a cardiac nurse for many years however her training and qualifications were in the monitoring of warfarin which is a different anticoagulant medication with different monitoring and is not transferable…"

Dr 1 in his oral evidence said that the case record in relation to Patient C did not constitute a DOAC review. Colleague A said, in her oral evidence that part of it could be a DOAC. She was also asked if there was anything on the entry of Patient C's medical records on 18 November 2020 that implied that there was a DOAC review. Colleague A said she was not sure.

With regards to the first part of Charge 5, namely whether you had undertaken a DOAC review on 18 November 2020 in relation to Patient C, the panel was of the view that the evidence is vague and contradictory. Additionally, the panel considered that some of the

witnesses had changed their accounts with regards to what constituted a DOAC review and whether you had conducted a DOAC review on Patient C.

The panel concluded that no reasonable panel, properly directed, could find that you have a case to answer in respect of charge 5.

Therefore, you have no case to answer in respect of this charge.

Charges 6a(i), 6a(ii) and 6b

6) On or around 18 November 2020 in relation to Patient D:
a) When assessing renal issues did not:
i) Review their medication
ii) Request a kidney function test
b) Did not document the consultation adequately or at all

The NMC evidence matrix identifies the evidence in support of this charge as being Patient D's medical records and paragraphs 22 of Colleague A's witness statement. Colleague A stated, "When reviewing the consultation, the Registrant held at 11am…on 18 November 2020 with Patient D, it looked like Patient D had renal deterioration. When a patient presents with significant renal deterioration, the appropriate action is to flag the issue with a doctor straight away, as delay in management poses a risk of harm being caused to the patient. It was noted that the Registrant would speak with [Dr 1] but then there is no documentation of that conversation having taken place or any outcome. When the Registrant was later questioned about the matter by me, she stated that she did discuss the patient with [Dr 1]. As this is not documented I do not know whether this took place or not. Due to the concern regarding this patient a GP had to do a home visit to see Patient D who actually decided he did not. want intervention with his renal function and from that point became palliative. The seriousness of this action was in regards to the lack of documentation either of the conversation or the outcome of the conversation. Sometimes patients with renal deterioration need admitting to hospital, they at the very

least need their BP doing and their medication reviewed with a repeat kidney function test being done urgently, none of this was done for this patient at the time as the patient was not escalated appropriately. | think it unlikely a conversation with a doctor took place as the above actions would have been recorded on the notes and they aren't."

Colleague A in her oral evidence stated that she was too harsh in her witness statement as she had subsequently found an urgent task to a GP you had raised in Patient D's medical notes. She also stated that her witness statement is not correct in relation to Patient D.

Dr 1 in his oral evidence stated that Patient D did not require a kidney function test at the appointment and that you were not qualified or required to review Patient D's medication at the appointment.

In light of the oral evidence of Dr 1 and Colleague A, there remained no evidence to support a charge based on a duty to review Patient D's medication and request a kidney function test when assessing Patient D's renal issues. The panel concluded that no reasonable panel, properly directed, could find that such a duty existed.

Therefore, you have no case to answer in respect of charges 6a(i) and 6a(ii).

With regards to charge 6b, the panel noted that you raised an urgent task with the GP. Further, as you had no duty in relation to charges 6a(i) and 6a(ii), you have no case to answer in respect of charge 6b.

Charges 7a and 7b

7) On or around 18 November 2020 in relation to Patient E:
a) Did not use the correct template form
b) Did not record a VTE risk assessment

The NMC evidence matrix identifies the evidence in support of this charge as being Patient E's medical records and paragraphs 23 of Colleague A's witness statement. Colleague A stated, "When I studied the appointment of Patient E at 15.10pm referenced on Exhibit CJ01 of the audit undertaken on 18 November 2020, I found that the Registrant was not using the correct documents for that patient consultation. The registrant was undertaking an HRT review and stated that the patient was at low risk of thromboembolism, there was no documentation or template filled in to back this up. Oral HRT increases the risk of thromboembolism and thus for patient safety an adequate risk assessment should have been undertaken this was missing in the notes."

Colleague A in her oral evidence said that using the correct template form was optional as long as all the relevant information was included.

In light of the oral evidence of Colleague A, there remained no evidence to support a charge based on a duty to use the correct template form in relation to Patient E when using such a template form was optional. The panel concluded that no reasonable panel, properly directed, could find that such a duty existed.

Therefore, you have no case to answer in respect of charge 7a.

With regards to charge 7b, the panel took account of Patient E's medical records. It noted that you have made an entry on 18 November 2020 which stated: "Low risk of venous thromboembolism (XaXgG)."

The panel noted that there is a risk rating as well as a code within Patient E's notes.

There is also contradictory evidence from Dr 1 who told the panel that the SystemOne code for a VTE risk assessment outcome would be automatically generated once the risk assessment was completed.

The panel was of the view that there was insufficient evidence to demonstrate that you did not record a VTE risk assessment as the patient record does not show what you did on this day.

The panel concluded that no reasonable panel, properly directed, could find that you have a case to answer in respect of charge 7b.

Therefore, you have no case to answer in respect of this charge.

Charge 8a

8) On or around 18 November 2020 in relation to Patient K:
a) Did not use a template for the consultation

The NMC evidence matrix identifies the evidence in support of this charge as being Patient K's medical records and paragraphs 23 of Colleague A's witness statement. Colleague A stated, "Patient K was seen at 16.35pm for a pill review. This consisted of one line in the notes and no template was used. There was no adequate clinical information and the contraceptive pill had not been issued despite telling the patient to take the pill back-to-back, this is where the patient takes the contraceptive pill continuously rather than having a 7 day break every 21 days."

However as with charge 7a, Colleague A in her oral evidence said that using the correct template form was optional.

In light of the oral evidence of Colleague A, there remained no evidence to support a charge based on a duty to use the correct template form in relation to Patient K when using such a template form was optional. The panel concluded that no reasonable panel, properly directed, could find that such a duty existed.

Therefore, you have no case to answer in respect of charge 8a.

Charges 11 and 12

11) Stated to colleague A you had only failed the ARTP because you had put patient names on the spirometry when you had also failed in other areas
12) Your actions in charge 11 above were dishonest in that:
a) You sought to avoid and / or minimise the reasons for your failure

The NMC evidence matrix identifies the evidence in support of this charge as being Patient E's medical records and paragraphs 23 of Colleague A's witness statement. Colleague A stated, "We explained that as a number of concerns had arisen, this had prompted Dr McCormick to ask for a copy of all of the Registrant's qualifications. These show that although the Registrant had stated in her CV, job application and skills matrix that she had certain qualifications, she was unable to provide a copy of her qualifications, when requested."

The panel took account of the Spirometry Assessment report contained in the exhibit bundle. It noted that it stated "The first two tests have the patients names clearly visible with no attempt made to remove them…There are several other faults with your testing (No VCs) and your interpretation which makes it unlikely you would have passed however I have to fail on two episodes which breach patient confidentiality." The panel concluded that there is no evidence that you failed in other areas as these were not considered.

The panel concluded that no reasonable panel, properly directed, could find that you have a case to answer in respect of charge 11.

Charge 12 will also fall as it is contingent on finding a case to answer for charge 11.

Therefore, you have no case to answer in respect of charge 11 and 12.

Decision and reasons on facts

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Dr 1: General Practitioner ('GP') at the Surgery
- Colleague A: GP at the Surgery
- Ms 2: Practice Manager at the Surgery
- Dr 3: GP at the Surgery
- Dr 4: GP at the Surgery
- Mr 5: Practice Manager at the Surgery
- Ms 6: Your Line Manager at the time of the allegations and a Lead Nurse at the Surgery

The panel also heard evidence from you under oath.

The panel also heard evidence from Mr 11 called by you as a character reference.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence and written submissions provided by both the NMC and Ms Bayley. The panel took into account that

you are of good character in the sense of having no previous regulatory referrals or findings in its assessment of the evidence.

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

Charge 3

"That you, a registered nurse:

3) On 4 November 2020, in relation to Patient F, did not escalate chest pain concerns appropriately.

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient F's records together with your evidence and that of Dr 3.

The panel determined that as a registered nurse, you have a duty to escalate chest pain concerns.

The panel noted that you were clear that Patient F did not present with chest pain at their appointment with you on 4 November 2020. Dr 3 supported this in their oral evidence.

The panel noted the record you entered on 4 November 2020 on Patient F's record in which you briefly outlined Patient F's medical history, including their history of chest pain.

In Dr 3's oral evidence they stated that this record could have been fuller. Whilst the panel considered that your entry on Patient F's record could have been fuller, it determined that you did set out Patient F's history of chest pain and accepted your evidence that Patient F did not present with chest pain at their appointment on 4 November 2020.

The panel determined that there is insufficient evidence before it to suggest that Patient F presented with chest pain at their appointment on 4 November 2020.

Having found it more likely than not that Patient F did not present with chest pain on 4 November 2020, the panel determined that there was no duty on you to escalate this.

Charge 4a

"That you, a registered nurse:

4) On or around 18 November 2020 in relation to Patient B:

a) Did not follow recommendation from Colleague A that their contraceptive medication be changed

This charge is found NOT proved.

In reaching this decision, the panel considered the medical records of Patient B together with your evidence.

The panel noted that you followed Patient B's prescription that had been in place for over 21 years. It determined that you acted reasonably by administering this medication.

The panel noted that this contraceptive medication was administered before Colleague A's recommendation, which was received on 19 November 2020, the day after you administered the medication.

The panel noted that you are not a nurse prescriber and so it would not be your duty to change Patient B's prescription.

The panel therefore determined that it would not have been possible for you to have acted upon Colleague A's recommendation as you had already administered the contraceptive medication before Colleague A made their recommendation and as you are not a nurse prescriber, it would not be your duty to prescribe medication to Patient B.

The panel therefore found this charge not proved.

Charge 4b

"That you, a registered nurse:

4) On or around 18 November 2020 in relation to Patient B:

b. Did not discuss with Colleague A why you had not followed their advice.

This charge is found NOT proved.

The panel noted the evidence provided of the one-to-one meeting on 18 December 2020 between you and Colleague A. It noted that you discussed the advice provided by Colleague A at this meeting when it was raised with you and that you added a task at 17:53 on 18 December 2020 to Patient B's records for a GP to discuss changing their medication.

The panel determined that, on the balance of probabilities, it is more likely than not that you did discuss Colleague A's recommendation with them in the one-to-one on 18 December 2020.

Charge 4c

"That you, a registered nurse:

4) On or around 18 November 2020 in relation to Patient B

c. Did not document why the recommendation was not followed.

This charge is found NOT proved.

As the panel have found charges 4a and 4b not proved, this charge falls away.

Charge 8b

That you a registered nurse:

8. On or around 18 November 2020 in relation to Patient K:

b. Did not provide adequate clinical information

This charge is found proved.

In reaching this decision, the panel paid particular attention to your oral evidence and that provided by Dr 1.

The panel noted your acceptance in your evidence that there is a duty for a registered nurse to provide clinical justifications for their actions. The panel agreed with this.

The panel then considered the oral evidence of Dr 1, who when questioned about your record stated:

'You might want to add some more detail as to when and how long the bleeding has been going on, but I have not seen these notes before and so I don't know what issues have already been covered by the earlier appointments.

[…]

The way I see it is that if you take a full history or ask more questions, then that is evidence that you have asked those questions and you have taken those issues into consideration. If this was the first time the patient was seeing this practitioner for this, then I would expect more information.'

When asked specifically what information was missing from the record, Dr 1 stated:

'*Just how long the bleeding, whether it is clotting, what has been done before in the past, what investigation and perhaps some notes around those kind of considerations.'*

The panel noted that this appointment was the first time that you had seen Patient K.

It determined that the record you made was not sufficient as it should have included more history of the concern including the nature of the bleeding, how long it had been going on for and should have included more information explaining your decision for Patient K to take the medication 'back-to-back'. The panel determined that your record of your recommendation to Patient K to take the medication 'back-to-back' did not provide a clear rationale for your recommendation such as would have enabled future treating clinicians to understand the clinical justification for your recommendation.

The panel therefore concluded, on the balance of probabilities, it is more likely than not that on or around 18 November 2020 in relation to Patient K you did not provide adequate clinical justification.

Charge 9a

That you a registered nurse:

9. Held out to the Practice that you had ARTP in Spirometry by:

a. stating you had completed the course

This charge is found proved.

In making its decision, the panel first considered what was meant by 'held out' in the charge. It determined that for you to have 'held out to the Practice' you would have had to state that you had the ARTP in spirometry by stating that you had completed the course and maintained this position.

The panel considered whether you have passed the ARTP in spirometry. It noted that there is contradictory evidence in relation to this. You told the panel during oral evidence that you had passed the ARTP in spirometry as you had passed the '*logbook evidence'* part of the course. However, in your statement you state that you were midway through this course at the time of your interview with the Practice, and you listed in your CV and application form, prior to this interview, the ARTP in spirometry alongside other courses that you had passed or successfully completed without any clarifying comments to indicate that this course had not been completed.

The panel considered the Spirometry Portfolio Assessment marking criteria provided which states that your final marks under '*logbook evidence'* was 37/50 and a PASS but your final marks under '*patient test and problems encountered'* was 0/150 and a FAIL. This marking criteria also states, '*N.B. A FAIL in either section results in a FAIL overall regardless of overall %'.* Additionally, the panel was not provided with a certificate of completion or an email/letter from where you attended the course to confirm whether you had passed the ARTP in spirometry. Based on this evidence, the panel determined that it is more likely than not that you did not successfully complete the ARTP in Spirometry.

The panel considered that a reasonable person looking at a CV or application form would assume that the courses listed were fully and successfully completed/passed unless it stated otherwise. The panel noted that in your application form you stated that you had '*not completed'* a course listed as '*access to health care*'. The panel therefore determined

that from the perspective of a reasonable person, in your CV and application form you did state that you had successfully completed the ARTP in spirometry. Whilst the panel noted your evidence that this was your first time completing a CV, it determined that your CV and application form outline suggest that you had successfully completed the ARTP in spirometry.

The panel noted your evidence that you mentioned this issue in your interview. However, it noted that Dr 4, who was an interviewer, did not recall this conversation but was made aware of you not passing the ARTP in Spirometry sometime after the interview. Additionally, Ms 2 stated that you told her that you did not pass ARTP in Spirometry at some point between July 2019 and October 2020. The panel preferred the corroboratory evidence of Ms 2 and Dr 4.

The panel therefore determined that you did state that you had completed the ARTP in Spirometry before your interview in your CV and your application form and it is more likely than not that you maintained this position during your interview when you had not successfully completed the ARTP in Spirometry.

Charge 9b

That you a registered nurse:

9. Held out to the Practice that you had ARTP in Spirometry by:
    b. Stating you were a 4 on the skills matrix for the Practice

This charge is found NOT proved.

The panel noted the oral and written evidence on the Practice's skills matrix. The panel determined that there was no clear guidance available on how to complete the skills matrix. It further determined that, as a self-assessment tool, given the lack of clear

guidance, there was a significant degree of subjectivity in how individual nurses filled in the skills matrix.

The panel was of the view that given the above context you did hold out to the Practice that you had the ARTP in Spirometry by stating you were a 4 on the Practice's skills matrix. The panel concluded that it is more likely than not that you honestly assessed your competence in spirometry as a 4 when you filled in the skills matrix.

The panel therefore determined that it is more likely than not that you did not hold out to the Practice that you had the ARTP in Spirometry by stating you were a 4 on the skills matrix.

Charge 10a

That you, a registered nurse:

10. Your actions in charge 9 above were dishonest in that:
    a. You had failed the ARTP in spirometry

This charge is found proved.

In considering dishonesty, the panel had regard to the legal assessors advice concerning the test for dishonesty set out in the case of *Ivey v Genting Casinos [2017] UKSC 67* and applied that test to its consideration of the evidence. The panel noted that there have been no concerns about your honesty prior to this referral or since this referral. Additionally, the panel noted all of the positive testimonials as well as the oral evidence of Mr 11 attesting to your honesty and integrity. The panel placed weight on all of this information when making its decisions about dishonesty.

The panel noted the wording of this charge, particularly that ‘you had failed’. It determined that this charge can only be proved from the point you had failed the ARTP in spirometry and not before that point.

The panel noted its findings at charge 9a that you had not completed the ARTP in Spirometry when you created your CV and filled out the application form. It additionally considered the evidence of Dr 4 and Ms 2 who informed the panel that they were made aware that you had failed the ARTP in spirometry some time after the interview.

The panel was of the view that as soon as you were made aware that you had failed the ARTP in Spirometry you had a duty to inform your employer. The panel was of the view that despite Dr 4 and Ms 2 becoming aware that you had failed the ARTP in spirometry, you failed in your duty to inform your employers as soon as you found out.

The panel therefore determined that it is more likely than not that your actions in charge 9a were dishonest in that you had failed the ARTP in spirometry.

Charge 10b

That you, a registered nurse:

10. Your actions in charge 9 above were dishonest in that:
    b. they were intended to induce others to believe you are qualified in this area when you are not

This charge is found proved.

The panel was mindful of its findings at charge 9a in that you conceded in your written statement that you had not completed the ARTP in Spirometry at the point of writing your CV and application form. The panel were mindful of its findings that a reasonable person

would expect courses listed in a CV and application form to be successfully completed unless clearly stated to the contrary.

The panel therefore determined that your actions at charge 9a were dishonest as you intended to induce others to believe you are qualified in this area when you were not.

Charge 13a

That you, a registered nurse:

13. Held out to the Practice that you had a diabetes diploma by:
    a. stating you had completed the course

This charge is found proved.

In reaching its decision, the panel paid particular attention to your CV and application form, your oral evidence and written statement and Ms 2 and Dr 4's evidence.

The panel noted that you had detailed a diabetes diploma alongside other courses that you had successfully completed in your CV. On your application form you again listed a diabetes diploma completed in 2019, from Bradford Primary Care Training Centre, amongst courses you had undertaken.

The panel was of the view that using the words '*diabetes diploma'* is misleading as this is a widely recognised qualification and you gave evidence that at the time of completing your CV and application form you were aware of this qualification and understood that you did not possess it.

The panel noted your oral evidence that you corrected this '*error'* during your interview. However, the panel also heard evidence from Dr 4 and Ms 2. Dr 4 was clear that you had

told them that you had a diabetes diploma. Ms 2 also stated that you had told her that you had a diabetes diploma.

The panel determined that you did state that you had completed the diabetes diploma on your application form and in your CV and you ‘held out’ this position to Dr 4 and Ms 2.

Charge 13b

That you, a registered nurse:

13. Held out to the Practice that you had a diabetes diploma by:
    b. Stating you were a 4 on the skills matrix for the practice

This charge is found not proved.

The panel adopted its findings at charge 9b with regards to the lack of guidance provided at the time you completed the skills matrix and the significant degree of subjectivity in its completion.

The panel therefore finds this charge not proved.

Charge 14a

That you, a registered nurse:

14. Yours actions in charge 13 above were dishonest in that:
    a. You were aware you had not completed the diploma

This charge is found proved.

In reaching its decision the panel paid particular attention to your evidence.

The panel noted your oral evidence that you knew what a diploma in diabetes was when you completed your CV and application form and that it is a recognised qualification. Additionally, the panel noted that the course that you were undertaking, a certificate in Diabetes Management in Primary Care, was at a Level 5. However, the panel also noted that at the time of completing your application form you had not completed the 250 hours of CPD required for completion of the second part of this qualification and so you would have known you had not completed this course and in any case it was not a diploma in diabetes.

The panel therefore determined that as you knew that you had not completed the course at the time of writing your CV and application form, and as you knew it was not a diploma in diabetes, you were dishonest in that you were aware you had not completed the diploma.

Charge 14b

That you, a registered nurse:

14. You actions in charge 13 above were dishonest in that:
    b. They were intended to induce others to believe you had passed the diploma

This charge is found proved.

The panel relied upon its findings at charge 14a that your actions were dishonest because you were aware that you had not completed the diploma.

The panel considered that it was reasonable to infer that you would only add this information to your CV and application form if you were seeking to persuade your prospective employer that you had this qualification.

The panel determined that it is more likely than not that you did this with the intention to induce others to believe you had passed the diploma in diabetes.

Charge 15a

That you, a registered nurse:

15. Held out to the Practice that you were competent in asthma treatment by:
    a. stating you had completed training in the ARTP course.

This charge is found NOT proved.

In reaching its decision, the panel paid particular attention to this section of your written statement:

> *'The course itself provides the theory required to understand the main 2 types of respiratory conditions, asthma and COPD, over a 2 day time period, followed by practical assessments in performing the tests. I never claimed any way, neither written nor verbally, to have studied to a level to interpret any results from the tests, these would always be referred to the GPs for analysis.'.*

The panel heard very little evidence in relation to this charge and none which contradicted your assertions in the above statement. The panel determined that there was no evidence before it to suggest that by stating that you had completed the ARTP course that you were suggesting that you were competent in asthma treatment.

The panel therefore determined that the NMC has not discharged its burden of proof in relation to this charge.

Charge 15b

That you, a registered nurse:

15. Held out to the Practice that you were competent in asthma treatment by:
    b. Stating you were a 3 on the skills matrix for the practice

This charge is NOT proved.

The panel adopted its findings at charges 9b and 13b with regard to the lack of guidance provided at the time you completed the skills matrix and the significant degree of subjectivity in its completion.

Whilst the panel noted your oral evidence that you should have stated you were a 2 rather than a 3, it determined that this was a reasonable error.

For the reasons outlined at charges 9b and 13b, the panel determined you did not hold out to the Practice that you were competent in asthma treatment by stating that you were a 3 on the skills matric for the practice.

Charge 16a, b & c

That you a registered nurse:

16. Your actions in charge 15 above were dishonest in that:
    a. you were aware that you had not completed the training in the ARTP
    b. you were aware that you were not a Level 3 on the skills matrix
    c. they were intended to induce others to believe you had completed the training and / or were competent to carry out asthma treatment

These charges are found NOT proved.

As the panel found charges 15a and 15b not proved, charges 16a, 16b and 16c fall away.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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 kindly, safely 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 and impairment

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.'*

You gave evidence to the panel under oath in relation to misconduct and impairment. You explained that the reflections provided to the panel today (Tuesday 9 January 2024) are your own thoughts and feelings that you have written through a reflective template you

have found. You stressed that all of the words are your own. You took the panel through your working history since the beginning of the NMC investigation. You explained that you were employed whilst under an interim conditions of practice order, however you resigned from this position as you felt that you were being put in a position that your '*PIN was in jeopardy'* as you were asked to be the only nurse in charge which went against your interim conditions of practice order.

You explained that you have provided a screenshot of a course titled '*diabetes awareness diploma course'* to show that there are many courses available, some of which are worded as a diabetes diploma and others as a diploma in diabetes. You stated that this highlights the misinterpretation in your mind at the relevant time. You stated that you accept dishonesty, and it is with deep regret that this occurred.

Following questions from Ms Girven, on behalf of the NMC, you stated you have not completed training specific to dishonesty, but that ethical decision making was a component of some of the other courses you have undertaken. You explained that there is an actual course on ethical decision making that you can enrol in which you intend to do.

Ms Girven 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. Ms Girven identified the specific, relevant standards where she submitted your actions amounted to misconduct.

Ms Girven submitted that whilst there is only one instance of inaccurate record keeping, she invited the panel to find misconduct as the facts found proved do fall short of what would be proper in the circumstances. She submitted that there was a risk of harm to patients as you could have been assigned patients that you would not have been if your employer was aware of your actual qualifications.

Ms Givern submitted that the dishonesty found in holding out that you had qualification that you did not have is serious misconduct and referred the panel to the NMC Guidance at FTP-3a.

In relation to impairment, Ms Girven took the panel through the test outlined in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin). She submitted that whilst record keeping is something that can be easily remedied, dishonesty is not. She acknowledged that your insight is developing however it is not yet sufficient. She further submitted that whilst you have completed some training, this training was not specific to dishonesty and ethical practice. Additionally, she acknowledged that there were positive testimonials provided but submitted that the majority of these predated the allegations. Ms Girven therefore submitted that you have shown insufficient evidence of insight to lessen the risk of repetition of your actions.

Ms Girven took the panel through the questions outlined in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and submitted that all limbs of this test are engaged. Ms Girven submitted that a finding of impairment is necessary on the ground of public protection in relation to the dishonesty concerns in this case and submitted that a finding of impairment is otherwise necessary in the public interest to uphold confidence in the nursing profession and the NMC as regulator.

Ms Bayley provided the panel with written submissions which were supplemented by oral submissions. Ms Bayley submitted that the panel can be assured that you can practice kindly, safely and effectively as your practice has never been called into question before and that you intend, in future, to make sure that all of your records are thorough and accurate. She therefore submitted that there is no risk of repetition and so there is no need for a finding of impairment on public protection grounds in relation to the record keeping concerns.

In relation to the dishonesty concerns, Ms Bayley submitted that this was a matter of misrepresenting your qualifications through your CV. She reminded the panel that your employer at the time was aware that you had not completed the ARTP in spirometry. She submitted that it is clear in your evidence that you did not intend to misrepresent your qualifications, but you accept the findings of the panel. Ms Bayley highlighted the case of *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin) (paragraph 25), in which Mr Justice Morris highlighted the principles to be applied in "rejected defences" cases:

> *"([…]*
> *(3) It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. Admitting misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it.*
> *[…]."*

She submitted that you have shown genuine remorse and you have made it clear that you had changed your CV to ensure accuracy.

Ms Bayley reminded the panel that you have engaged fully throughout the NMC process, and you have provided candid and clear evidence. Ms Bayley in her written submissions referred to the case of *Professional Standards Authority for Health and Social Care v NMC* [2017] CSIH 29, a Scottish appeal case in which the Court of Session refused an appeal by the Professional Standards Authority in circumstances where charges of dishonest misconduct had been admitted by the Registrant without a subsequent finding of impaired fitness to practise. In refusing the appeal, Lord Malcolm said:

> *"We do not agree with the submission that a perceived need for a penalty means that a finding of current impairment must be made. Whether to make such a finding is a discrete exercise to be addressed on its merits. In any event, in the circumstances of the present case, we would echo the comments of the learned judge in [Professional Standards Authority for Health and Social Care v GMC and Uppal [2015] EWHC 1304*

(Admin)] to the effect that professional standards and public confidence have been upheld by a rigorous regulatory process which resulted in a finding of misconduct."

Ms Bayley reminded the panel that you have been subject to an interim conditions of practice order for almost three years and that the facts found proved will be part of your record. She submitted that you are an honest nurse and the panel can be assured that there is no ongoing risk of harm and so there is no necessity for a finding of impairment on public protection grounds or otherwise in the public interest.

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

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

In reviewing the charges found proved, the panel concluded that your actions in relation to charge 8b were of a different nature to those in the remaining charges. Therefore, the panel looked at the issue of misconduct separately in relation to charge 8b. The panel concluded that your actions with regard to charge 8b amounted to a breach of the Code, specifically:

'10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

***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 .'*

However, the panel was of the view that charge 8b by itself does not amount to a serious breach of the fundamental tenets and noted that your actions in relation to 8b were isolated in nature. It concluded that whilst they may have fallen short of the standards expected of a registered nurse they were not so serious as to amount to misconduct.

In relation to charges 9a, 10a, 10b, 13a, 14a and 14b the panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

'20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 *keep to and uphold the standards and values set out in the Code*

20.2 *act with honesty and integrity at all times,'*

It determined that the dishonesty concerns in this case are sufficiently serious to amount to a finding of misconduct as these fall well below the standards expected of a registered nurse.

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.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

‘The question that will help decide whether a professional’s fitness to practise is impaired is:
“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”
If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’

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

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

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

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

‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

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

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

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

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

The panel finds that patients could have been put at risk of harm as a result of your misconduct in that you may have been assigned patients that you were not qualified to treat. The panel finds that your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not consider charges relating to dishonesty as matters of the utmost seriousness.

The panel then considered the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) to determine:

'1. Whether the conduct that led to the charge(s) is easily remediable
2. Whether it has been remedied
3. Whether it is highly unlikely to be repeated'

The panel gave consideration to the seriousness of the dishonesty in this case. It noted the NMC Guidance on dishonesty and determined that there was a potential for financial gain as the panel noted that the Surgery was looking for a nurse with knowledge and skills in diabetes and so inflating these qualifications could have contributed to you securing this

employment. Additionally, the panel determined that patients were put at risk of harm as you could have been put into a situation where you were practising outside of your scope of competence. However, the panel noted that there was no evidence of actual harm to patients occurring. Whilst the panel noted that the dishonesty in this case relates to information on your CV and application form, it considered that this was not corrected and so this dishonesty did continue over a period of time. For these reasons the panel determined that whilst this dishonesty is not at the highest end of the scale and is capable of remediation, it is serious.

Regarding insight, the panel considered your written reflections put before it today, together with your previous reflective statements, testimonials from employers and your oral evidence. The panel considered that in your written reflections and oral evidence to the panel you adopted different positions. It noted in your written reflection you state that your actions were an '*honest and clumsy mistake'* whereas in your oral evidence you accepted that your actions were dishonest. Additionally, the panel was of the view that your written reflection, despite its length, lacked a detailed analysis of your thinking at the time of writing your CV and application form. It also did not address how these documents were likely to have been interpreted by potential recipients. The panel was concerned that you did not reflect on why you had included courses you had not completed/passed on your CV and application form without highlighting this fact and the potential impact this would have had on those employing you. For these reasons the panel determined that your insight is still developing.

The panel considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. It noted your evidence of the work you have undertaken since this incident in 2020 in that you have worked as a registered nurse under conditions. The panel also noted the positive references from your employer in 2022. The panel was of the view that you have taken steps to strengthen your practice.

In answer to the questions set out in *Cohen* the panel determined that your dishonesty is serious but is capable of being remedied, however it has not yet been remedied as your insight into your dishonesty is developing.

The panel, therefore, is of the view that there is a risk of repetition based on your incomplete insight into your dishonesty. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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, given its finding that there remains a risk of repetition of your dishonesty, 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 suspension order for a period of four months. The effect of this order is that the NMC register will show that your 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. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Girven informed the panel that the NMC had advised you that it would seek the imposition of a striking off order if the panel found your fitness to practise currently impaired. She submitted that this remains the case.

Ms Girven submitted that no further action and a caution order are not appropriate in this case due to the public protection and public interest factors identified by the panel. She submitted that a conditions of practice order would not be workable or proportionate in the circumstances. She submitted that a suspension order is not appropriate due to your incomplete insight and the risk of repetition of your dishonesty found by the panel.

Ms Girven referred the panel to the case of *General Medical Council v Theodoropoulos [2017] EWHC 1984 (Admin)* ('GMC v Theodoropoulos').

In the above case, Ms Justice Lewis concluded that:

> *'In light of the conclusions reached, and the case law referred to above, the appropriate and proportionate sanction for dishonesty of this kind in this context would be erasure from the register. The conduct affected the system of qualifications and the integrity of the system of job applications and put at risk the proper operation of a system designed to protect the public by ensuring that only those licensed to practise did so.'*

Ms Girven submitted that this case involved a doctor forging their licence to practice medicine in the UK whilst your case involved the overinflating of qualifications they bore a similarity in that both types of conduct had the potential to put at risk the proper operation of the system of registration and qualifications designed to protect the public.

Ms Girven submitted that in light of your developing insight there remain fundamental questions about your professionalism in the context of a clinical setting. She submitted

that public confidence in the nursing profession and NMC as regulator could not be maintained without you being removed from the register due to the seriousness of the misconduct identified. Whilst Ms Girven accepted that a suspension order would protect the public for the period it is in place, she submitted that a suspension order would not maintain public confidence in the profession. She submitted that the conduct identified is so serious that the only appropriate sanction is that of a striking off order.

Ms Bayley submitted that a striking off order would be entirely disproportionate and went against the principle of 'right touch' regulation. She submitted that there is a public interest in allowing a nurse who is capable of kind, safe and effective care to return to unrestricted practice as soon as possible. Additionally, she submitted that the public interest has been served as you have complied with an interim conditions of practice order for just under three years.

In response to the case of GMC v Theodoropoulos, Ms Bayley submitted that this case relates to someone amending a certificate fraudulently and intentionally. She submitted that there is no factual similarity between this case and yours, and that the level of dishonesty in GMC v Theodoropoulos went beyond yours to a significant degree.

Ms Bayley submitted that you maintain that what you did was not intentionally dishonesty but accept that it was dishonest. She submitted that you maintaining that your actions were not intentional does not amount to an aggravating factor and referred the panel to the NMC Guidance at *SAN-2*.

Ms Bayley referred to the panel's findings at misconduct and impairment and submitted that there is no evidence that you acted outside the scope of your competence. Whilst Ms Bayley accepted the panel's finding that there was a risk of harm to patients as a result of your dishonesty, she submitted that this was an indirect risk as you could have refused to treat any patients that were outside of your scope of competence.

Ms Bayley submitted that the NMC's submission that a substantive conditions of practice order is not appropriate is not supported by the fact that you have been subject to an interim conditions of practice order for 33 months without any further concerns arising. She submitted that a short suspension order would have the effect of marking the seriousness of the misconduct and address the public protection issues identified. She submitted that a period of four weeks would allow you to show your further insight to a future panel.

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:

- An act of dishonesty in your professional life which you then failed to rectify;
- Dishonesty in relation to qualifications that are directly related to your practice;
- Although no evidence of working outside of your scope of competence, there was a risk that you may have been referred patients that you were not qualified to assess/treat. Even if such patients were referred on by you, it could have led to a delay in patient treatment.

The panel also took into account the following mitigating features:

- You have been subject to an interim conditions of practice order for 33 months, during this period you have worked without concerns;

- You have expressed remorse and shown developing insight into the seriousness of the concerns and the importance of honesty.

The panel considered the submissions in relation to the case of GMC v Theodoropoulos. It accepted the submissions of Ms Bayley in that the case of GMC v Theodoropoulos refers to actual fraud and sophisticated and planned dishonesty. It determined that this case has only limited similarities to your case. The key differences between the two cases identified by the panel include:

- Dr Theodoropoulos did not attend his tribunal hearing or the subsequent appeal hearing;
- Dr Theodoropoulos held himself out to have a licence to practice when he did not have one was in and of itself a criminal act;
- Dr Theodoropoulos's case involved a sophisticated forgery with a clear intent to gain employment and therefore financial gain;
- There were no submissions from Dr Theodoropoulos at either hearing and therefore no evidence of insight, remorse or strengthening practice;
- There was no communication from Dr Theodoropoulos between July 2016 up to and including the appeal hearing which took place in June 2017.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the risk of repetition. 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 not at the lower end of the spectrum and that a caution order would be inappropriate

in view of the issues identified. 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 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:

- *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 noted that you have been subject to an interim conditions of practice order for 33 months. However, it noted that these conditions were based on the original charges against you which contained significant clinical concerns, most of which were not found proved. The panel noted that the concerns that amounted to your impairment were those that related to dishonesty which is inherently difficult to put right. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges found proved in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate where some of 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;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. The panel had earlier concluded that the conduct is remediable and that you have taken some steps to strengthen your practice since the events in question. It determined that you have shown developing insight, significant remorse and you have been open and honest with the panel. It was of the view that a suspension order would adequately protect the public and would also provide you an opportunity to address the gaps in insight identified. It was of the view that a suspension order would mark the public interest concerns identified by marking the seriousness of the dishonesty identified, when viewed in conjunction with your full engagement and having regard to the interim restrictions which were imposed on your practice.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to protect the public whilst you develop full insight and 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.

In making this decision, the panel carefully considered the submissions of Ms Girven in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a striking off order would not be appropriate as a suspension order is sufficient to protect the public and is also sufficient to mark the public interest in this case.

The panel determined that a suspension order for a period of four months was appropriate in this case to mark the seriousness of the misconduct. It noted that you have been subject to an interim conditions of practice order for a long period of time and that this further period of time would give you the opportunity to address the gap in your insight identified by the panel and hence address the risk of repetition.

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

Any future panel reviewing this case would be assisted by:

- Your reflection on the panel's findings;
- Your attendance at any review of this order;
- Testimonials from any work undertaken during the period of suspension;
- Evidence of any CPD undertaken.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, Ms Girven made an application on behalf of the NMC for the imposition of an interim suspension order. The panel considered Ms Givern's application for the imposition of an interim order. 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 your own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Ms Girven made an application for the imposition of an interim suspension order for a period of 18 months on the same grounds of the substantive suspension order to cover the appeal period given the panel's findings.

Ms Bayley submitted that it is accepted that there is a necessity for an interim order based on the panel's findings. She submitted that the panel must first consider an interim conditions of practice order. She submitted that an interim suspension order would in fact increase the length of the substantive suspension order.

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. The panel had regard to the seriousness of the facts found proved and its finding that there was a risk of repetition of the conduct. Therefore, it concluded that it was necessary to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim

suspension order for a period of 18 months in order to adequately protect the public and satisfy the public interest during the appeal period. The panel determined that an interim order is required for a period of 18 months to cover the length of any possible appeal period.

The panel noted that irrespective of whether an interim order is imposed the substantive order will not come into effect until the 28-day appeal period has lapsed.

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

That concludes this determination.