Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 29 September 2025 – Wednesday, 8 October 2025

2 Stratford Place, Montfichet Road, London, E20 1EJ
&
Virtual Hearing

Name of Registrant:	Theresa Ann Bates
NMC PIN:	18H0204E
Part(s) of the register:	Registered Nurse Adult Nurse (Level 1) - 3 October 2018
Relevant Location:	Bournemouth
Type of case:	Misconduct
Panel members:	David Hull (Chair, lay member) Julia Briscoe (Registrant member) David Newsham (Lay member)
Legal Assessor:	Juliet Gibbon
Hearings Coordinator:	Adaobi Ibuaka
Nursing and Midwifery Council:	Represented by Dr Marcia Persaud, Case Presenter
Mrs Bates:	Not present and unrepresented
Facts proved:	Charges 1 in its entirety, 2, 5 and 7
Facts not proved:	Charges 3, 4 and 6
Fitness to practise:	Impaired
Sanction:	Conditions of practice order (1 year)
Interim order:	Interim Conditions of Practice Order (18 months)

Application to adjourn the hearing until tomorrow

Dr Persaud made an application to adjourn the hearing until Tuesday 30 September 2025. She submitted that there were a number or of reasons as to why the hearing could not begin today.

Dr Persaud told the panel that the Hearings Coordinator has spoken to Mrs Bates on the phone, to gauge whether Mrs Bates would be attending virtually or in person. [PRIVATE].

Dr Persaud drew the panel's attention to an email from Mrs Bates to the Hearings Coordinator, dated 29 September 2025 at 09:30am which stated the following:

> *'Further to our discussion on the phone, I would like to request an adjournment if possible.*
>
> [PRIVATE]*'*

Dr Persaud further submitted that there had been an issue with the bundles, where certain prejudicial information had not been redacted as it should have been and therefore, need to be redacted. Dr Persaud told the panel that the bundle had been redacted by the case officer but it was now in an unworkable format and therefore would have to be redone causing a further delay.

Dr Persaud further submitted to the panel that this adjournment would not affect witnesses 2 and 3 who were warned for Tuesday and Thursday. However, this adjournment could affect witness 1 who was warned for today and Tuesday.

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

The panel allowed the application to adjourn the hearing until tomorrow.

In making its decision, the panel bore in mind that it must consider both the public interest and fairness to Mrs Bates. It took into account that the charges alleged are serious, and that there is a strong public interest in the expeditious disposal of this case. It further took into account that NMC Witness 1 is due to attend on days one and two of the hearing.

The panel took into account that Mrs Bates has been engaging by communicating with the NMC and has been keeping them up to date in regard to [PRIVATE]. The panel further considered that the bundles, which have to be redone, would not be available today.

The panel determined that it would be in the interest of fairness to Mrs Bates and the NMC if the hearing were adjourned until tomorrow. In addition, it noted that the first for days one and two of the hearing, will still able to attend.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Bates was not in attendance and that the Notice of Hearing letter had been sent to Mrs Bates's registered email address by secure email on 28 August 2025.

Dr Persaud, 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 allegation, the time, dates and venue of the hearing and how Mrs Bates could attend the hearing virtually, including instructions on how to join and, amongst other things, information about Mrs Bates'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 Bates 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 Bates

The panel next considered whether it should proceed in the absence of Mrs Bates. It had regard to Rule 21 and heard the submissions of Dr Persaud who invited the panel to continue in the absence of Mrs Bates. She submitted that Mrs Bates had voluntarily absented herself from today's proceedings.

Dr Persaud referred the panel to an email dated 29 September 2025, from Mrs Bates which stated the following;

> *'Further to our discussion on the phone, I would like to request an adjournment if possible.*
>
> [PRIVATE].*'*

Dr Persaud submitted that Mrs Bates has not provided [PRIVATE]. She further submitted that as of this morning the hearings coordinator and case officer have attempted to contact Mrs Bates via email and phone call, to no avail.

Dr Persaud referred the panel to further documents demonstrating prior correspondence Mrs Bates had with the NMC asking for a postponement/adjournment. Dr Persaud submitted that the NMC had given Mrs Bates advice on how to apply for a postponement and referred her to the NMC guidance CMT-11, however, Mrs Bates had not provided any evidence to support her application for an adjournment.

Dr Persaud submitted that the panel should proceed in the absence of Mrs Bates, as she has been aware of this hearing since 29 August 2025, witnesses have been warned for

yesterday, today and Wednesday, and there is a strong public interest in the expeditious disposal of this case.

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 and the NMC Guidance: CMT – 11 .

The panel has decided to proceed in the absence of Mrs Bates. In reaching this decision, the panel has considered the submissions of Dr Persaud, and accepted 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:

- Mrs Bates had indicated on a number of occasions that she wishes to make an application for an adjournment, but she has not provided any [PRIVATE] evidence [PRIVATE].
- Mrs Bates has been engaging with the NMC however she has not responded to any of the calls or emails to join the hearing today;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A number of witnesses are due to attend today and tomorrow 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 2022 to 2024;
- 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 Bates in proceeding in her absence. Although the evidence upon which the NMC will rely on, has been sent to Mrs Bates at her registered email address, 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, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Bates's decision to absent herself from the hearing, waive her right 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 Bates. The panel will draw no adverse inference from Mrs Bates's absence in its findings of fact.

Decision and Reasons Recusal

The legal assessor in the absence of Mrs Bates, brought to the panel's attention the issue of a possible recusal. The panel had sight of documents which contained prejudicial evidence and were not related to this case. The legal assessor referred to the case of *Findlay v United Kingdom* 24 EHRR 221 [1997] which was a European Courts of Human Rights (ECTHR) case where the UK had violated Article 6 of the European Convention on Human Rights, by not offering a "fair hearing" by an "independent and impartial tribunal".

Although, the prejudicial information contained within the bundles has now been redacted, the panel will have to consider the test set out in *Porter v Magill* [2001] UKHL 67. The legal assessor invited the panel to consider the existence of an apparent bias, and, whether a fair-minded and informed observer would conclude that there was a real possibility of bias.

The legal assessor also referred the panel to the guidance issued in *Lawal v Northern Spirit Limited* [2003] UKHL 35, which adopted the test set out by Kirby J in the case of

Johnson v Johnson [2000] 200 CLR 488*,* at paragraph 53*,* Where he stated that *'a reasonable member of the public is neither complacent nor unduly sensitive or suspicious'.*

The legal assessor also referred the panel to the cases of *Medicaments and Related Classes of Goods* (No 2) [2001] 1 WLR 700, A Restrictive Practices Court case which also set out the test for judicial bias of the hypothetical "fair-minded" and "informed observer" who knows all relevant facts and is considered to be neither complacent nor overly suspicious, having considered the facts, would conclude there was a real possibility of bias. Furthermore, the legal assessor made reference to the case of *Locabail (UK) Ltd v Bayfield Properties Ltd* [2000] QB 451, which sets out the principles for judicial disqualification on grounds of apparent bias, introducing the "real danger" test: there must be a real possibility of bias to the fair-minded and informed observer.

The legal assessor stated that this is a matter for the panel to consider.

Dr Persaud submitted that the NMC's case was that the panel did not need to recuse itself. She referred the panel to the well-established test in *Porter v Magill* and submitted that the threshold has not been met in this case. She further submitted that tribunals such as this one are routinely exposed to material later found to be irrelevant or inadmissible, and she referred the panel to the case of *Locabail (UK) Ltd v Bayfield Properties*, which confirmed that prior knowledge or exposure to potentially prejudicial information does not in itself justify recusal, and that tribunals, particularly specialist bodies, are presumed capable of disregarding irrelevant or inadmissible material.

Dr Persaud referred to the NMC's Fitness to Practise Rules and Committee Members' Guidance which require the panel to disregard such material and to base its decision solely on admissible evidence. She further submitted that it is for these reasons, the fair-minded and informed observer would not see a real possibility of bias, and therefore submitted that the panel should not recuse itself.

Dr Persaud further submitted that a recusal is also unnecessary as any risk can be fully addressed by way of a clear and express direction from the Chair, supported by advice

from the legal assessor, that the material in question is irrelevant and must be disregarded. She further submitted that the panel can then confirm in its determination that its decision is based solely on admissible evidence, and that this safeguard ensures fairness without the disruption and delay that a recusal would cause.

The panel decided that it would not recuse itself.

The panel was of the view that it would be able to easily distinguish and identify what information was prejudicial and put it out of its mind. The panel will make its decisions solely on the admissible evidence. The panel was confident that a fair minded and informed observer would not conclude that there was a real possibility of bias in this case.

The panel was therefore satisfied that it did not need to recuse itself in this case.

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

At the outset of the hearing, Dr Persaud made a request that this case be held partly in private on the basis that proper exploration of Mrs Bates's case involves references to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined to go into private session as and when such issues are raised in order to protect Mrs Bates privacy.

Details of charge

That you, a registered nurse:

1) Between 12 and 13 April 2024 did not follow policies and procedures in that:

    a) You did not wash your hands prior to medication administration.

    b) Tipped tablets from the container into unwashed hands before putting them in a pot.

    c) Did not store the medicine trolley in a temperature-controlled environment.

    d) Allowed a patient to be given a tablet that had fallen on the floor.

    e) Gave the medicine keys to an untrained support worker to access the trolley and give pre-potted medications.

2) Between 14 April 2022 and 16 February 2023 worked shifts as a nurse for University Hospitals Dorset whilst in receipt of sick pay from Dorset HealthCare, KPU District Nursing Team.

3) Your actions at charges 2 were dishonest in that you represented to the Dorset HealthCare, KPU District Nursing Team that you were entitled to receive sick pay when you knew that you were not.

4) On 21 January 2023 asked Colleague A to sign the Controlled Drug book without having witnessed it being taken out of the cupboard or be prepared for administration.

5) On 21 January 2023 failed to follow the correct procedure of a documenting error in diamorphine was written in the controlled drug book and then crossed through.

6) On 22 January 2023 made an entry in the Controlled Drug book for someone

which stated that 2.5mg of morphine sulphate was administered but 7.5mg wasted and not signed for or administered.

7) On 7 February 2023 asked Colleague B to sign the Controlled Drug book without following the correct procedure on more than one occasion.

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

Background

The charges arose whilst Mrs Bates was employed as a Band 5 nurse by University Hospitals Dorset (UHD) working in the District Nursing team. The NMC received a referral on 30 March 2023 from UHD. Mrs Bates was employed as a Band 5 bank nurse at UHD from December 2020 to May 2023.

It is alleged that Mrs Bates worked bank shifts for Dorset Health Care University NHS Foundation Trust (DHC) whist receiving sick pay from UHD. This was investigated by DHC.

It is further alleged that Mrs Bates did not follow the controlled drugs procedure correctly whilst working at UHD, on a number of occasions. This was investigated locally by DHC, and statements were taken from Mrs Bates and her Line Manager who had a robust discussion with Mrs Bates regarding the need to follow Controlled Drug policy and procedure. However, the concerns were not progressed to a formal investigation. Following the referral further concerns came to light from St Martha's Hospital (the Hospital), where Mrs Bates was employed as a staff nurse, regarding Mrs Bates's management of medicines.

Decision and reasons on application to amend the charge

The panel heard an application made by Dr Persaud, on behalf of the NMC, to amend the wording of the stem of charge 1 before the live evidence of Witness 3.

The proposed amendment was to rectify the dates stated in charge 1, from between 12 and 13 April 2024, to between 11 and 12 April 2024. It was submitted by Dr Persaud that the proposed amendment would provide clarity and more accurately reflect the evidence.

The stem of charge 1 currently reads as follows:

1) *'Between 12 and 13 April 2024 did not follow policies and procedures in that:…'*

The proposed amendment to the stem of charge 1 is as follows:

1) *'Between **11 and** 12 ~~and 13~~ April 2024 did not follow policies and procedures in that:…'*

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that the proposed amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to Mrs Bates and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to reflect the correct dates.

Details of charge (as amended)

That you, a registered nurse:

1) Between 11 and 12 April 2024 did not follow policies and procedures in that:

a) You did not wash your hands prior to medication administration.

b) Tipped tablets from the container into unwashed hands before putting them in a pot.

c) Did not store the medicine trolley in a temperature-controlled environment.

d) Allowed a patient to be given a tablet that had fallen on the floor.

e) Gave the medicine keys to an untrained support worker to access the trolley and give pre-potted medications.

2) Between 14 April 2022 and 16 February 2023 worked shifts as a nurse for University Hospitals Dorset whilst in receipt of sick pay from Dorset HealthCare, KPU District Nursing Team.

3) Your actions at charges 2 were dishonest in that you represented to the Dorset HealthCare, KPU District Nursing Team that you were entitled to receive sick pay when you knew that you were not.

4) On 21 January 2023 asked Colleague A to sign the Controlled Drug book without having witnessed it being taken out of the cupboard or be prepared for administration.

5) On 21 January 2023 failed to follow the correct procedure of a documenting error in diamorphine was written in the controlled drug book and then crossed through.

6) On 22 January 2023 made an entry in the Controlled Drug book for someone which stated that 2.5mg of morphine sulphate was administered but 7.5mg wasted and not signed for or administered.

7) On 7 February 2023 asked Colleague B to sign the Controlled Drug book without following the correct procedure on more than one occasion.

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

Decision and reasons on application to amend charges

Following the live evidence of Witness 2 the panel invited Dr Persaud, on behalf of the NMC, to review the wording of the stem of charges 4, 5, 6 and 7.

The proposed amendment was to alter the way in which the specified charges were phrased to particularise the correct CD drugs and patients the charges applied to. It was submitted by Dr Persaud that the proposed amendments would provide clarity and more accurately reflect the evidence.

The stem of charge 4 currently reads as follows:

4) *'On 21 January 2023 asked Colleague A to sign the Controlled Drug book without having witnessed it being taken out of the cupboard or be prepared for administration.'*

The proposed amendment to the stem of charge 4 is as follows:

4) ***'**On **22** January 2023 **at 03:00 hours** asked Colleague A to sign the Controlled drug book **for Diamorphine 12.5mg had been administered to Patient A; when it was later noted that this entry was written in error.***

The stem of charge 5 currently reads as follows:

5) *'On 21 January 2023 failed to follow the correct procedure of a documenting error in diamorphine was written in the controlled drug book and then crossed through'*

The proposed amendment to the stem of charge 5 is as follows:

5) ***'**On 22 January 2023* ***at 03:00hours*** *failed to follow the correct procedure of documenting an error* ***for 2.5mg Morphine Sulphate for Patient C in the*** *Controlled Drug book which was crossed through**.'***

The stem of charge 6 currently reads as follows:

6) *'On 22 January 2023 made an entry in the Controlled Drug book for someone which stated that 2.5mg of morphine sulphate was administered but 7.5mg wasted and not signed for or administered.'*

The proposed amendment to the stem of charge 6 is as follows:

6) ***'**On 22 January 2023* ***at 03:00 hours*** *made an entry in the Controlled Drug Book for* ***Patient A which recorded*** *that 2.5mg of Morphine Sulphate was administered and 7.5mg wasted ~~and not signed for or administered~~**.***

The stem of charge 7 currently reads as follows:

7) *'On 7 February 2023 asked Colleague B to sign the Controlled Drug book without following the correct procedure on more than one occasion.'*

The proposed amendment to the stem of charge 7 is as follows:

7) *'On 7 February 2023 asked Colleague B to sign the Controlled Drug book* ***for Morphine Sulphate*** *without following the correct procedure ~~on more than one occasion~~.'*

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that the proposed amendments, as applied for, in regard to charge 5, charge 6 and charge 7 were in the interests of justice as the nature of the charges had not changed. The panel was satisfied that there would be no prejudice to Mrs Bates and no injustice would be caused to either party by the proposed amendments in relation to these charges being allowed. It was therefore appropriate to allow the amendments, as applied for, in relation to charge 5, charge 6 and charge 7, to ensure clarity and accuracy.

The panel, however was of the view that the amendment, as applied for, in regard to charge 4, was not in the interests of justice. The panel considered that the proposed amendments would change the substance of the charge to such an extent that there would be potential prejudice to Mrs Bates as she had not had an opportunity to respond to the proposed amendment to the charge.

The panel noted that charge 4 could still be amended and invited the NMC to correct the date and to particularise and clarify what "it" referred to.

Dr Persaud made a further application to amend charge 4 following the panel's decision. The stem of charge 4 currently reads as follows:

4) *'On 21 January 2023 asked Colleague A to sign the Controlled Drug book without having witnessed it being taken out of the cupboard or be prepared for administration.'*

The new proposed amendment to the stem of charge 4 is as follows:

4) On **22** January 2023 **at 03:00 hours** asked Colleague A to sign the Controlled Drug book **that Diamorphine 12.5 mg had been** taken out of the cupboard without having witnessed it, **and it was later noted that this entry was written in error.**

The panel was of the view that the proposed amendment, as applied for, in regard to charge 4, was in the interests of justice. The panel was satisfied that there would be no prejudice to Mrs Bates and no injustice would be caused to either party by the proposed amendment being allowed. Mrs Bates has had an opportunity to provide her response to the charge. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (final amendments)

That you, a registered nurse:

1) Between 11 and 12 April 2024 did not follow policies and procedures in that:

    a) You did not wash your hands prior to medication administration.

    b) Tipped tablets from the container into unwashed hands before putting them in a pot.

    c) Did not store the medicine trolley in a temperature-controlled environment.

    d) Allowed a patient to be given a tablet that had fallen on the floor.

    e) Gave the medicine keys to an untrained support worker to access the trolley and give pre-potted medications.

2) Between 14 April 2022 and 16 February 2023 worked shifts as a nurse for University Hospitals Dorset whilst in receipt of sick pay from Dorset HealthCare, KPU District Nursing Team.

3) Your actions at charges 2 were dishonest in that you represented to the Dorset HealthCare, KPU District Nursing Team that you were entitled to receive sick pay when you knew that you were not.

4) On 22 January 2023 at 03:00 hours asked Colleague A to sign the Controlled Drug book that Diamorphine 12.5 mg had been taken out of the cupboard without

having witnessed it, and it was later noted that this entry was written in error.

5) On 22 January 2023 at 03:00 hours failed to follow the correct procedure of a documenting error for 2.5mg Morphine Sulphate for Patient C in the Controlled Drug book which was crossed through

6) On 22 January 2023 at 03:00 hours made an entry in the Controlled Drug book for Patient A which recorded that 2.5mg of morphine sulphate was administered but 7.5mg wasted

7) On 7 February 2023 asked Colleague B to sign the Controlled Drug book for Morphine Sulphate without following the correct procedure.

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

Decision and reasons on facts

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

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

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: Head of Counter Fraud
- Witness 2: Lead Nurse
- Witness 3: Hospital Director

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witnesses' live evidence and documentary evidence provided by both the NMC and Mrs Bates.

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

Charge 1

1) Between 11 and 12 April 2024 did not follow policies and procedures in that:

    a) You did not wash your hands prior to medication administration.

    b) Tipped tablets from the container into unwashed hands before putting them in a pot.

    c) Did not store the medicine trolley in a temperature-controlled environment.

    d) Allowed a patient to be given a tablet that had fallen on the floor.

    e) Gave the medicine keys to an untrained support worker to access the trolley and give pre-potted medications.

This charge is found proved in its entirety

In reaching this decision, the panel took into account the evidence before it including, the written statement and live evidence of Witness 3.

The panel considered all the sub charges together as the evidence relied upon came from Witness 3 who had reviewed the CCTV footage of the incident shortly after the incident took place.

Witness 3, in his written statement, explained that he had to review the CCTV footage on 12 April 2024, and observed Mrs Bates failing to follow the Hospital's policies and procedures.

> *'My observation in relation to the nurse's medicine management was that the policies and procedures were not followed on multiple occasions. Some examples of this were: not washing her hands prior to medication administration, and tipping tablets from the container into her (unwashed) hand, before putting them in a pot; Not storing the medicine trolley and give pre-potted medications. Whilst she was in the same office area, the nurse did not observe this action… The registrant also gave the medicine keys to an untrained support worker to access the trolley and give pre-potted medications.'*

Witness 3 further reiterated this in his live evidence, describing in detail what he had observed on the CCTV footage he viewed. Witness 3 also explained the positions of the cameras, stating one of the cameras was directly over the sink, and how he had a clear view of the room.

The panel considered that the CCTV recording was objective and contemporaneous evidence. The panel asked Witness 3 if he still had access to the CCTV footage, however, Witness 3 subsequently let the panel know that the footage was no longer available. The panel noted that Mrs Bates had not addressed these allegations in her reflections, but further noted that she would have been aware of these allegations and had sufficient time to address them.

The panel considered that Witness 3 was consistent and reliable in his written and live evidence. The evidence Witness 3 gave was detailed and the panel determined that he had no reason to lie. The evidence was examined and tested, and Witness 3 had been unequivocable about what he had seen on the CCTV footage.

The panel concluded that on the balance of probabilities, it is likely that what was alleged in charge 1 did happen and the panel therefore found charge 1 proved in its entirety.

Charge 2

> Between 14 April 2022 and 16 February 2023 worked shifts as a nurse for University Hospitals Dorset whilst in receipt of sick pay from Dorset HealthCare, KPU District Nursing Team.

This charge is found proved

In reaching this decision, the panel took into account; the Investigation Meeting Interview Summary, Summary of UHD Shifts, the Cross-reference of UHD shifts with Dorset Healthcare, The Health, [PRIVATE], The Investigation report, the witness statement of Witness 1, Witness 1's live evidence and Mrs Bates written reflections.

Witness 1 in his written statement stated the following:

> *'Between 14 April 2022 and 16 February 2023, the registrant completed 46 bank shifts for UHD… We crossed referenced the periods of sickness absence (Dorset Healthcare) with the bank shifts (UHD)… The analysis highlighted that the registrant had worked bank shifts on 20 occasions, between 14 April 2022 and 16 February 2023, when she was absent* [PRIVATE] *from her Dorset Healthcare role. 10 of the UHD shifts were worked when the registrant was absent from her Dorset HealthCare role* [PRIVATE]*. The other 10UHD shifts were worked when the registrant was absent from her Dorset HealthCare role for reasons other than* [PRIVATE]*'*

Witness 1 also confirmed this in his live evidence. The panel considered that Witness 1's evidence was detailed, reliable and consistent. It noted that Witness 1 was the Head of Counter Fraud at DHC and acted as the Accredited Local Counter Fraud specialist in the organisation. The panel determined that Witness 1 had no reason to lie or be biased.

The panel noted paragraph 11 of DHC's Health, Wellbeing and Attendance Policy.

> *'If the individual holds more than one contract with the Trust or undertakes work with an agency/other employer, any periods of sickness should affect all work. The only exception to this would be when a medical practitioner or occupational health determines that specific work would be therapeutic for the individual. In these circumstances confirmation from the medical practitioner would be required. This would not prevent the manager requesting a second opinion from the occupational health practitioner if appropriate. If the individual does not provide evidence that the work is therapeutic before undertaking such work then the matter may be dealt with under the disciplinary and capability policy and accompanying procedures and/or may be considered as fraud.'*

During the Investigation Meeting, Witness 1 asked Mrs Bates if she was aware of this paragraph and she responded:

> *"I wasn't. I had read my contract when I started back with Dorset Healthcare and there was nothing in there to say that. I'm not saying there isn't anything on Doris to say different , but I had gone by my contract which didn't state that. It just said that if you 've got another employment, your manager must be aware which they were. I was very open that Dorset Healthcare that I worked nights at the hospital."*

The panel noted that Mrs Bates made a number of frank admissions to working as a bank nurse while signed off sick from her substantive role. This is detailed in both the Investigation Meeting Interview Summary, dated 24 April 2023 and her written reflections dated 6 April 2023.

In her written reflection she further states:

‘We discussed the investigation with UHD, [PRIVATE]*. I explained I had not as I genuinely was unaware, I had to. I had also checked my contract with Dorset Healthcare and did not see anything that stated I had to disclose this.’*

Mrs Bates in her written reflection also stated the following;

[PRIVATE]

The panel noted the live evidence of Witness 1 who was unable to confirm that Mrs Bates would have read the policy.

The panel considered that there were 20 occasions shown and cross referenced in the documents provided, where Mrs Bates had worked for UHD as a bank nurse whilst off sick from her substantive role at DHC.

Therefore, taking into account the evidence before it, the panel found this charge proved.

Charge 3

Your actions at charges 2 were dishonest in that you represented to the Dorset HealthCare, KPU District Nursing Team that you were entitled to receive sick pay when you knew that you were not.

This charge is found NOT proved

In reaching this decision, the panel took into account Mrs Bates’s written reflective statement, the written statement and live evidence of Witness 1 and the submissions made by Dr Persaud.

The panel carefully considered all the evidence before it in relation to charge 3.

The panel paid particular attention to the specific wording of charge 3, which related to Mrs Bates's actions in relation to charge 2 being dishonest in that she "represented" to DHC, KPU District Nursing Team that she was entitled to receive sick pay when she knew she was not. [PRIVATE].

[PRIVATE].

The panel noted the NMC had not presented the case for dishonesty in the way the charge is alleged. The panel considered whether it should take a pro-active approach and ask the NMC to consider amending the charge. It was of the view however, that such an amendment, would change the substance of the charge to such an extent that it would amount to an entirely new charge of dishonesty, which would be very prejudicial to Mrs Bates who would not have had an opportunity to respond to any proposed amendment of the charge.

The panel concluded that it would have to consider charge 3 as currently worded, in the interest of fairness and justice. Therefore, taking into account all of the above, the panel was not satisfied that the NMC had proved that Mrs Bates had acted dishonestly as alleged and it therefore found this charge not proved.

Charge 4

> On 22 January 2023 at 03:00 hours asked Colleague A to sign the Controlled Drug book that Diamorphine 12.5 mg had been taken out of the cupboard without having witnessed it, and it was later noted that this entry was written in error.

This charge is found NOT proved

In reaching this decision, the panel took into account the entry in the Controlled Drugs book, Mrs Bates local statement, Witness 2's written statement and live evidence.

The panel considered the local statement of Mrs Bates, where she accepted that she did not follow the correct procedure for opening the Controlled Drug cupboard.

> *'Whilst waiting for [Colleague A] I opened the CD cupboard and got morphine 30mg vial and CD book out ready in preparation. I then began getting the syringes and alcohol wipes and putting in the white medical trays. [Colleague A] entered the treatment room as I was prepping the tray. To note, the vial was still intact and had not been opened prior to her entering the room. [Colleague A] the witnessed me open and prepare the Morphine 17.5mg S/C, showing her the contents in the syringe and the remaining amount in the vial (12.5mg), which was then discarded in the sharps bin. We were both present throughout the entire sub cut preparation as well as the disposal of the remaining contents in sharps bin. [Colleague A] and I both evidenced this by countersigning in the controlled drugs book. We then both attended to [Patient C] together and checked wristband and patient details before I administered the medications via his Saf-T line (Witnessed by [Colleague A].*
>
> *Following reading the UHD CD drug policy prior to this, I accept that the CD cupboard should never be opened unless there are 2 nurses present and will ensure I always practice and advocate this when dealing with controlled drugs. I have since heavily reflected on this incident and will ensure this is not done again and to challenge if I witness this being done.'*

The panel noted that it did not have a written NMC statement from Colleague A, nor were they called as a witness by the NMC, further the NMC had not made any application for Colleague A's local statement to be admitted as hearsay evidence. The panel considered the written statement of Witness 2 dated 2 July 2024, stating;

> *'Theresa had asked [Colleague A] to sign a Controlled Drug (CD) without her having witnessed it being taken out of the CD cupboard , or being prepared for administration. Theresa had approached [Colleague A] once the CD cupboard door was locked. [Colleague A] did sign for the CD as the second checker* [PRIVATE]. *[Colleague A] raised this concern to [Colleague B]. I also note that [Colleague A]*

has signed as the lead ("responsible for") for the medication in the CD book, rather than the witness - which Theressa signed… Best practice would be that, if you are a nurse preparing a CD, there always needs to be two nurses present to witness the CD being removed from the cupboard, counting the stock balance and recording the entry in the CD book. Both nurses also need to attend the patient's bedside together to administer the medication. What Theresa did was wrong and she should have approached [Colleague A] to check the CD with her before undertaking the process.'

In her live evidence, Witness 2, provided further detail and was clear in her evidence that it was Morphine Sulphate which had been taken out the controlled drug cupboard without another nurse having witnessed it, and that it was recorded in the Diamorphine controlled drug book in error. Witness 2 told the panel that it was not a misadministration of a controlled drug but rather a recording error by Mrs Bates, and that there was no deficit of Diamorphine and she was confident the correct drug had been administered to the correct patient.

The panel noted that the evidence presented before it, was in relation to Morphine Sulphate being taken out the controlled drug cupboard without being witnessed and further noted that it was recorded in error in the Diamorphine section of the Controlled Drug book. It referred back to the wording of charge 4, which was only in relation to Diamorphine being taken out of the Controlled Drugs cupboard and not being witnessed.

Therefore the panel concluded that the NMC had not discharged it's burden of proof and found this charge not proved.

Charge 5

On 22 January 2023 at 03:00 hours failed to follow the correct procedure of documenting an error for 2.5mg Morphine Sulphate for Patient C in the Controlled Drug book which was crossed through.

This charge is found proved

In reaching this decision, the panel took into account Mrs Bates local statement, The UHD drugs policy and Witness 2's written statement and live evidence.

The panel had sight of Mrs Bates own admission to this charge.

> *'After administering the second dose of morphine sulphate at 03:00 hrs (as stated as above) with [Colleague A], I mistakenly recorded this one the Diamorphine page in the controlled drugs book. At the time neither myself or [Colleague A] recognised this error, and this medication was signed and countersigned in error. Shortly after, the controlled drugs check was completed with [Colleague D] with me and [Colleague C] present. It was at this time I noticed that I had incorrectly documented [patient C's] medication as diamorphine rather than the morphine sulphate. [Colleague D] then crossed through the diamorphine, and we recorded the morphine sulphate correctly.*
>
> *The documentation of the error being crossed through in the CD book was performed by [Colleague D] and witnessed by both [Colleague C] and me. Upon time spent reflecting on this and consulting the UHD Controlled Drugs policy, I am now aware that any records found to be incorrect in the CD Record Book must be corrected by use of square brackets around the incorrect entry to provide a complete audit trail. A clear explanation of the amendment must be written next to it (or on the next available line), and this must be signed and dated and also countersigned by an approved witness. Admittedly I was unaware of this before, and admittedly this is something I have never seen be done when seeing errors written and recorded in any CD books on the wards, I have worked on at UHD. However, this is something I will now ensure I challenge and explain policy to staff if I see this being performed moving forward in my career.*

I can only sincerely apologise that I was not familiar with this section of the policy and accept full accountability that had I been familiar, I should have voiced this to ensure the correct procedure was adhered to.'

The panel considered UHD's Controlled Drugs Policy, which stated the following;

'Correction of errors: Any records found to be incorrect in the CD Record Book must be corrected by use of square brackets around the incorrect entry to provide a complete audit trail, see Appendix I. A clear explanation of the amendment must be written next to it (or on the next available line) and this must be signed and dated and also countersigned by an approved witness …

It is never acceptable to cross through any documented record as all entries, even when incorrect, must always remain legible.'

The panel also considered Mrs Bates's account that it was Colleague D that crossed out the error. The panel determined that even if she was not the one who crossed the incorrect entry out she should have noticed this error and corrected it in accordance with the policy, given she had made the original entry and indicated she was present when it was crossed out. The panel noted that as a registered nurse Mrs Bates had a duty to follow the correct procedure and it therefore, found this charge proved.

Charge 6

On 22 January 2023 at 03:00 hours made an entry in the Controlled Drug book for Patient A which recorded that 2.5mg of morphine sulphate was administered but 7.5mg wasted.

This charge is found NOT proved

In reaching this decision, the panel took into account the entry in the Controlled Drugs book, Witness 2's written statement and live evidence.

Witness 2 in her written statement stated:

> *'This error was confusing to read when I looked at it initially. A patient's name is written in (c), then crossed through, a second patients name is written in (a), then crossed through, patient a written in again (a) and finally the first patient is written in again (c). I can see from a deeper exploration that Patient C did in fact receive the medication according to the drug chart…'*

During her live evidence, Witness 2 further clarified and detailed that both entries made were in fact related to Patient C and not Patient A. Witness 2 was adamant that the correct medication had been given to the correct patient, in this case Patient C.

The panel also considered Mrs Bates's local statement where she stated:

> *'Without having access to the controlled drugs book and medication charts I am unable to fully recall this, however I can confidently state that at no point during this night (or any other occasion) have I ever administered a controlled drug without a second RGN present and as a witness to countersign.*

The panel considered the evidence before it and referred back to the wording of the charge. The panel found that there was no evidence that the entry was made in relation to Patient A and it therefore found this charge not proved.

Charge 7

> On 7 February 2023 asked Colleague B to sign the Controlled Drug book for Morphine Sulphate without following the correct procedure.

This charge is found proved

In reaching this decision, the panel took into account Witness 2's written statement and Mrs Bates's local statement. The panel had not heard live evidence from Colleague B and did not have an NMC witness statement from Colleague B. The NMC had not made any application for Colleague B's local statement to be admitted as hearsay evidence.

In Witness 2's written statement, she stated:

> *'[Colleague B] in her local statement said that when she went to the treatment room, Theresa had the medication ready, the CD book had been signed and the CD cupboard was locked. She said that she expressed her concern to Theresa, who then became quite defensive, stating that 'she knew what she was doing because she works in the community .. .. [Colleague B] reminder (sic) her again that the process needed to start again from the beginning. She eventually checked everything with Theresa and then when it came to approaching the patient's bedside, Theresa told her that she could go alone, and [Colleague B] reminder her that that it not how it works…*
>
> *Theresa did provide a response to the above matter in her local statement. She stated the other nurse with her on the ward was on her break and she did not want to disturb her, and so she went to the Hospice at Home office and asked [Colleague B] if she would be able to assist her with the CD check. [Colleague B] agreed and told her it had to be quick as she was busy, so Theresa said she began to prepare everything before her arrival. She said [Colleague B] came into the treatment room a few minutes later and despite her having opened the vial already and tray being prepared, apparently [Colleague B] said "Ah lovely, it's all ready to go". Theresa said they both then checked the medication and administered it to the patient together'*

Witness 2 further reiterated this in her live evidence.

The panel noted that Mrs Bates had made frank admissions to this charge in her local statement.

> *'I do however completely accept that I am accountable for my actions and that I have made errors in opening the controlled drug cupboard and getting the medication vials out and opening them without [Colleague B] initially present… I can completely accept this is not following the correct policy or procedure and would like to reassure that lessons have been learned and this will not happen again.'*

The panel also had sight of UHD's Controlled Drug Policy, and noted the specific part of the policy breached, 15(c)(4);

> *'The CD must be prepared (if appropriate) by the practitioner who will be administering the CD and in full view of the second practitioner acting as a witness.'*

Therefore, as a result of the above evidence, including Mrs Bates's admissions, the panel found this charge 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 Bates'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, Mrs Bates's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Dr Persaud invited the panel to take the view that the facts found proved amount to misconduct.

Dr Persaud further invited the panel to consider the case of *Johnson & Maggs v NMC* [2013] EWHC 2014 (Admin) which stated that to find misconduct, the failure had to be seen as deplorable by fellow practitioners and involved a serious departure from acceptable standards.

Dr Persaud submitted that the following regulatory concerns were considered by the NMC:

1. Poor medications practice:
    a. Failure to follow the correct procedures in the storage and administration of medications.
    b. Failure to follow controlled drugs procedures.

Dr Persaud identified the specific, relevant standards where Mrs Bates' actions amounted to misconduct, and referred the panel to the NMC Standards for Medicines Management Ensuring Safe and Effective Patient Care.

Dr Persaud submitted the following provisions of the Code were breached and referred the panel to the charges they applied to.

1. Code 1.1 in relation to charges 1a – d, where Mrs Bates had failed to administer the correct medication following the correct procedures whist engaging in poor medication administration.
2. Code 11, 11.1, and 11.3 in relation to charge 1e, where Mrs Bates did not engage with the support worker on the outcome of the task.
3. Code 10.3 and 18.2 in relation to charges 5 and 7, where Mrs Bates failed to follow the correct procedures in regards to the Controlled Drug book for Morphine sulphate.
4. Code 20.1 in relation to charge 2, where Mrs Bates worked shifts at a different hospital when she was off sick from her substantive post and received sick pay from her substantive post, while earning bank/agency wages from a different hospital.

Dr Persaud submitted that in her reflections, Mrs Bates stated that her actions were not financially motivated as she regularly did shifts at each location back to back. [PRIVATE]. Dr Persaud submitted that it appeared to [PRIVATE], rather than misunderstandings of the contract, that could have resulted in the breaches of the Code.

Dr Persaud invited the panel to find that the charges found proved amounted to misconduct.

Submissions on impairment

Dr Persaud moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) as well as references to the NMC guidance at FTP – 14a.

Dr Persaud referred the panel to the several reflections submitted by Mrs Bates. Dr Persaud submitted that the reflections are in relation to charges 2 to 7, which suggests

that Mrs Bates has reasonable insight into why the correct management of controlled drugs is so crucial as well as appreciating the seriousness of her actions. She further submitted that it appears that Mrs Bates has taken responsibility and accepted that she failed to follow the correct procedure, however, Dr Persaud submitted that this reflection only extends to the failings which occurred on 7 February 2023.

Dr Persaud submitted that there is a real risk of repetition as the medication management failings were across two different hospitals and invited the panel to consider the risk of patient harm in the absence of regulatory intervention.

Dr Persaud submitted that in relation to charge 2, Mrs Bates sought to justify her actions, on the basis that she could work in one place but not the other. She submitted that this explanation showed a continued lack of insight, and that without genuine insight the risk of repetition remains.

Dr Persaud referred the panel to the *Grant* test, and submitted that limbs a, b and c were engaged as Mrs Bates had breached the fundamental tenets of the profession and brought the profession in disrepute. She further submitted that Mrs Bates's conduct fell far below the standards expected of a registered nurse, involved the risk of unwarranted harm to patients and had the potential to damage the reputation of the profession.

Dr Persaud also referred the panel to the cases of *Meadows v GMC* [2007] QB 462, 48H and *Cohen v GMC* [2008] EWHC 581 (Admin), submitting that if the panel finds that the misconduct is serious the panel must assess the level of remediation and how likely it considered the risk of repetition. She further submitted that that Mrs Bates has had limited engagement with the NMC process and has not attended the substantive hearing.

Dr Persaud submitted that a finding of impairment is necessary on public protection and public interest grounds. Dr Persaud submitted that a member of the public, knowing the seriousness of the conduct demonstrated by the registrant would be surprised and concerned that such a finding was not made on these grounds. She submitted that the misconduct is in this case is serious, particularly in the light of the potential patient safety

risks, poor medication practice, record keeping and collecting sick pay whilst working bank shifts at another hospital.

For these reasons, Dr Persaud invited the panel to find that Mrs Bates's fitness to practise is impaired both on the grounds of public interest and to protect the public.

Decision and reasons on misconduct

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), Mallon v General Medical Council | [2007] ScotCS CSIH_17, *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin) and General Medical Council v Meadow [2007] QB 462 (Admin).

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

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

> *'11.1. Only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions.* (in relation to charge 1e)

18.2. keep to appropriate guidelines when … using controlled drugs and recording the…, dispensing or administration of controlled drugs' (in relation to charge 7)

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

The panel first considered each of the medication charges individually, and then considered them collectively.

In relation to charge 1a to d, the panel determined that each charge was a departure from the standards expected of a registered nurse. The panel noted that each incidents occurred during one night shift, was isolated, in that it was only seen on that one shift and there is no suggestion that this conduct was repeated by Mrs Bates. Therefore, although these incidents fell below standards expected, the panel determined that they were not sufficiently serious to amount to misconduct.

In relation to charge 1e, the panel determined that this was a serious departure from the standards expected of a registered nurse and very poor practice. The panel noted that there was a serious risk to patients by Mrs Bates giving the medication trolley keys to a support worker who was unqualified, untrained and not competent to administer medication. The panel noted that Mrs Bates in her discussion with Witness 3 stated that she did not know the support worker was untrained. The panel heard live evidence from Witness 3 who stated that this support worker had been untrained and was not competent in medication management, and that he had administered the pre-potted medications throughout the shift. Witness 3 further told the panel that Mrs Bates did not undertake any observations or supervision of the support worker nor did she retrieve the keys from him at any point during the entire shift. The panel concluded that Mrs Bates's explanation did not justify her conduct. The panel decided that this was not a momentary lapse in judgement on the part of Mrs Bates as these actions extended across the 12 hour shift. The panel concluded that Mrs Bates should have confirmed with the support worker whether they

were competent and qualified to access to the medication trolley and administer pre-potted medications. By failing to do so Mrs Bates had put patients' safety at risk. Therefore, the panel found that Mrs Bates's conduct was sufficiently serious to amount to misconduct.

In relation to charge 5, the panel determined that this was a departure from the standards expected of a registered nurse and poor practice. The panel noted that this was the incorrect procedure for recording an error in the Controlled Drugs book in that Mrs Bates had allowed an error in the CD book to be crossed out by another nurse and had not corrected the error by using square brackets although she was the nurse who had administered the medication to the patient. However the panel noted that this was an isolated incident and was not a misadministration of the wrong medication. Further no patients had been put at risk of harm. The panel also heard from Witness 2 who stated it was a recording error and was sure the correct medication had been administered to the right patient. The panel concluded that there was a duty on Mrs Bates to recognise if another nurse had not documented something properly and address it in accordance with correct procedures. However, taking everything into account the panel found that the conduct was not sufficiently serious to amount to misconduct.

In relation to charge 7, the panel determined that this was a serious departure from the standards expected of a registered nurse. The panel noted that it did not have an NMC witness statement from Colleague B, however, noted that this was poor practice by Mrs Bates. The panel considered that as a nurse when dealing with controlled drugs the potential consequences of failing to adhere to the policies and procedures in place are even more serious. The panel further considered that Mrs Bates had placed a colleague in a potentially vulnerable situation by asking them to sign that they had followed the correct procedure for witnessing the preparation of a controlled drug when they had not. Therefore, the panel found that Mrs Bates conduct was sufficiently serious to amount to misconduct.

The panel then went on to considered whether charges 1 a - d and 5 amounted to misconduct collectively as they all related to Mrs Bates's medication management. The

panel noted 1a-d and 5 occurred on two different shifts in two different hospitals. It noted that all the incidents amounted to poor practice and were departures from the standards expected of a registered nurse. The panel however, took into account that it had received evidence from Witnesses 2 and 3 that apart from these incidents there had been no further concerns raised about Mrs Bates's management of medication and as such, they were isolated incidents. In the circumstances the panel found that even collectively these charges were not sufficiently serious as to amount to misconduct.

In relation to charge 2, the panel considered this separately as it was not related to Mrs Bates's medication management. The panel noted that Mrs Bates stated that she would regularly undertake extra shifts as a bank nurse and that people knew she would do this in both places with no issues being raised. [PRIVATE]. However Mrs Bates stated that she found UHD to be [PRIVATE] and more enjoyable place to work where she felt supported by management. The panel noted that there had been an investigation by the counter fraud team however, this investigation did not result in any further action being taken. The panel noted that the NMC did not establish that Mrs Bates was ever made aware of the relevant policy, and it was not cited in her contract.

Therefore the panel found that charge 2 was not sufficiently serious as to amount to misconduct.

The panel found that Mrs Bates's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct, in relation to charge 1e and charge 7.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her/ fitness to practise is impaired in the sense that S/He:

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

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

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

d) *…'*

The panel finds that limbs a – c are engaged in this case.

The panel found that patients were put at risk of harm in relation to charge 1e and charge 7 as a result of Mrs Bates's misconduct. Mrs Bates's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Further the panel also concluded that Mrs Bates is liable to act in future in a way that places patients at risk of unwarranted harm, breach fundamental tenets of the profession and bring the profession into disrepute.

Regarding insight, the panel noted that Mrs Bates had previously provided a written reflection detailing where she had fallen short of the standards of the profession, departed from the code and expressed remorse for her actions in relation to charge 7. It noted that Mrs Bates had not demonstrated any insight into her failings in charge 1e which occurred after she had undertaken further medicine management training on 7 July 2023. This training postdated charge 7 but pre dated charge 1e where a further medication management error occurred. The panel noted that Mrs Bates has not offered any insight, reflection or apology following 11 – 12 April 2024 (charge1e). The panel considered that Mrs Bates's reflections were focused on herself and did not demonstrate sufficient insight

into how her actions may have affected patients and colleagues or impacted public confidence in the profession and the NMC as a regulator. The panel therefore determined that Mrs Bates had not yet developed sufficient insight into her failings.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Bates has taken sufficient steps to strengthen her practice. The panel took into account the written testimonials provided by Mrs Bates in 2023 as well as the relevant training she had undertaken. The panel gave Mrs Bates's testimonials little weight as they were undated, unsigned and some were from people she had not directly worked with or been line managed by that could speak to her current practice. The panel noted that Mrs Bates had completed Medication Safe Handling and Awareness training before the incident in April 2024. Mrs Bates did not provide any evidence of how she had applied what she had learned from the training to strengthen her practice.

The panel is of the view that there is a risk of repetition that Mrs Bates could repeat the matters of the kind found proved and noted it did not have any further information or evidence to demonstrate that Mrs Bates had sufficiently strengthened her practice to address the concerns. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required. The panel considered that the public would expect the regulator to take action in cases where a nurse had failed to follow trust policies and procedures and potentially risked patient safety.

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

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of one year. The effect of this order is that Mrs Bates's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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

Submissions on sanction

Dr Persaud informed the panel that the NMC had advised Mrs Bates that it would seek the imposition of a striking-off order if it found Mrs Bates's fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that a suspension order with a review is now more appropriate in light of the panel's findings.

Dr Persaud submitted that there are aggravating and mitigating factors in Mrs Bates's case, such as:

Aggravating factors:

- Conduct that puts patients at risk of harm
- Lack of insight into failings
- No evidence of Mrs Bates strengthening her practice

- Limited engagement with the proceedings and did not attend the final hearing

Mitigating factors:

- No evidence of direct harm to patients
- No previous history of regulatory findings

Dr Persaud referred the panel to the NMC guidance SAN-3. Dr Persaud provided the panel with submissions on the sanctions available to it, going through the appropriateness and proportionality of each sanction and highlighting the relevant NMC guidance that the panel could refer to. She submitted that a suspension order is the only order that would be appropriate and sufficient to protect patients, address the public interest, protect the public from harm and maintain public confidence in the profession.

Decision and reasons on sanction

Having found Mrs Bates'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 decided that the following aggravating features applied in this case:

- Lack of insight into failings, in that Mrs Bates had shown some insight after the conduct in charge 7 occurred, undertook relevant training and reflected upon the incident having read relevant policy. However, Mrs Bates then repeated similar medicines management failings in relation to the conduct at charge 1e. Mrs Bates has not provided any explanation for her conduct or demonstrated any insight in relation to charge 1e.
- A repetition of similar medicines management failings.
- Conduct which potentially put patients at risk of suffering harm.

The panel decided the following mitigating features apply in this case:

- [PRIVATE].

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that although Mrs Bates was not present at the hearing it noted that Mrs Bates has in her written reflections expressed a desire to continue practising as a nurse and has previously undertaken relevant retraining to strengthen her practice. The panel also noted there was no evidence of harmful deep seated personality or attitudinal problems. Nor was there evidence of general incompetence regarding Mrs Bates's practice. Therefore, the panel was of the view that given the area of concern related to one specific aspect of the nursing practice: Medicines Management, it determined that it would be possible formulate conditions that were relevant, proportionate, workable and measurable that would sufficiently protect the public and address the public interest

The panel had regard to the fact that these incidents occurred on two separate occasions, and it was of the view that it was in the public interest that, with appropriate safeguards, Mrs Bates was capable of returning to practice as a nurse.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel did go on to consider a suspension order. In making this decision, the panel carefully considered the submissions of Dr Persaud in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a suspension order would be unduly punitive, and would not facilitate Mrs Bates to strengthen her practice or further develop her insight.

The panel was also of the view that to impose a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mrs Bates's case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will provide the necessary degree of public protection, mark the importance

of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must limit your nursing practice to one substantive employer in one location. You must not undertake night duties.

2. You must ensure that you are supervised by a registered nurse any time you are working. Your supervision must consist of:

    a) Working at all times on the same shift as, but not always directly observed by, a registered nurse of band 6 or above.

3. You must not prepare or administer medication unless supervised by a registered nurse of Band 6 or above (except in life threatening emergencies).

4. You must have monthly meetings with your line manager to review your competence in relation to your medicines management and compliance with relevant medicines management policy and procedures. These meeting dates should be recorded and a summary of them to be provided to the panel at the substantive order review hearing.

5. You must provide a report from your line manager in relation to your medicines management to be provided to the panel at the substantive order review hearing.

6. You must complete medicines management training and provide evidence that you have successfully completed this to be provided to the panel at the substantive order review hearing.

7. You must keep a personal development log which documents dated practice examples, signed by your line manager, of your medicines management and compliance with medicines policies and procedures. These should be provided to the panel at the substantive order review hearing.

8. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

9. You must keep us informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

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

c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

11. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

12. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for up to one year.

The substantive conditions of practice order will be reviewed before the order expires. At the review hearing the panel may revoke the order, it may extend the order, it may vary any condition of it or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- An up to date reflective piece which demonstrates your insight of into the consequences of your actions on patients, colleagues, the profession and the NMC as a regulator.
- Up to date testimonials in relation to your nursing practice regarding medicines management, from current colleagues on the same band as you or higher. These testimonials should be signed and dated.

- Your engagement and attendance at a review hearing.

This will be confirmed to Mrs Bates in writing.

Interim order

As the conditions of practice 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 is in Mrs Bates's own interests until the conditions of practice 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 Dr Persaud. She submitted that the panel should impose an interim conditions of practice order for a period of 18 months to cover any potential period of appeal, to protect the public and satisfy the public interest in this case.

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 the appropriate interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months due to cover any potential appeal period.

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

That concludes this determination.