# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Monday 18 August 2025 – Friday 22 August 2025**
**Tuesday 26 August – Wednesday 27 August 2025**

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

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|---|---|
| **Name of Registrant:** | **Julie Clare New** |
| **NMC PIN:** | 07B0167E |
| **Part(s) of the register:** | Nurses part of the register Sub part 1<br>RNA,Registered Nurse – Adult ( 20 April 2007 )<br>RNLD,Registered Nurse - Adult( 20 April 2007 ) |
| **Relevant Location:** | Oxfordshire |
| **Type of case:** | Misconduct |
| **Panel members:** | Derek Artis (Chair lay member)<br>Sharon Aldridge - Bent (Registrant member)<br>Chantelle Whitehead (Lay member) |
| **Legal Assessor:** | Nigel Ingram |
| **Hearings Coordinator:** | Karina Levy<br>Stanley Udealor (22 August 2025) |
| **Nursing and Midwifery Council:** | Represented by Jayesh Jotangia, Case Presenter |
| **Mrs New:** | Not Present and unrepresented |
| **Facts proved:** | Charges 1a, 1b, 1d, 1e, 3, 4, 5, 6, 7, 8 |
| **Facts not proved:** | Charges 1c, 2a, 2b, 9 |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Suspension Order (9 Months)** |
| **Interim order:** | **Interim Suspension Order (18 Months)** |

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Mrs New was not in attendance and that the Notice of Hearing letter had been sent to Mrs New's registered email address by secure email on 17 July 2025.

Further, the panel noted that the Notice of Hearing was also sent to then representative at the Royal College of Nursing (RCN) on 17 July 2025.

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

The panel accepted the advice of the legal assessor.

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

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

**Decision and reasons on proceeding in the absence of Mrs New.**

The panel next considered whether it should proceed in the absence of Mrs New. It had regard to Rule 21 and heard the submissions of Mr Jotangia who invited the panel to continue in the absence of Mrs New. He submitted that Mrs New had voluntarily absented herself.

Mr Jotangia submitted Mrs New would no longer be attending the hearing and she also no longer had representation. Since being notified of these changes, there has

been no more contact with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The NMC received an email dated 13 August 2025, from Mrs New's RCN representative informing them they are no longer instructed, and they had been informed that Mrs New will no longer be attending the hearing.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mrs New;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses were due to attend this week to give live evidence.
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020 - 2022;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and

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

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

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

**Details of charge**

That you, a registered nurse:

1) On 30 July 2020, you:

   a) Erased and/or altered one or more entries in the Controlled Drug Book

   b) Forged signature on the Controlled Drug Book

   c) Altered entry onto a Resident's T Mar Chart.

   d) Forged signature on T Mar Chart

e) Administered controlled drugs without having a witness present.

2) In or around April 2020, you:

a) Did not give one or more Resident's medication who were on PEG feeds.

b) Recorded PEG feeds as given in advance.

3) On one more than one occasion between 07 February 2022 and 09 February 2022, you administered Haloperidol to a patient that was no longer prescribed the medication.

4) On 09 February 2022, you placed a medicine order for Mirtazapine which had already been ordered.

5) On 03 March 2022, did not update care plans properly by using another patient's name in the care plan.

6) On 09 March 2022, did not record incidents in patient's notes.

7) On one or more occasions between 27 March 2021 and 09 March 2022, you did not attend to monitor and attend to distressed patient under your care.

8) Your conduct at charges 1 and/or 3 and/or 4 was dishonest, in that you intended to cover up care and medication administration errors.

9) Your conduct at charge 2 was dishonest, in that you intended to create a misleading impression that you had administered PEG feeds when you had not.

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

**Background**

Mr Jotangia opened the case for the NMC and outlined that the allegations cover the period of April 2020 – March 2022 at two different places of work.

Mrs New was employed by Volarum Care Group and on 20 May 2019 started work at John Masefield House. Mrs New had some history of medication errors and was under a supervision plan in relation to Percutaneous Endoscopic Gastrostomy (PEG) feeding tube.

On 30 July 2020, a Controlled Drug, gabapentin, error was detected. Following the employer producing an investigation report they convened a disciplinary hearing where a finding of gross misconduct was found and Mrs New's employment was ended. Mrs New did appeal but this was not upheld. Her employment was restored but Mrs New submitted her notice and did not return to work there.

On 21 September 2020, Mrs New was employed at Wemyss Lodge. Concerns arose which included those similar to the concerns at John Masefield House, being poor administration and administering of drugs. Mrs New resigned from this job 28 March 2022.

**Decision and reasons on application to admit hearsay evidence**

The panel heard an application made by Mr Jotangia under Rule 31 to admit the statements of Colleague A and Colleague B into evidence.

1. Witness Statement from Colleague A dated 20 December 2022

2. Witness Statement from Colleague B dated 10 July 2025

Mr Jotangia submitted that, under the circumstances, that the statement of Colleague A be admitted due to her being deceased. Mr Jotangia further submitted that the statement of Colleague B be admitted due to her being abroad on holiday.

He stated that Colleague B is exhibiting business documents, and she did not have any direct role dealing with Mrs New.

Mr Jotangia made regard to *Thorneycroft v NMC* [2014] EWHC 1565.

The panel accepted the advice of the legal assessor

The panel considered the application in regard to Colleague A's witness statement. The panel took into account that Colleague A's statement had been prepared in anticipation of these proceedings. In addition, the panel noted that there were also minutes of an investigation meeting in which Colleague A describes the incident which Colleague A has signed.

The panel considered whether Mrs New would be prejudiced by the change in the NMC's position of moving from reliance upon the live testimony of Colleague A to that of allowing hearsay testimony into evidence.

The panel considered that Mrs New had been provided with a copy of Colleague A's statement but would not have had the opportunity to cross examine her in any event due to her death. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement and exhibits of Colleague A but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

The panel considered the application in regard to Colleague B's witness statement. The panel took into account that Colleague B's statement had been prepared in anticipation of these proceedings. In addition, the panel noted that Colleague B was principally responsible for the production of business documents on behalf of Valorum Care Group.

The panel considered whether Mrs New would be prejudiced by the change in the NMC's position of moving from reliance upon the live testimony of Colleague B to that of allowing hearsay testimony into evidence.

The panel considered that Mrs New had been provided with a copy of Colleague B's statement but would not have had the opportunity to cross examine her in any event due to her being abroad on holiday, and Mrs New not being in attendance. As the panel noted that Colleague B was only the producer of business documents, there remained a public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement and exhibits of Colleague B but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

**Decision and reasons on facts**

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Jotangia.

The panel has drawn no adverse inference from the non-attendance of Mrs New.

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

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

- Witness 1: Registered Manager at time of incidents.

- Witness 2: Care Practitioner at the time of incidents

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC.

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

**Charge 1a**

1. That you, a registered nurse on 30 July 2020, you:

    a) Erased and/or altered one or more entries in the Controlled Drug Book

**This charge is found proved.**

In reaching this decision, the panel had regard to Colleague A's statement where she explains seeing her signature on an altered entry in the Controlled Drug Book (CDB) and that the references to the counting of the missing gabapentin were erased.

> *'I was shown the CDB, and I knew immediately that what I saw wasn't what was originally written and wasn't the entry that I had signed for.'*
>
> *'I noticed the entry had been erased and new information had*

*been entered. I recall signing the CDB for the found tablets between 14:00 (2pm) and 14:30 (2:30pm) and not at 16:00 (4pm).'*

The panel took into account the relevant evidence and clear admission made from Mrs New, within the notes of the Investigation Meeting on 30 August 2020 with her manager.

The panel noted that Mrs New, during the meeting had stated:

*'Because I found the 2 missing Gabapentin in the drug trolley in the drug basket, foiled, I assumed they were for __ as the 2 that were missing. I then put them safely in the blister, with an 'opened' label, so they didn't go missing. I irresponsibly erased the previous documentation of 2 missing and 2 found capsules in the controlled drug book which was signed by [Colleague A]'*

The panel considered the extract from the CDB which did not make any reference to the missing Gabapentin on 30 July 2020

The panel therefore found charge 1a proved

**Charge 1b**

1. That you, a registered nurse on 30 July 2020, you:
    b) Forged signature on the Controlled Drug Book

**This charge is found proved.**

In reaching this decision, the panel had regard to Colleague A's statement where she said that she had not signed the CDB

*'I knew the entry had been altered because I had finished work at 15:00 (3pm) and had left work so could not have signed the CBD at 16:00 (4pm) when I wasn't there to sign it'*

The panel considered the extract from the CDB which appeared to show a signature of Colleague A at 16.00

The panel took into account the relevant evidence and clear admission made from Mrs New, within the notes of the Investigation Meeting on 30 August 2020 with her manager. The panel noted that Mrs New, during the meeting had stated:

> '*I agree that [Colleague A ] had left JMH at 15.00'*

Mrs New's Manager said:

> '*You also tried to erase [Colleague A's] signature, but it did not happen cleanly, so you kept her signature, but change the information completely. This is a forgery'*

Mrs New responded, '*Yes I forged the signature'.*

The panel therefore found charge 1b proved.

**Charge 1c**

1. That you, a registered nurse on 30 July 2020, you:
    c) Altered entry onto a Resident's T Mar Chart.

**This charge is found NOT proved.**

The panel was unable to find any evidence to support this allegation.

The panel noted that the NMC had not set out what was alleged to have been altered on Resident T's MAR (Medication Administration Record) Chart so therefore the panel could not find this charge proved

**Charge 1d**

1. That you, a registered nurse on 30 July 2020, you:
    d) Forged signature on T Mar Chart

**This charge is found proved.**

In reaching this decision, the panel had regard to Colleague A's statement where she said:

> *'I did not sign the (Mar) Chart for the 4pm signature because I had finished work'*

The panel considered the extract from the T-MAR chart which appeared to show two signatures at 16.00.

The panel considered the disciplinary workbook document which included a meeting summary of the disciplinary hearing on 7 August 2020. Mrs New said that she had only signed for herself and not anyone else.

The panel took into account that during the investigation, other staff members who were on shift were interviewed and no one had said it was their signature on the T-MAR chart.

The panel noted that Mrs New, within the notes of the Investigation Meeting on 30 August 2020 with her manager had said in respect of the CDB entry

> '*I kept [Colleague A's] signature for the teatime medication…due to not having anyone at the time to sign*'

The panel had already found that Ms New had forged a signature on the CDB which was a regulatory document and not followed process in respect of the witnessing of giving medication. Therefore, on the balance of probabilities, the panel thought it was likely that she also forged a signature on the T-MAR Chart.

The panel therefore found charge 1d proved

**Charge 1e**

1. That you, a registered nurse on 30 July 2020, you:
    e) Administered controlled drugs without having a witness present.

**This charge is found proved.**

The panel referred to Colleague A's witness statement where she states that Mrs New was not present when administering the medication.

> *'After we signed the CDB Miss New administered the medication to the resident and while I wasn't with her at the time'*

The panel noted that when asked about administering the gabapentin on 30 July 2020, Mrs New, within the notes of the Investigation Meeting on 30 August 2020 said that:

> '*I should have insisted that [Colleague A] came with me*'

and

> *'in hindsight as [another Colleague] was hovering in Activities, I should have asked him to come with me*'

Mrs New also said '*I gave [a resident] his teatime medication unwitnessed*'.

The panel therefore found charge 1e proved.

**Charge 2a**

2. In or around April 2020, you:

a) Did not give one or more Resident's medication who were on PEG feeds.

**This charge is found NOT proved.**

The panel considered the Investigation report dated 5 August 2020 which refers to the background to the employee and says that Mrs New "*Is subject to performance management in relation to matters relating PEG feeds administration*".

The NMC referred the panel to a supervision review form dated April 2020; however, the panel observed that the document is unclear and there is no detail provided, outlining what happened or when it happened. The panel further noted that the limited references to PEG by Mrs New's manager were not witnessed by her and had been considered by another manager when Mrs New's manager was on leave.

The panel noted that the NMC has not provided any specifics in respect of this allegation including date, time, location, any reference to anyone who was present at the time of the allegation or any notes or documents from the relevant manager. The panel further noted that there is no medical evidence, no charts and no policy in respect of the PEG feeds provided

The panel considered that the evidence is sole and decisive as well as "*double*" hearsay, with no detailed account of specific incidents.

In reaching this decision, the panel had regard to the NMC guidance on Evidence, particularly, Hearsay (DMA-6) which states:

> *'Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in*

*respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested'*

The panel therefore found charge 2a not proved

**Charge 2b**

2. In or around April 2020, you:

    b) Recorded PEG feeds as given in advance.

**This charge is found NOT proved.**

The panel found this charge not proved for the same reasons at charge 2a

**Charge 3**

3. You administered Haloperidol to a patient that was no longer prescribed the medication.

**This charge is found proved.**

In reaching this decision, the panel had regard to Witness 1's statement:

*'Miss New was allocated the patient and did not familiarize herself with the patients notes, Care Plan or MAR chart and medication requirements. Over three (3) consecutive days, Miss New administered Haloperidol to the patient when she shouldn't have.'*

The panel also heard the oral evidence of Witness 1 and considered her evidence to be credible, consistent and reliable.

The panel considered an undated document Mrs New has provided for this Fitness to Practice process titled '*NMC reflections on practice'*.

> *'During my drug round on this particular resident she had Haloperidol to be given at 22:00hrs. I administered this because it was due and it was put on the system I was only following my medication policy of administering medications… It was not brought to my attention that this was an error until weeks later with my manager which led to her asking me to resign from my post. My manager pointed out the medication was stopped, and this was documented on her notes'*

The panel therefore found charge 3 proved.

**Charge 4**

4. You placed a medicine order for Mirtazapine which had already been ordered.

**This charge is found proved.**

In reaching this decision, the panel had regard to Witness 1's statement

> *'The patient's Mirtazapine was initially administered on the night time medication round at 10pm but had been changed from being administered at night time to tea time at 5pm. Miss New didn't look to notice the change when she was placing her order, and this meant that the patient would have received a double dose of the medication*.'

In her oral evidence, Witness 1 explained that the organisation had a "*virtual stock cupboard"* and Mrs New creating a second order of mirtazapine "g*ave [the system] a new rule so created a requirement to give drugs at nighttime*".

The panel considered an undated document Mrs New has provided for this Fitness to Practice process titled '*NMC reflections on practice'*.

'*I had put this on the system with my colleague but there were issues whereby it was already on the system and my colleague, and I sorted this out between us….*
*We use electronic e-mar which requires two signatures for any changes to a persons medication whether that is dose or time or if a medication has been discontinued, and always follow the emar, if someone has a change in medication it should not be a guessing game*'.

The panel therefore found charge 4 proved.

**Charge 5**

5. On 03 March 2022, did not update care plans properly by using another patient's name in the care plan.

**This charge is found proved.**

In reaching this decision, the panel had regard to Witness 1's statement:

*'On 3 March 2022, Miss New completed a patient's care plan however recorded incorrect information on the care plan. Miss New had written a different patient's name instead of the patient's name. The Care plan for this patient was correct in all aspects except for the different names inserted'*

Witness 1 confirmed this in her oral evidence.

The panel considered an undated document Mrs New has provided for this Fitness to Practice process titled '*NMC reflections on practice'*.

*'I used and looked at other resident care plans to see whether or not there was any relevant information I could use that was similar to her care needs and I cut and pasted a sentence and when proof reading it back I changed the name however I did not check the whole document as I was called away to*

*assist in an emergency situation… I admit that this was an error on my part and I realise I should have been more careful'.*

The panel therefore found charge 5 proved

**Charge 6**

6. On 09 March 2022, did not record incidents in patient's notes.

**This charge is found proved.**

In reaching this decision, the panel took into account the statement of Witness 1

In respect of an incident concerning wound management of a resident's toe on 9 March 2022, Witness 1 said:

*'Miss New had documented that a patient's wounds were healing when in fact the wound had deteriorated in that the bone was visible through the toe. The patient was bed bound and had grade four (4) pressure wounds before his admission to the Home. The patient's heel wounds had deteriorated and the patient's two (2) big toes became necrotic which was noted on the Patients Care plan on 2 March 2022*

Witness 1 in live evidence said that Mrs New had recorded it as showing healing even when deteriorating and that the entry told her that Mrs New was *'not actually understanding wound care or the grading or severity of the wound'.*

The panel considered the entry made by Mrs New on the patient's notes on 9 March 2022 as well as the evidence of Witness 1.

The panel considered an undated document Mrs New has provided for this Fitness to Practice process titled 'NMC reflections on practice' in which Mrs New explains how she conducted her assessment of the patient's wound.

The panel considered that there was no evidence that Mrs New had deviated from the care plan. There was insufficient information provided by Witness 1 about her clinical assessment of the wound to suggest that Mrs New did not record incidents in the notes, particularly when considering the other entries within the patients notes

The panel therefore concluded that Mrs New had appropriately recorded information in respect of this incident.

There were two other patient safety incidents on 9 March 2022 which were captured on close circuit television (CCTV) and viewed by Witness 1 on 10 March 2022 when alerted to them by another staff member. Witness 1 said that the CCTV footage '*clearly showed a patient had left their room and needed the toilet and had wandered into another patient's room and urinated'*. Witness 1 also said that she saw *'a patient was out of bed and wearing their underwear over their head'*.

In reaching this decision, the panel took into account the statement of Witness 1 *"Miss New failed to document incidents involving two (2) patient's that occurred on her shift. The incidents were not recorded in the patients notes or Care Plans"*

The panel therefore found charge 6 proved

**Original Charge 7**

7. On one or more occasions between 27 March 2021 and 09 March 2022, you did not attend to monitor and attend to distressed patient under your care.

During the course of panel's deliberations, on taking legal advice under Rule 28 of the Rules in respect of amending charges under the panel's volition, the panel amended the wording as follows:

**On 27 March 2021 and 9 March 2022, you did not attend to monitor and attend to distressed patient under your care.**

**This charge is found proved.**

In respect of the events of 27 March 2021, the panel considered the statement of Witness 2, her nearly contemporaneous notes made on 30 March 2021 and her oral evidence.

Witness 2 said in her statement:

> *'A newly employed Carer was trying to help the resident back to her room, but the resident was screaming at the Carer and pushing her away, possibly due to the resident being unfamiliar with the new Carer. The resident was calling out to Miss New for help. I looked around for Miss New and saw her sitting at the computer and ignoring the resident. I asked Miss New, "What is the matter?" and she shrugged her shoulders at me. The resident was visibly upset, crying and very agitated and smelt very strongly of urine.'*

In her oral evidence, Witness 2 said that the resident was "*probably 3 ft away from [Ms New] screaming and asking for help".*

Witness 2 explained that she assisted the resident.

Witness 2 said that Mrs New "*should have got up and helped her like I had done*". The panel found Witness 2's evidence to be credible, consistent and reliable.

In her statement, Witness 2 said:

> '*then I then went into the nurse's office and asked Miss New why she hadn't helped the Carer with the resident. Miss New seemed quite annoyed at me and said "Well I couldn't, could I." I explained to Miss New that the resident may have a urine infection because she smelt strongly of urine and because of her behaviour. I picked up the diary and said that I would write it in for a urine sample to be sent on Monday morning which was the following day. Miss New snatched the diary from me and said, "I'm dealing with it". I replied,*

*"Good so you will be calling the out of hours Doctor now then?" and I left it with her to follow up'*

Witness 2 said that she raised concerns to the nurse in charge on the next day and that Mrs New had not progressed the urine investigation with the Doctor. She said:

*'When I came to work the following day on 28 March 2021, I found out that Miss New did not try and contact a Doctor, so I asked [the nurse in charge] to phone the Doctor because the resident might have a urine infection. From what I can recall, Miss New was not working that day otherwise I would have gone to her and not another RGN.'*

The panel considered an undated document Mrs New has provided for this Fitness to Practice process titled '*NMC reflections on practice'* in which she stated that she provided the necessary care. However, the panel preferred the evidence of Witness 2 as an accurate account of what happened on 27 March 2021.

In respect of 9 March 2022, there were two other patient safety incidents on 9 March 2022 which were captured on close circuit television (CCTV) and viewed by Witness 1 on 10 March 2022 when alerted to them by another staff member. Witness 1 said that the CCTV footage '*clearly showed a patient had left their room and needed the toilet and had wandered into another patient's room and urinated*'.

Witness 1 further stated in her statement:

*'I couldn't see any staff on the monitors, and this meant they weren't monitoring properly.*
*The CCTV footage showed Miss New was situated at the nurse's station and that she didn't react quickly enough to patient incident. I saw [a carer] went to get Miss New when the incident happened, and it appeared Miss New was in no rush to go to the patient'.*

Witness 1 also said that she saw *'a patient was out of bed and wearing their underwear over their head'.* She said:

*‘Had Miss New been monitoring as she should have been, this incident may not have occurred.’*

The panel therefore found charge 7 proved.

**Charge 8**

8. Your conduct at charges 1 and/or 3 and/or 4 was dishonest, in that you intended to cover up care and medication administration errors.

**This charge is found proved**

The panel considered the NMC Guidance on Making decision on dishonesty charges and the professional duty of candour (DMA-8). The panel decided that the conduct that took place in charge 1 was dishonest because she knew that the expectation required of her was to record entries into CDB accurately and that by altering and forging entries, she knew what she was doing was wrong. Further, the panel took account of the fact that she had earlier accepted her dishonesty. At the disciplinary hearing on 7 August 2020, Mrs New said:

*‘I was trying to protect the Home…..I thought that one coverup would not hurt’*

The panel found this charge proved in relation to charge 1.

In relation to charge 3, the panel considered the NMC Guidance on Making decision on dishonesty charges and the professional duty of candour (DMA-8):

*‘It is important that the panel considers whether there is an alternative explanation for the nurse, midwife or nursing associate’s conduct, which points away from them having behaved dishonestly. It can be useful to ask whether their mind was engaged with what they were doing, or could they simply have made an innocent or careless mistake?’*

The panel noted that Witness 1 said in her statement:

*‘When the patient was first admitted, I could understand if Miss New had made a human error to begin administering Haloperidol to the patient, but she continued to administer the medication over three (3) days which demonstrated to me that she had not familiarised herself with the patient by reviewing the patient's documentation which had also been sent by the Dementia Later Life Liaison Team (“DLLT”).*

*However, I don't believe Miss New is fully responsible for the medication error. I would apportion fault at 50/50 between Miss New and the Previous Care Home where the patient had been sent from before admission to Wemyss. The Care Home had sent the Haloperidol with patient, despite the patient no longer requiring the medication, so are partially responsible for the error occurring. Miss New, however, should have read everything beforehand to know she wasn't to administer Haloperidol’*

Given the above, the panel was of the view that there was an alternative reasonable explanation, consequently, the panel found Mrs New’s conduct in charge 3 was not dishonest.

In relation to charge 4, the panel considered the NMC Guidance on Making decision on dishonesty charges and the professional duty of candour (DMA-8), quoted above.

The panel took account of the Reflective Account from Miss New dated 17 February 2022 where Mrs New stated:

*‘…..I clicked on the entry, and I didn’t have the box that flagged up to say stock received instead there was a box that said replace existing which I clicked on and then it was countersigned by my colleague….What I was completely unaware of and didn’t check that it was on the nighttime schedule. Had I checked this I would have sopped this order so that ended would appear on the system.’*

In her oral evidence, Witness 1 confirmed that the Home had changed back to a paper-based system as it was not just Mrs New doing this but sometimes, the pharmacy had done *"double ent*ry" and the electronic system was "*not safe enough*". Given the above, the panel was of the view that there was an alternative reasonable explanation, consequently, the panel found Mrs New's conduct in charge 4 was not dishonest.

**Charge 9**

9. Your conduct at charge 2 was dishonest, in that you intended to create a misleading impression that you had administered PEG feeds when you had not.

**This charge is found NOT proved**

The panel did not find charge 9 proved given that charge 2 was not found proved.

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all

the circumstances, Mrs New's fitness to practise is currently impaired as a result of that misconduct.

**Submissions on misconduct**

Mr Jotangia submitted that misconduct is a serious departure from the standards expected of a registered nurse or midwife, as outlined in the NMC Code as it is not merely an error or lapse but conduct that fellow professionals would regard as deplorable or falling seriously short of what is proper. He stated that this threshold of seriousness is essential, as not every failing constitutes misconduct warranting regulatory intervention.

Mr Jotangia referred the panel to the case of *Roylance v General Medical Council* [1999] UKPC 16, where Lord Clyde emphasised that misconduct must involve a '*serious departure from the standards expected'* going beyond mere negligence to actions that bring the profession into disrepute. Mr Jotangia also referred the panel to the case of *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin) where Mr Justice Collins stressed that misconduct requires a '*degree of seriousness*' distinguishing it from minor infractions. Mr Jotangia further referred the panel to the case of *Doughty v General Dental Council* [1988] AC 164 where the House of Lords described misconduct as conduct '*connected with the profession in which the practitioner has fallen short... and such falling short is serious.'*

Mr Jotangia provided a summary of the charges found proved against Mrs New as follows:

> ***'Failings in Medication Administration:***
>
> - *Administering controlled drugs without a witness.*
> - *Administering Haloperidol to a patient for three days after it was no longer prescribed.*
> - *Placing a duplicate order for Mirtazapine, resulting in a double dose for a patient.*

***Poor recordkeeping:***

- *Erasing and altering entries in the Controlled Drug Book.*
- *Forging signatures on medication records.*
- *Failing to update care plans accurately, including using another patient's name.*

***Dishonesty:***

- *Intentionally covering up medication administration errors.*
- *Creating a misleading impression.*

***Poor Patient Care:***

- *Failing to monitor and attend to distressed patients under her care.'*

Mr Jotangia submitted that Mrs New's actions represent a significant departure from the standards outlined in the NMC Code, including the duty to act with honesty and integrity, maintain accurate records, and prioritise patient safety. He asserted that the repeated nature of the incidents, across two separate employers, demonstrates a pattern of behaviour that is incompatible with the standard expected of a registered nurse. Mr Jotangia submitted that the following parts of the Code: Professional standards of practice and behaviour for nurses and midwives 2018 (the Code) are engaged in this case and have been breached. They are sections 8.2, 8.5, 10.1, 10.2, 10.3, 10.4, 18.2, 18.3, 19.1, 20.1, 20.2 and 20.3.

Mr Jotangia submitted that Mrs New's actions amount to misconduct of the most serious nature. He submitted that the aggravating features of this case include:

- Limited Insight**:** Mr Jotangia submitted that Mrs New has demonstrated limited insight into her actions, particularly regarding the dishonesty allegations. He submitted that while some admissions have been made, there is a lack of meaningful reflection on the seriousness of her misconduct and its impact on patients, colleagues, and the profession.

- Dishonesty**:** Mr Jotangia submitted that Mrs New's actions involved dishonesty, including erasing and altering controlled drug records, forging

signatures, and thus creating a misleading impression. He asserted that dishonesty is a serious breach of trust and is difficult to remediate.

- Pattern of Misconduct**:** Mr Jotangia submitted that Mrs New's misconduct occurred over a prolonged period (2020–2022) and across two separate employers, indicating a pattern of behaviour rather than isolated incidents. He argued that this suggests deep-seated attitudinal issues.

- Risk to Patient Safety**:** Mr Jotangia submitted that Mrs New's actions placed patients at a real and serious risk of harm. He asserted that the errors in medication administration, inaccurate record-keeping, and failure to attend to distressed patients could have had significant consequences for patient care.

- Impact on Colleagues**:** Mr Jotangia submitted that Mrs New's behaviour created additional burdens for colleagues, who had to ensure records were accurate and patients were safe. He asserted that this undermines teamwork and trust within the workplace.

- Breach of Fundamental Professional Standards**:** Mr Jotangia submitted that Mrs New's actions breached core tenets of the NMC Code, including honesty, integrity, accurate record-keeping, and prioritising patient safety. He argued that these breaches undermine public confidence in the nursing profession.

- Failure to Learn from Supervision**:** Mr Jotangia submitted that, despite being placed under a supervision plan at her first employer, Mrs New repeated a similar misconduct at her second employer, demonstrating a failure to learn from previous interventions.

- Attitudinal Issues**:** Mr Jotangia submitted that the dishonesty and repeated nature of the misconduct suggest underlying attitudinal problems, which are unlikely to be resolved through training or supervision alone.

Mr Jotangia submitted that these aggravating factors collectively highlight the seriousness of the case and the risks posed by Mrs New's continued practice without significant remediation. In conclusion, Mr Jotangia invited the panel to find that Mrs New's actions in the charges found proved amounted to misconduct.

**Submissions on impairment**

Mr Jotangia submitted that impairment is a forward-looking assessment, focusing on whether the professional's ability to practise safely and effectively is compromised, posing a risk to patients, colleagues, or the profession's reputation. He stated that it encompasses both personal components such as remediation and insight as well as public components such as maintaining confidence and declaring standards.

Mr Jotangia submitted that, in considering impairment, the panel should consider the test formulated by Dame Janet Smith in the *Fifth Shipman Report,* quoted in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin). He further referred the panel to the test set out in the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Jotangia submitted that Mrs New has not provided any insight or remedial activity addressing the concerns. He highlighted that Mrs New has failed to engage with the NMC and these proceedings.

Mr Jotangia referred the panel to the case of *Bolton v Law Society* [1994] 1 WLR 512, where Sir Thomas Bingham MR emphasised that professional discipline serves to '*maintain the reputation of the solicitors' profession as one in which every member... may be trusted to the ends of the earth.'* He submitted that, in impairment assessments, this means prioritising public perception over individual hardship.

Mr Jotangia invited the panel to consider both the personal and public components of impairment. In terms of the personal component, he submitted that Mrs New has demonstrated limited insight into her actions. He argued that while Mrs New has admitted to some of the charges and provided a reflective piece, she has failed to

adequately address the dishonesty allegations or the impact of her actions on patients, colleagues, and the profession.

Mr Jotangia submitted that the dishonesty concerns suggest an attitudinal issue that is difficult to remediate. He highlighted that, despite completing a period of supervision at her first employer, Mrs New repeated similar behaviours at her second employer, indicating a lack of meaningful learning or change. Mr Jotangia asserted that the risk of repetition remains high, as Ms. New has not fully acknowledged the seriousness of her actions or demonstrated sufficient insight into the underlying causes of her misconduct.

In terms of the public component, Mr Jotangia submitted that Mrs New's actions undermine trust in the nursing profession and in the NMC's ability to uphold professional standards. He submitted that Mrs New's dishonesty is particularly damaging, as it strikes at the heart of the trust placed in nurses to act with integrity and prioritise patient care.

Mr Jotangia submitted that the risk of harm to patients and colleagues is significant as Mrs New's conduct poses a real and serious risk to the safety and well-being of patients in her care. He argued that Mrs New's repeated failings, dishonesty, and lack of sufficient insight demonstrate that her fitness to practise is currently impaired. This impairment poses a risk to patient safety, undermines public confidence in the profession, and demonstrate a failure to uphold the standards expected of a registered nurse.

In conclusion, Mr Jotangia invited the panel to find that Mrs New's fitness to practise is impaired on both public protection and public interest grounds.

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 was of the view that Mrs New's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code. Specifically, the following sections of the Code:

***'Practise effectively***

***8 Work cooperatively***
*To achieve this, you must:*

***8.2** maintain effective communication with colleagues*
***8.5** work with colleagues to preserve the safety of those receiving care*

***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:*

***10.1** complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
***10.2** identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
***10.3** complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
***10.4** attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*

***Preserve safety***

***18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations***
*To achieve this, you must:*

***18.2** keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs*
***18.3** make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines*

***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***
*To achieve this, you must:*

***19.1** take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

***Promote professionalism and trust***

***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, treating people fairly and without discrimination, bullying or harassment*
***20.3** be aware at all times of how your behaviour can affect and influence the behaviour of other people'*

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

**Charges 1a, 1b and 1d**

The panel noted that although these incidents occurred in one shift, it demonstrated a pattern of behaviour which was pre-meditated and deliberate. The panel noted that Mrs New stated that her actions were an attempt to cover up for her employer. However, the panel rejected such explanation, and it was of the view that it was an attempt by Mrs New to cover up for her failure to follow her employer's Administration of Medicines Policy and Procedure (the Policy) as well as to conceal her error. The panel therefore found Mrs New's conduct to be extremely serious and that it constituted a serious breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain.

Although there was no evidence of actual direct harm caused to residents, the panel was of the view that Mrs New's conduct potentially placed them at risk of harm. The panel also found Mrs New's behaviour to amount to an abuse of her position of trust as lead nurse on the shift.

The panel concluded that Mrs New's conduct would be seen as unacceptable by other members of the profession and the public. Accordingly, the panel determined that Mrs New's behaviour in charges 1a, 1b and 1d amounts to misconduct.

**Charge 1e**

The panel considered that Mrs New failed to adhere to the Policy, which was to have a witness present whilst administering controlled drugs to a resident. The panel noted that the provisions of the Policy with respect to the administration of medication were made to ensure the safety of the residents and therefore Mrs New's failure to follow those provisions placed residents at risk of harm.

The panel determined that Mrs New's conduct amounted to a failure to uphold the standards of the nursing profession. Consequently, the panel determined that Mrs New's conduct in charge 1e was sufficiently serious to amount to misconduct.

**Charges 3 and 4**

In respect of charge 3, the panel noted that Witness 1 stated in her witness statement that despite the fact that the patient's care home could be partially blamed for the error, as the drug did appear on the T MAR chart, Mrs New had continued to administer the medication over three days which demonstrated that she had failed to familiarise herself with the patient by reviewing the patient's documentation, namely the admissions letter that stated that the drug had been discontinued. The panel further noted that the error may not have occurred if Mrs New had also adhered to the Policy.

The panel was of the view that Mrs New's conduct in charge 3 demonstrated an unacceptable attitude towards the administration of medication and the duty of care towards her patients. The panel was of the view that although there was no evidence of actual harm, Mrs New's medication errors posed a risk of harm to the patient's safety as they had been given an unprescribed medication.

The panel therefore determined that Mrs New's actions fell short of the standard of nursing care expected from a registered nurse and amounted to a breach of fundamental duty of care to patients. Consequently, the panel determined that Mrs New's conduct in charge 3 was serious and amounts to misconduct.

In relation to charge 4, the panel noted that Mrs New's conduct was as a result of lapses in the electronic data system of Wemyss Lodge and Witness 1 had described the electronic system to be "*not safe enough*" and that the pharmacy had also made a *"double entry"*. The panel had earlier accepted these explanations, and it had found that Mrs New's conduct was not dishonest. In this regard, the panel determined that Mrs New's conduct in charge 4 was not so serious as to amount to misconduct.

**Charges 5 and 6**

The panel considered accurate record-keeping and effective communication as some of the fundamental tenets of the nursing profession. The panel was of the view that Mrs New's conduct in charge 5 would not individually been sufficiently serious to

amount to misconduct as her conduct could be regarded as a mere human error. However, when viewed together with Mrs New's conduct in charge 6, it demonstrated a pattern of behaviour which suggests a careless disregard for accurate recordkeeping by Mrs New.

The panel noted that Mrs New's failings would have deprived her colleagues, her employer and the appropriate health professionals from being appraised with the relevant information pertaining to the patients' care. The panel determined that this could have had a consequent impact on those patients' continuity of care and posed a potential risk of harm to them. The panel therefore determined that Mrs New's actions amounted to a serious failure in a fundamental aspect of nursing practice. The panel concluded that Mrs New's actions in charges 5 and 6 were serious and amounts to misconduct.

**Charge 7**

The panel considered Mrs New's conduct on charge 7 to be wholly inappropriate, unacceptable and that it fell short of the standard of care expected from a registered nurse. The panel noted that the patients were vulnerable persons who were dependent on Mrs New and other health professionals. The panel was of the view that Mrs New's failure to monitor and attend to distressed patients under her care placed such patient at risk of harm. The panel considered Mrs New's conduct to amount to a serious failure in fundamental aspects of nursing practice and to amount to a dereliction of her nursing duties. The panel determined that Mrs New's conduct amounted to a breach of the fundamental duty of care, and as such was deplorable, and fell short of the fundamental obligations that registered nurses have to residents under their care. The panel concluded that Mrs New's conduct in charge 7 was serious and amounted to misconduct.

**Charge 8**

The panel considers honesty, integrity and trustworthiness to be the bedrock of the nursing profession and, in being dishonest, it found Mrs New to have breached a fundamental tenet of the nursing profession and brought the nursing profession into

disrepute. It noted that Mrs New's dishonest conduct posed a risk of harm to residents and demonstrated a lack of accountability and transparency on her part. The panel considered Mrs New's dishonest behaviour to be extremely unprofessional and would be seen as deplorable by other members of the profession and the public. Therefore, the panel was in no doubt that Mrs New's dishonest behaviour in charge 8 amounts to misconduct.

Consequently, having considered the proven charges individually and in totality, the panel determined that Mrs New's actions in charges 1a, 1b, 1d, 1e, 3, 5, 6, 7 and 8 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

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

Registered nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust 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.

The panel had regard to the NMC Guidance on Impairment especially the question which states:

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

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 first considered whether any of the limbs of the *Grant* test were engaged as to Mrs New's past conduct. The panel was of the view that Mrs New's misconduct placed patients at unwarranted risk of harm.

The panel found that Mrs New's misconduct constituted a serious breach of fundamental tenets of the nursing profession in that she failed to practise effectively, preserve safety and promote professionalism and trust. It determined that Mrs New failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute. The panel also found Mrs New to have acted dishonestly.

The panel therefore concluded that limbs a, b, c and d of the *Grant* test are engaged in respect of Mrs New's past conduct.

The panel next considered whether the limbs of the *Grant* test are engaged as to the future. In this regard, the panel considered the case of *Cohen v GMC* in which the Court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

In this regard, the panel also considered the factors set out in the NMC Guidance on Insight and strengthened practice (FTP-15).

The panel first considered whether Mrs New's misconduct is capable of being addressed. In the NMC Guidance – Can the concern be addressed (FTP-15a), the panel noted the following paragraph:

> *'In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.*

*Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*

- *….*
- *dishonesty, particularly if it was serious and sustained over a period of time, or is directly linked to the nurse, midwife or nursing associate's professional practice*

*Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include:*

- *medication administration errors*
- *poor record keeping*
- *failings in a discrete and easily identifiable area of clinical practice'*

The panel was of the view that Mrs New's clinical misconduct with respect to medication administration errors, poor recordkeeping and failings in fundamental areas of nursing practice, could be addressed through a process of insightful reflections, retraining in the areas of concern and evidence of good practice. Therefore, the panel determined that it is capable of remediation.

In respect of Mrs New's dishonest conduct, the panel noted that the NMC Guidance set out that dishonesty was generally difficult to address. The panel considered that Mrs New's dishonesty in this case was opportunistic and not done for personal gain. However, it did have the potential to negatively impact on vulnerable patients and pose a risk to people receiving her care. The panel in considering her behaviour in the context of the working environment was not satisfied that this was premeditated or systematic but was a consequence of custom and practice in the workplace.

The panel then went on to consider whether the concerns have been addressed and remediated. It had regard to the NMC Guidance – Has the concern been addressed (FTP-15b). The panel took into account Mrs New's undated reflective statement, her training certificates and the various references made on her behalf.

The panel also considered the context of the misconduct. It noted that Mrs New had raised allegations of bullying and harassment, during her disciplinary appeal process at John Masefield House, and that she felt isolated from the team there.

The panel accepted there was a culture of general lapse in custom and practice in relation to witnessing Controlled Drugs administration.

The panel also noted that there was a failure with the electronic data system at Wemyss Lodge. However, the panel was of the view that, given Mrs New's experience as a registered nurse, such failures at the time of the incidents were not reasonable justifications for her misconduct. Mrs New did not attend to or monitor patients progress with the result that patients were distressed and did not receive timely intervention or appropriate care.

Regarding insight, the panel considered that Mrs New made some admissions during the investigative meetings, demonstrated some insight into the seriousness and impact of her actions as well as what she could have done differently. However, the panel noted that Mrs New sought to deflect responsibility for some of her actions and tended to provide justifications for them. The panel was concerned that Mrs New failed to demonstrate sufficient insight into her dishonest conduct and its impact on patients, her colleagues, the nursing profession and the wider public. The panel further noted that Mrs New's reflective statement was undated, and in the absence of her engagement with these proceedings, the panel could not evaluate her current insight into her misconduct.

In considering whether Mrs New has strengthened her nursing practice, the panel considered the various training certificates and references made on her behalf. The panel noted that some of the training certificates were outdated, irrelevant or made prior to the incidents. The panel also noted that although Mrs New's testimonials were positive, they were outdated as the most recent reference was two years ago. The panel therefore could only attach limited weight to them given that it is considering current impairment and there is no updated information on Mrs New's current practice.

In light of this, the panel was not satisfied that Mrs New's misconduct had been remediated, nor has she strengthened her nursing practice. Accordingly, the panel determined that Mrs New's misconduct is not highly unlikely to be repeated. Therefore, limbs a, b, c and d of the *Grant* test are engaged as to the future.

Consequently, the panel concluded that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel had regard to the serious nature of Mrs New's misconduct and the public protection issues identified. It determined that public confidence in the profession, particularly as the misconduct involved dishonesty, would be undermined if a finding of impairment were not made in this case. For these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that Mrs New's fitness to practise is currently impaired on both public protection and public interest grounds.

**Sanction**

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

**Submissions on sanction**

Mr Jotangia submitted that, given the panel's findings of serious misconduct and impairment as well as the severity of the charges found proved, it is the NMC's position that the proportionate and appropriate sanction in this case is a striking-off order.

Mr Jotangia submitted on behalf of the NMC that the proven facts are not isolated incidents. The events occurred over a prolonged period, spanning over two employers. Mr Jotangia further submitted that Mrs New remains a significant, serious risk to patients and users of the NHS and that her actions have led to her trustworthiness and integrity to be questioned. Mr Jotangia made regard to the fact that Mrs New's poor clinical practice had the potential to lead to the harm of patients.

Mr Jotangia went on to highlight to the panel the aggravating factors. He submitted that Mrs New had limited insight and although there were some admissions made by Mrs New during the investigation stage by her employer, she has still failed to demonstrate any meaningful insight. Mrs New has previously provided reflections which are now outdated and at present, she has not provided anything current to demonstrate her strengthening of practice or further learning.

Mr Jotangia submitted that Mrs New's outdated reflective piece does not outweigh the seriousness of offences, therefore a strike off is the only suitable outcome. He further submitted that a lesser sanction would not provide adequate protection to the public and that Mrs New's attitudinal issues are not remediable due to her having made these mistakes whilst under supervision.

In conclusion, Mr Jotangia submitted that every nurse should strive to uphold honesty, professionalism and integrity in all aspects of their work and in light of Mrs New's actions, it should be made clear that such behaviour is unacceptable.

The panel accepted the advice of the legal assessor.

**Decision and reasons on sanction**

Having found Mrs New's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the NMC's Sanction Guidance (SAN-1 and SAN-2). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Dishonesty
- Breach of trust as nurse in charge
- At two separate homes on two separate occasions
- Lack of any recent meaningful insight into failings
- Conduct which put vulnerable patients at risk of harm.

The panel also took into account the following mitigating features:

- Challenging working environment at both homes
- Some insight during early stages of her engagement with the regulator
- Some evidence of subsequent relevant training and education provided
- Within employer references there were strong recommendation of safe, current and future practice

The panel considered the SG San-2 Sanctions for particularly serious cases and determined that the dishonesty in this case was at the lower end of the spectrum.

However, honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore, allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. However, in every case, the Fitness to Practise

Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious.

- *The panel found that Mrs New deliberately breached her professional duty of candour by covering up when things went wrong, namely by erasing reference to the loss and subsequent recovery of controlled drugs. However, the panel determined that her actions did not cause direct harm to patients*
- *The panel noted that 2 of the charges related to conduct, which was intrinsically dishonest, being the forging of signatures*

The panel considered it was less serious for the following reasons.

- *Opportunistic conduct that occurred on one shift*
- *No direct personal financial gain*
- *Her actions were not premeditated, systematic or a long standing deception*

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs New's 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 Mrs New's 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 Mrs New's registration would be a sufficient and appropriate response. The panel took into account that there is no up to date information of Mrs New being in employment and the panel are not aware if Mrs New would agree to a condition of practice order.

A condition of practice order should be relevant, proportionate, workable and measurable but in the absence of Mrs New, the panel are unable to impose conditions that would meet that criteria even if condition of practice was appropriate.

Consequently, the panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges 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 Mrs New's 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 panel was satisfied that in this case the misconduct was not fundamentally incompatible with remaining on the register.

The panel considered the guidance within SAN-3d and determined that it was sufficiently serious and required a temporary removal from the register.

The panel have taken particular note of the reference dated 16 August 2023 in which the registered nurse and registered manager spoke *"I have witnessed good practice. Mrs New is fit to practice as a registered nurse without restrictions…her practice is safe and effective".*

Consequently, a period of suspension would be sufficient to protect patients and public confidence in nurses.

The panel 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 Mrs New's case to impose a striking-off order.

The panel recognised the importance of competent nurses remaining on the register to continue their nursing practice.

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 could inevitably cause Mrs New, however this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of nine months was appropriate in this case to mark the seriousness of the misconduct.

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:

- Mrs New's engagement with the NMC and attendance at any future hearings
- Updated reflective piece, particularly addressing the issue of insight into the proven charges

- Information on her recent relevant education and training
- Current employers reference

This will be confirmed to Mrs New in writing.

**Interim order**

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

**Submissions on interim order**

The panel took account of the submissions made by Mr Jotangia. He submitted that in light of the panel's decision to impose a suspension order to mark the seriousness of this case, the NMC is applying for an 18-month interim order due to the risk Mrs New could still pose to the public.

**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 the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim condition 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, not to impose an interim suspension order would be inconsistent with the panel's findings.

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

That concludes this determination.