Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday, 16 December 2025 - Wednesday, 17 December 2025

Virtual Meeting

Name of Registrant:	Joanne Marie Millard
NMC PIN:	14F0662E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (20 September 2014)
Relevant Location:	England
Type of case:	Misconduct
Panel members:	Rachel Forster (Chair, lay member) Sarah Morgan (Registrant member) Anjana Varshani (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Ifeoma Okere
Facts proved:	Charges 1(b) and (2)
Facts not proved:	Charge 1(a), (c), (d), (e) and (f)
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months, subject to review)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Miss Millard's registered email address by secure email on 3 November 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation and the date after which the meeting will be held.

In light of all of the information available, the panel was satisfied that Miss Millard has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse on 4 July 2020:

1. Did not complete adequate records for Resident 1, in that you:
   a. Did not record his BP.
   b. Did not record Resident 1's deteriorating reaction to the sternal rub.
   c. Did not document Resident 1's reduced urine output
   d. Did not record that Resident 1 was difficult to rouse and/ or floppier than usual.
   e. Did not record that you had been informed that Resident 1 was less responsive and /or unresponsive
   f. Did not record the time you called an ambulance on Resident 1's Client Daily Living Record.

2. Did not take appropriate and /or timely action upon being told that Resident 1 was less responsive and/or unresponsive

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

Background

The charges arose whilst Miss Millard was employed as a registered nurse at [PRIVATE] ("the Nursing Home"), operated by [PRIVATE]. Miss Millard was entered onto the Nursing and Midwifery Council register as a Registered Nurse Adult (RNA) on 20 September 2014.

At the material time, Miss Millard was employed as a Registered General Nurse and had commenced employment at [PRIVATE] ("the Nursing Home") on 23 October 2019.

On 19 August 2020, the NMC received a referral from the Home Manager at [PRIVATE] following a safeguarding concern raised by the Ambulance Service in relation to the care of Resident 1 on 4 July 2020.

It was alleged that on that date Miss Millard, who was working as the nurse in charge on the [PRIVATE] , failed to maintain adequate clinical records for Resident 1. In particular, it was alleged that she did not record vital observations, including blood pressure; did not document Resident 1's deteriorating responsiveness, reduced urine output, or difficulty in rousing him; and did not record the time an ambulance was called in the Client Daily Living Record.

It was further alleged that Miss Millard did not take appropriate and or timely action after being informed that Resident 1 was less responsive and or unresponsive.

The concerns were investigated locally by the employer. While the safeguarding investigation concluded that the concerns were unsubstantiated, the employer identified significant concerns regarding Miss Millard's record keeping, her response to Resident 1's deteriorating condition, and her insight into the seriousness of the incident.

Following a disciplinary process, Miss Millard's employment was terminated on 24 July 2020 on the grounds of gross misconduct.

The matter was subsequently referred to the Nursing and Midwifery Council. On 23 November 2022, the Case Examiners determined that the case should be referred to the

Fitness to Practise Committee. On 8 January 2025, a panel decided that the case should be dealt with by way of a substantive meeting, in light of Miss Millard's lack of engagement with the proceedings.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Home Manager at the Nursing;
- Witness 2: Deputy Manager at the Nursing Home;
- Witness 3: Staff nurse at the Nursing home;
- Witness 4: Staff member at the Nursing Home;
- Witness 5: Care worker at the Nursing Home

The panel also had regard to written material provided by Miss Millard, including:

- a local statement dated 8 July 2020**,** prepared as part of the employer's internal investigation;
- reflective statements dated 19 January 2022**;**
- emails from Miss Millard regarding her employment status and further training; and

- documentary material contained within the bundle relating to her engagement with the NMC process.

The panel noted that Miss Millard did not submit any formal written representations or a completed response-to-charges form for the substantive meeting**.**

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

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

Charge 1a)

"Did not complete adequate records for Resident 1, in that you:

a. Did not record his BP."

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence and Miss Millard's accounts provided during the employer's investigation.

The panel noted that the Miss Millard accepted in the course of her internal investigation interview that she did not take Resident 1's blood pressure on 4 July 2020. However, the panel considered that the allegation was framed as a failure to record blood pressure, rather than a failure to take it.

The panel determined that if a blood pressure reading had not been taken, it would not have been recorded. The panel therefore concluded that the wording of the charge did not accurately reflect the evidence relied upon. As a result, the panel was not satisfied that the NMC had proved, on the balance of probabilities, that Miss Millard failed to record Resident 1's blood pressure as alleged.

Charge 1b)

"Did not complete adequate records for Resident 1, in that you:

b. Did not record Resident 1's deteriorating reaction to the sternal rub."

This charge is found proved.

In reaching this decision, the panel took into account the Client Daily Living Record and Miss Millard's local statement.

The panel noted that Miss Millard accepted in her written statements that she performed sternal rubs on Resident 1 and observed his responses. The panel further noted that the contemporaneous daily care records did not contain any reference to sternal rubs or Resident 1's reactions to them. Accordingly, the panel found Charge 1(b) proved.

Charge 1c)

"Did not complete adequate records for Resident 1, in that you:

d. Did not document Resident 1's reduced urine output"

This charge is found NOT proved.

In reaching this decision, the panel considered the Client Daily Living Record entries relating to Resident 1's catheter output.

The panel noted that the records included an entry documenting that Resident 1's catheter was draining a small amount, which was recorded by care staff and subsequently marked as read and agreed by Miss Millard.

While the panel considered that the documentation lacked precision and detail, it nevertheless accepted that a record had been made by Resident 1's carer regarding "catheter draining small", which shortly after was read and agreed by Miss Millard.

The panel therefore concluded that it could not be satisfied that Miss Millard failed to document Resident 1's reduced urine output as alleged. Charge 1(c) was accordingly not proved.

Charge 1d)

> "Did not complete adequate records for Resident 1, in that you:
>
> d. Did not record that Resident 1 was difficult to rouse and/ or floppier than usual."

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence and witness statements describing Resident 1's condition.

The panel noted that the Client Daily Living Record included entries describing Resident 1 as unresponsive, and that these entries were marked as read and agreed by Miss Millard. The panel considered that this documentation reflected some concerns relating to Resident 1's level of responsiveness.

The panel determined that, while the records did not use the specific wording alleged in the charge, they nevertheless reflected the substance of the concern. The panel was therefore not satisfied that the NMC had proved that Miss Millard failed to record that Resident 1 was difficult to rouse or floppier than usual.

Charge 1e)

> "Did not complete adequate records for Resident 1, in that you:
>
> e. Did not record that you had been informed that Resident 1 was less responsive and /or unresponsive."

This charge is found NOT proved.

In reaching this decision, the panel considered entries made by care staff which recorded concerns about Resident 1's responsiveness.

The panel noted that those entries explicitly indicated that the nurse in charge was aware of the concerns and that Miss Millard shortly afterwards marked those entries as read and agreed. The panel considered that this constituted documentation which showed that Miss Millard had been informed of Resident 1's condition.

Although the panel considered that clearer and more detailed recording would have been preferable, it concluded that the evidence did not support a finding that Miss Millard failed to record having been informed of Resident 1's reduced responsiveness.

Charge 1f)

> "Did not complete adequate records for Resident 1, in that you:
>
> f. Did not record the time you called an ambulance on Resident 1's Client Daily Living Record.."

This charge is found NOT proved.

In reaching this decision, the panel took into account the Client Daily Living Record, the investigation documents, and the witness evidence.

The panel noted inconsistencies within the documentary evidence as to what entries were made by Miss Millard, when those entries were made, and whether the records before the panel represented the complete and original version of the Client Daily Living Record. The panel observed that references in the meeting minutes of Witness 1 suggested that Miss Millard had made an entry relating to Resident 1's transfer to hospital at a later time and with different language. The timing and wording described in that document did not fully correspond with the Client Daily Living Record contained within the bundle.

Therefore, the panel was not satisfied that the records before it clearly demonstrated an absence of any recording by Miss Millard of calling the ambulance, nor was it satisfied that

it could reliably determine whether any omission was due to a failure to record or to subsequent alteration of entries within the Client Daily Living Record.

In light of these uncertainties, the panel concluded that the evidence was insufficiently clear and reliable to establish, on the balance of probabilities, that Miss Millard failed to record the time she called an ambulance. Accordingly, Charge 1(f) was not proved.

Charge 2)

> "Did not take appropriate and /or timely action upon being told that Resident 1 was less responsive and/or unresponsive"

This charge is found PROVED.

In reaching this decision, the panel took into account the written witness statements, the documentary evidence, and Miss Millard's own accounts provided during the employer's investigation.

The panel accepted the evidence of multiple witnesses that Resident 1's condition deteriorated over the course of 4 July 2020 and that concerns about his responsiveness, breathing, and urine output were raised with Miss Millard on several occasions. The panel noted that care staff repeatedly reported that Resident 1 was less responsive and that they were worried about his condition. The panel noted in particular the contemporaneous hand written statement of Witness 5. In this statement, she recorded that she had observed a deterioration in Resident 1's condition and had alerted Miss Millard as the nurse-in-charge on a number of occasions.

The panel noted that Miss Millard accepted that she was aware of Resident 1's deteriorating condition and that she performed sternal rubs, observed a raised temperature, and recognised that he was unresponsive for a prolonged period. The panel also took into account Miss Millard's acknowledgement, during the investigation, that she should have called for emergency assistance earlier.

The panel considered that, despite being aware of Resident 1's condition, Miss Millard did not escalate concerns in a timely manner. In particular, the panel noted that no emergency

call was made for several hours after concerns were first raised, and that no alternative urgent escalation, such as contacting a GP or senior clinical support, was undertaken during that period.

The panel placed weight on the evidence of other healthcare professionals, including a fellow nurse and the attending paramedics, who expressed concern that Resident 1 had been left for too long without appropriate escalation. The panel also noted that the Ambulance Service raised a safeguarding concern following their attendance.

The panel was therefore satisfied that Miss Millard did not take appropriate and/or timely action upon being told that Resident 1 was less responsive and/or unresponsive. Accordingly, Charge 2 is 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 Miss Millard'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 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, Miss Millard's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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.'

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

The NMC submitted that Miss Millard's failure to take appropriate and timely action in response to Resident 1's deteriorating condition and the failures in her documentation represented a serious departure from the standards expected of a registered nurse. The NMC identified that Miss Millard's actions breached multiple provisions of the Code relating to prioritising people, preserving safety, working with colleagues, and responding appropriately in emergency situations. The NMC submitted that the misconduct was serious, placed a vulnerable patient at risk of harm, and fell far below acceptable professional standards.

Miss Millard did not submit written representations addressing misconduct or impairment for the substantive meeting. The panel noted that Miss Millard had previously provided a local statement and reflective material as part of the employer's investigation and subsequent correspondence with the NMC. However, no formal written representations were made by Miss Millard or a representative in relation to misconduct or impairment.

The NMC reminded the panel of its overarching objective to protect the public and the wider public interest. This included the need to declare and uphold proper professional standards and to maintain public confidence in the profession and in the NMC as a regulator. The panel had regard to *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin).*

The NMC invited the panel to find Miss Millard's fitness to practise impaired on the grounds that she had placed a patient at unwarranted risk of harm, breached fundamental

tenets of the nursing profession, and brought the profession into disrepute. The NMC submitted that Miss Millard had demonstrated limited insight, had not provided evidence of remediation, and had disengaged from the regulatory process, giving rise to a risk of repetition.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had careful regard to the terms of *The NMC Code: Professional standards of practice and behaviour for nurses and midwives (2015)* ("the Code").

The panel found Miss Millard's failure to document Resident's 1 deteriorating condition would not individually amount to misconduct. However, when considered in conjunction with Charge 2 it did, in the panel's view, amount to misconduct.

The panel was satisfied that Miss Millard's failure to take appropriate and timely action in response to Resident 1's deteriorating condition fell significantly short of the standards expected of a registered nurse. The panel considered that Miss Millard was the nurse in charge on the unit and was therefore responsible for recognising clinical deterioration, responding appropriately, and escalating concerns without delay.

The panel identified that Miss Millard's conduct breached multiple provisions of the Code, including:

***'3* - Make sure that people's physical, social and psychological needs are assessed and responded to**

3.1 - *Pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*

8 – Work cooperatively

***8.5** – Work with colleagues to preserve the safety of those receiving care.*

The panel noted that care staff repeatedly raised concerns about Resident 1's condition and sought guidance. Despite this, Miss Millard did not act on those concerns in a manner that preserved patient safety.

10 - Keep clear and accurate records relevant to your practice

***10.1 -** Complete records at the time or as soon as possible after an event, recording if the notes are written sometime 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 records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

13 – Recognise and work within the limits of your competence

***13.1** – Accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

***13.2** – Make a timely referral to another practitioner when any action, care or treatment is required*

***13.3** – Ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*

The panel determined that Miss Millard failed to take prompt and appropriate action despite clear indicators that Resident 1 was acutely unwell. The panel considered that the prolonged delay in escalation represented a serious failure to preserve patient safety.

15 – Always offer help if an emergency arises in your practice setting or anywhere else

***15.2** – Arrange, wherever possible, for emergency care to be accessed and provided promptly'*

The panel found that Resident 1's condition constituted a medical emergency. Miss Millard's failure to secure emergency assistance within a reasonable timeframe was a serious departure from expected professional standards.

In addition, the panel found that Miss Millard's conduct breached:

'20 – Uphold the reputation of your profession at all times
20.1 *– Keep to and uphold the standards and values set out in the Code.*
20.8 *– Act as a role model of professional behaviour for students and newly qualified nurses and nursing associates to aspire to.'*

The panel considered that Miss Millard's conduct, particularly while acting as nurse in charge, failed to demonstrate the leadership, accountability, and professionalism expected of someone in that position. The panel determined that not escalating concerns about a vulnerable resident in a timely manner was capable of undermining public confidence in the nursing profession.

The panel was mindful that not every breach of the Code will amount to misconduct. However, in this case, the panel concluded that the breach is not minor or technical. Resident 1 was vulnerable, unable to advocate for himself, and was wholly reliant on nursing staff for his safety. The failure to escalate his deteriorating condition over a prolonged period exposed Resident 1 to a real risk of serious harm.

The panel also took into account that other healthcare professionals, including a fellow nurse and the attending paramedics, expressed concern that Resident 1 had been left too long without appropriate intervention. The fact that the Ambulance Service raised a safeguarding concern further reinforced the seriousness of the conduct.

Taking all these matters into account, the panel concluded that Miss Millard's actions represented a serious departure from the standards expected of a registered nurse. The panel determined that her conduct fell far below what would be proper in the circumstances and therefore amounted to misconduct, as defined in Roylance.

Accordingly, the panel found that Miss Millard's actions 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, Miss Millard's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant [2011] EWHC 927 (Admin)* 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/their fitness to practise is impaired in the sense that S/He/They:

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) *....'*

Public protection

The panel first considered impairment from the ground of public protection.

The panel found that Miss Millard had, in the past, acted so as to put a patient at unwarranted risk of harm. Resident 1 was a vulnerable resident, unable to advocate for himself, and wholly reliant on nursing staff to recognise and respond to signs of clinical deterioration. Despite being informed on multiple occasions that Resident 1 was less responsive and unwell, and observing this for herself, Miss Millard did not take appropriate and timely action to escalate concerns or secure urgent medical intervention.

The panel considered that the misconduct went to the heart of patient safety. The failure to escalate a deteriorating patient, particularly over a prolonged period, represented a serious departure from the standards expected of a registered nurse, and one that exposed Resident 1 to a risk of significant harm.

In considering whether Miss Millard currently presents a risk to patients, the panel carefully assessed insight, remediation, and the likelihood of repetition. While the panel

acknowledged that Miss Millard had accepted, during the employer's investigation, that she should have called for emergency assistance earlier, it considered that this amounted to only limited insight. The panel was not provided with evidence demonstrating a clear understanding of why the misconduct occurred, the impact of the delay on Resident 1, or how similar situations would be managed differently in the future.

The panel also noted that Miss Millard's reflections focused predominantly on documentation, rather than on the core failing identified by the panel, namely the failure to escalate a deteriorating patient. The panel therefore concluded that Miss Millard had not demonstrated sufficient insight into the seriousness of the misconduct.

The panel accepted that the misconduct in this case was capable of remediation. However, it noted that Miss Millard had not provided evidence of any relevant training, refreshed clinical skills, or steps taken to strengthen her practice. In this regard, the panel placed weight on the fact that Miss Millard has not practised as a nurse since 2020. The absence of any evidence of recent practice or professional development significantly reduced the panel's ability to be reassured that she could return to practice safely.

The panel further took into account Miss Millard's limited engagement with the regulatory process. The panel noted her sporadic communication with the NMC, her failure to progress undertakings or voluntary removal. The panel noted Miss Millard's challenging personal circumstances as outlined in her correspondence with the NMC. While disengagement alone does not establish impairment, the panel considered that, in this case, it underlined the concerns identified and further reduced the panel's confidence that the risks arising from the misconduct had been addressed.

Taking all of these matters into account, the panel concluded that there remains a real risk of repetition of this conduct. The panel therefore found that Miss Millard's fitness to practise is currently impaired on the grounds of public protection**.**

Public interest

The panel then considered whether a finding of impairment was also required on public interest grounds.

The panel determined that Miss Millard's misconduct breached fundamental tenets of the nursing profession, including the duty to preserve patient safety and to respond appropriately in emergency situations. The panel considered that Miss Millard was acting as nurse in charge and was therefore expected to demonstrate leadership, sound clinical judgement, and accountability. Her failure to escalate concerns in these circumstances was particularly serious.

The panel placed weight on the evidence of other healthcare professionals, including another nurse and the attending paramedics, who expressed concern that Resident 1 had been left without appropriate intervention for too long. The panel also noted that the Ambulance Service considered the circumstances sufficiently concerning to raise a safeguarding referral. The panel considered that this objective professional concern reinforced the seriousness of the misconduct.

The panel acknowledged that this was a single episode. However, the panel concluded that this did not outweigh the seriousness of the misconduct or negate the need for regulatory intervention.

The panel was satisfied that public confidence in the nursing profession, and in the NMC as a regulator, would be undermined if no finding of impairment were made in circumstances where a nurse in charge failed to take timely action to escalate concerns about a vulnerable patient.

Accordingly, the panel determined that a finding of impairment was also required on public interest grounds, including the need to uphold proper professional standards and to maintain confidence in the profession.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six (6) months. The effect of this order is that the NMC register will show that Miss Millard's registration has been suspended.

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

Representations on sanction

The panel read submissions from the NMC that a Conditions of Practice order would be an appropriate order in this case.

Miss Millard did not submit written representations in advance of the meeting in relation to sanction. The panel noted that there were therefore no representations before it from Miss Millard nor a representative in relation to the appropriate sanction.

Decision and reasons on sanction

Having found Miss Millard'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 SG. The decision on sanction is a matter for the panel independently exercising its own judgement. The panel took into account the aggravating and mitigating features of this case.

The panel identified the following aggravating factors:

- Miss Millard was the nurse in charge, with responsibility for recognising deterioration and escalating concerns.
- The misconduct involved a vulnerable patient who was unable to advocate for himself.

- The failure to escalate concerns occurred over a period of at least four (4) hours.
- The misconduct placed Resident 1 at risk of significant harm.
- There has only been limited insight and no evidence of effective remediation by Miss Millard.
- Miss Millard has not practised since 2020, and there is no evidence of refreshed competence.

The panel identified the following mitigating factors:

- This was a single episode of misconduct.
- Miss Millard accepted during the employer's investigation that she should have called for emergency assistance earlier.
- The misconduct was capable of remediation, in principle.

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 Miss Millard'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 Miss Millard'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 Miss Millard's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- there was no evidence of harmful deep-seated personality or attitudinal problems;
- there were identifiable areas of Miss Millard's practice in need of assessment and/or

retraining, namely recognising and escalating clinical deterioration;
- there was no evidence of general incompetence; and
- any conditions imposed would need to be capable of protecting patients during the period they were in force and capable of being monitored and assessed.

However, having regard to Miss Millard's limited insight, lack of engagement with the regulatory process, including her lack of engagement with the offer of undertakings, together with the fact that she has not worked as a nurse since 2020, and the absence of any evidence of remediation, the panel was not satisfied that workable or effective conditions could be formulated in this case. Any conditions that could be formulated would be tantamount to a suspension. Further, the misconduct identified in this case was not something that can be addressed through retraining alone.

Furthermore, the panel concluded that the placing of conditions on Miss Millard'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 took into account the Sanctions Guidance, which states that a suspension order may be appropriate where:

- there is a single instance of misconduct, but a lesser sanction is not sufficient;
- there is no evidence of harmful deep-seated personality or attitudinal problems; and
- the misconduct is serious, but not fundamentally incompatible with remaining on the register.

The panel was satisfied that, in this case, the misconduct was not fundamentally incompatible with Miss Millard remaining on the register. The panel noted that the misconduct arose from a single episode, was potentially remediable, and did not involve dishonesty or deliberate harm.

However, the panel concluded that the seriousness of the misconduct, the public protection concerns identified, and the need to maintain public confidence in the profession meant that a lesser sanction would be insufficient. The panel therefore

determined that a suspension order was the appropriate and proportionate sanction in this case.

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 Miss Millard's 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 Miss Millard. However this is outweighed by the public interest in this case.

The panel considered that this suspension 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 also determined that the suspension order should be subject to review. The panel considered that a suspension order with a review would provide Miss Millard with time to demonstrate meaningful engagement with the NMC, to provide evidence of insight and reflection on the misconduct, and to confirm whether she wishes to return to nursing practice or take the option of voluntary removal from the register. The panel considered that a review would also provide Miss Millard an opportunity to produce evidence of any steps taken to maintain or refresh her clinical competence, including relevant training.

A future panel reviewing this case may be assisted by:

- Evidence of engagement with the NMC;
- A reflective piece addressing the misconduct, its impact on Resident 1, colleagues and the wider public and how she would manage similar situations differently in the future;

- Evidence of relevant training, particularly in recognising and escalating clinical deterioration; and
- Evidence of steps taken to maintain or refresh clinical competence.

This will be confirmed to Miss Millard 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 Miss Millard's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC, which submitted that an interim order was necessary for the protection of the public and was otherwise in the public interest, given the seriousness of the misconduct found proved and the panel's findings on impairment. The NMC submitted that, in light of the panel's conclusions that conditions of practice were not appropriate or workable, an interim suspension order was the only suitable interim measure.

Miss Millard did not submit written representations in relation to an interim order. Accordingly, there were no representations before the panel from Miss Millard or a representative on this issue.

Decision and reasons on interim order

The panel considered whether an interim order was necessary. It accepted the advice of the legal assessor.

The panel was satisfied that an interim order was necessary for the protection of the public and was otherwise in the public interest. In reaching this decision, the panel had regard to the seriousness of the facts found proved and the reasons set out in its determination for

imposing a substantive suspension order. The panel noted that the substantive order would not take effect until the expiry of the 28-day appeal period.

The panel first considered whether an interim conditions of practice order would be appropriate. However, for the same reasons set out in its decision on sanction, the panel concluded that interim conditions of practice would not be appropriate or proportionate. The panel was not satisfied that conditions would be workable or sufficient to protect the public.

The panel therefore determined that the only appropriate interim order was an interim suspension order**.**

The panel imposed an interim suspension order for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

If no appeal is made, the interim suspension order will be replaced by the substantive suspension order 28 days after Miss Millard is sent the decision of this meeting in writing.

That concludes this determination.