Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Friday, 5 September 2025 – Monday, 8 September 2025

Virtual Meeting

Name of Registrant:	Lorraine Hill
NMC PIN:	73D1349E
Part(s) of the register:	Registered Nurse, Sub Part 2 RN2: Adult Nurse, Level 2 (29 May 1975)
Relevant Location:	Sunderland City
Type of case:	Misconduct
Panel members:	Geraldine O'Hare (Chair, lay member) Catherine McCarthy (Registrant member) Christopher Bithell (Lay member)
Legal Assessor:	Charles Conway
Hearings Coordinator:	Clara Federizo
Facts proved:	All charges
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
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 Ms Hill's registered email address by secure email on 25 July 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, that the meeting would be taking place on or after 29 August 2025.

In the light of all of the information available, the panel was satisfied that Ms Hill 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:

1) On 8 and 9 February 2020 did not escalate Resident A's concerns about their NIPPY machine by;

    a) Failing to read Resident A's care plan **[PROVED]**
    b) Failing to check the Nippy machine tubing **[PROVED]**
    c) Failing to use the on-call system **[PROVED]**

2) On 9 February 2020 did not take observations and or escalate concerns following Resident A's fall **[PROVED]**

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

Background

The charges arose while Ms Hill was employed at Donwell House Care Home (the Home), part of the Bondcare Group. Donwell House is a purpose-built home that has 63 beds and is divided up into four units and provides three categories of care: General Nursing, General Residential and Dementia Residential.

Ms Hill was referred to the NMC on 26 February 2020 by the Bondcare Group following concerns about her nursing practice, specifically an alleged failure to assess a resident's needs and to follow established care plans and procedures, in circumstances leading to the resident's death.

Resident A, who suffered from chronic obstructive pulmonary disease, required long-term oxygen therapy and the use of a NIPPY machine (non-invasive ventilation) overnight. On 7 February 2020, a replacement NIPPY machine was delivered to the Home, following the failure of Resident A's previous device. Resident A experienced difficulties with the new machine and raised concerns with staff.

Ms Hill was on duty during the nights of 8 and 9 February 2020 when Resident A reported problems with the NIPPY machine. It is alleged that Ms Hill did not consult Resident A's care plan, did not check the machine tubing and did not escalate the concerns through the on-call system. Instead, the issues were handed over to the day nurse.

On 9 February 2020, Resident A also experienced a fall from her chair. Although Resident A reported no injury, it is alleged that Ms Hill did not carry out observations or escalate the incident.

Resident A was admitted to hospital on 10 February 2020 and died on 13 February 2020.

Following an internal investigation, Ms Hill was dismissed for gross misconduct on 21 February 2020. A police investigation concluded in May 2021 with insufficient evidence for criminal charges. Ms Hill is reportedly no longer working in healthcare.

Decision and reasons on facts

In reaching its decisions on the 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: Manager of the Home;
- Witness 2: Deputy Manager of the Home.

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 the NMC.

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

Charge 1a

1) *"On 8 and 9 February 2020 did not escalate Resident A's concerns about their NIPPY machine by;*

    a) *Failing to read Resident A's care plan"*

This charge is found proved.

In reaching this decision, the panel took into account the written evidence of Witness 1, the witness statement provided by Ms Hill to the police investigation on 25 February 2021 and the local fact finding meeting notes on 12 February 2020.

The panel had regard to the written evidence of Witness 1, which stated:

> *“Lorraine, on both night shifts, did not escalate any concerns regarding the nippy machine. Has not read care plan.”*

The panel found that Witness 1’s account was supported by the notes from the fact-finding meeting on 12 February 2020, during which Witness 1 asked Ms Hill directly whether she had read the care plan and Ms Hill replied:

> *‘ [Witness 1] "Have you read Care Plan?"*
> *LH ”No, not all of it" ’*

The panel considered this to be a clear admission that Ms Hill had not fully read the care plan. It further noted that the care plan was central to ensuring Resident A’s needs were properly met, particularly in relation to the safe use of the NIPPY machine.

The panel also considered Ms Hill’s subsequent police statement dated 25 February 2021, in which she stated:

> *“I was told to follow…care plan, this was situated in her room on top of the draws. It was always changing because of…condition therefore I made sure I was up-to-date with it. When I was on duty over that weekend I followed…care plan to the letter…never told me that she felt unwell…”*

The panel found this later account to be inconsistent with Ms Hill’s earlier admission at the fact-finding meeting.

The panel preferred the evidence of Witness 1, as her account was reinforced by Ms Hill’s own admission at the fact-finding meeting in February 2020. The panel concluded that this evidence was more reliable than Ms Hill’s subsequent police statement.

Therefore, on the balance of probabilities, the panel found that it was more likely than not that, on 8 and 9 February 2020, Ms Hill did not escalate Resident A’s concerns about their NIPPY machine by failing to read Resident A’s care plan.

Accordingly, the panel finds Charge 1a proved.

Charge 1b

1) *"On 8 and 9 February 2020 did not escalate Resident A's concerns about their NIPPY machine by;*

    b) *Failing to check the Nippy machine tubing"*

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1, the statement provided by Ms Hill to the police investigation on 25 February 2021, the fact-finding meeting on 12 February 2020 and the disciplinary meeting notes on 19 February 2020.

The panel had regard to the witness statement of Witness 1, who stated that Ms Hill:

"Did not check the nippy machine or its tubing."

The panel found that Witness 1's account was supported by the fact-finding meeting on 12 February 2020, where Witness 1 and Witness 2 directly questioned Ms Hill about the NIPPY machine tubing:

' [Witness 2] "…Did you check where the oxygen tubing was connected to?".
LH "No as it always worked".
[Witness 2] "I would always check any medical device is working before and after use. What do you think?"
[Witness 1] "Did you check the tubing?"
[Witness 2] "Did you see if anything was connected?"
LH "I can't remember, I didn't look." '

The panel considered this to be an admission by Ms Hill that she had not checked the NIPPY machine tubing as she relied on the assumption that it had previously always worked and therefore she did not look.

Further, the panel considered the notes at the disciplinary meeting on 19 February 2020, where Ms Hill acknowledged she was not competent in the use of the NIPPY machine:

> *"I thought I was competent but obviously I am not. No I wasn't 100% sure. I did tell [Witness 2] when…first came in but I should of looked it up. But [Witness 2] did give a run down and information on the use of this machine."*

The panel considered this to reinforce the likelihood that Ms Hill had not adequately checked the tubing.

The panel reviewed Ms Hill's police statement dated 25 February 2021:

> *"I knew that the machine has been changed on the Friday and it was brand new. I looked at the machine but could not see anything wrong with it, I checked the tubing and it seemed to be correct."*

However, the panel noted this was inconsistent with her earlier admissions during the fact-finding and disciplinary meetings. The panel also noted that although Ms Hill stated that she 'checked' the tubing, she did not appear to be sure that it was correct/working.

The panel found Ms Hill's evidence to be inconsistent and therefore unreliable. It preferred the evidence of Witness 1 and Witness 2, which was clear, consistent, contemporaneous and supported by Ms Hill's own earlier admissions.

Therefore, on the balance of probabilities, the panel found that it was more likely than not that, on 8 and 9 February 2020, Ms Hill did not escalate Resident A's concerns about their NIPPY machine by failing to check the Nippy machine tubing.

Accordingly, the panel finds Charge 1b proved.

Charge 1c

2) *"On 8 and 9 February 2020 did not escalate Resident A's concerns about their NIPPY machine by;*

   c) *Failing to use the on-call system"*

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1, the statement provided by Ms Hill to the police investigation on 25 February 2021, the fact-finding meeting on 12 February 2020 and the disciplinary meeting notes on 19 February 2020.

The panel had regard to the evidence of Witness 1, who stated:

> *"Lorraine, on both night shifts, did not escalate any concerns regarding the NIPPY machine… She is aware of the on-call system."*

The panel noted that this evidence suggested that Ms Hill had knowledge of the on-call procedure.

The panel found Witness 1's account to be credible and reliable as it was supported by the fact-finding meeting notes on 12 February 2020, where Ms Hill was asked:

> *'[Witness 1] "If an emergency door was broken what would you do?"*
> *LH "I would ring [Mr 1]".*
> *[Witness 1] "Exactly, you would ring someone. Do you know the On-Call Policy?".*
> *LH "Yes, I would ring you or [Witness 2]."'*

The panel considered this evidence to be a clear indication that Ms Hill knew how to access support but did not do so.

Further into the conversation at the fact-finding meeting, Ms Hill was asked in relation to support and using the on-call system:

‘[Witness 2] “If you needed any support I would help. I don’t understand why nobody got in touch with myself or [Witness 1] for something so serious, yet we get calls for minor things all the time.”
[Witness 1] “Do you feel supported?”
LH “Yes, I would come to you if needed.” ’

The panel concluded that Ms Hill had no reasonable justification for failing to use the on-call system.

The panel took into account Ms Hill’s police statement dated 25 February 2021. In this statement, Ms Hill said she was aware she could call Witness 1 or Witness 2, but she stated:

“I did not feel it warranted an out-of-hours phone call to the care-home manager”.

The panel noted that this explanation was inconsistent with her earlier responses at the fact-finding meeting and her admitted lack of competence in using the NIPPY machine. It found Ms Hill’s evidence to be inconsistent and therefore unreliable. It preferred the evidence of Witness 1 and the contemporaneous local investigation records (fact-finding and disciplinary meeting notes), which demonstrated that Ms Hill knew of the on-call system but failed to use it.

Therefore, on the balance of probabilities, the panel found that it was more likely than not that, on 8 and 9 February 2020, Ms Hill did not escalate Resident A’s concerns about their NIPPY machine by failing to use the on-call system.

Accordingly, the panel finds Charge 1c proved.

Charge 2)

2) *“On 9 February 2020 did not take observations and/or escalate concerns following Resident A’s fall.”*

This charge is found proved.

In reaching this decision, the panel took into account the disciplinary meeting held on 19 February 2020. During that meeting, the importance of the NIPPY machine was explained and Ms Hill was asked whether, given Resident A's condition, she should have taken observations when concerns about Resident A's breathing arose. Ms Hill initially stated:

> *"I did check her observations"*

However, the panel noted that when challenged, Ms Hill accepted that there was no record of any observations:

> *[Investigating Officer] "There is nothing written in her notes to say that you have taken her observations. What about [Resident A's] fall at 6.00am?"*
> *LH "She had just slid out of her chair"*
> *[Investigating Officer] "Was this usual for [Resident A]?"*
> *LH "No as she usually gets up and goes to the toilet"*
> *[Investigating Officer] "Is it likely that she had become unconscious and the poison had made her drowsy. Had any observations been done?"*
> *LH "No."*

The panel found that Ms Hill admitted in this meeting that no observations had been carried out.

The panel also had regard to the witness statement of Witness 1, which confirmed that Ms Hill had not taken steps to check whether the NIPPY machine was working correctly and had not escalated concerns appropriately:

> *"I asked her about the importance of the NIPPY machine and if she knew how to escalate concerns during the night, which she did. She stated that she had no concerns, she also stated that she did not check the NIPPY machine to see if it was working correctly."*

The panel considered Ms Hill's account to be inconsistent and unconvincing. Although Ms Hill initially claimed to have taken observations, her later admission that she had not and the absence of any documentary evidence to show any observations being undertaken, led the panel to conclude that no observations had been carried out by Ms Hill. Furthermore, the panel was concerned that Ms Hill had failed to escalate the incident to senior staff or use the on-call system, despite Resident A's vulnerability and the potential seriousness of the fall.

The panel preferred the evidence of Witness 1 and the contemporaneous records of the fact-finding and disciplinary meeting. Therefore, on the balance of probabilities, the panel found that it was more likely than not that Ms Hill failed both to take observations and to escalate concerns after Resident A's fall on 9 February 2020.

Accordingly, the panel finds Charge 2 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 Ms Hill'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, Ms Hill'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 Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

The NMC identified the specific, relevant standards where Ms Hill's actions amounted to misconduct and submitted the following in writing:

> *"The NMC considers that Ms Hill's conduct to not escalate Resident A's concerns about their NIPPY machine failing to read Resident A's care plan, checking the Nippy machine tubing and failing to use the on-call system. And then further not take observations and or escalate concerns following Resident A's fall, falls seriously short of the standards expected of a registered nurse. Ms Hill's conduct in this matter directly related to her work as a nurse.*
>
> *Prioritise people and practice effectively are fundamental tenets of the profession. It is submitted that her actions amount to misconduct.*
>
> *Ms Hill's conduct would be seen as deplorable by fellow practitioners and would damage the trust that the public places in the profession. Registered professionals occupy a position of privilege and trust in society and are expected at all times to be professional and to treat patients with care. Patients and families must be able to trust registered professionals."*

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Ms Hill's fitness to practise impaired and submitted the following in writing:

> *"It is the submission of the NMC that limbs i, ii, iii can be answered in the affirmative in this case. Dealing with each one in turn:*
>
> *Limb i) Ms Hill's conduct is serious and caused harm. She failed to act appropriately in response to clinical concerns, which include escalating concerns regarding patient A NIPPY machine and not escalating, taking appropriate observations and action after a patient fall, has the potential to put patients at risk of harm. The NMC consider that if this behaviour is not addressed then it has the potential to put future patients at risk of harm, if repeated.*
>
> *Limb ii) Ms Hill's actions is likely to bring or have brought the nursing profession into disrepute. The public would be extremely concerned to hear that a nurse did not escalate clinical concerns of a patient which is a fundamental basic nursing skill.*
>
> *She has clearly brought the profession into disrepute by the very nature of the conduct displayed. Registered professionals occupy a position of trust and must act and promote integrity at all times, which have been breached in this case.*
>
> *The public has the right to expect high standards of registered professionals. The seriousness of Ms Hill's action's are such that it calls into question Ms Hill's professionalism in the workplace. This therefore has a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute.*
>
> *Limb iii) Nurses are expected to uphold the reputation of their profession at all times and act with integrity and promote trust. Ms Hill's actions shows a lack of integrity and does not promote trust in the profession. Ms Hill has breached fundamental tenets of the profession by failing to act with integrity.*
> *…*

Failure to act appropriately in response to clinical concerns falls into this category of clinical failings and as such, is a concern that is capable of being addressed through evidence of insight, reflection further training and current safe practice. However Ms Hill conduct occurred on more than 1 occasions and directly linked to the nurse, midwife or nursing associate's practice. The NMC considers the seriousness of Ms Hill's conduct and the potential harm it caused, whilst acknowledging that Patient A died a few days later. There has however been a significant departure from the standards expected of a registered nurse which is not easily remediable.

…

It is submitted that Ms Hill has not provided evidence to suggest that she has insight or addressed the concerns. Ns Hill has not provided the NMC with a response to the concerns. Although she did make admissions during the local investigation, we do not consider the comments demonstrated sufficient insight as Ms Hill did not demonstrate an understanding of what she had learned from the incident and how she would act differently in the future.

…

The NMC considers there is a high risk of the conduct being repeated. As mentioned, Ms Hill has shown no insight into her actions and hasn't provided a reflective piece regarding the concern. Therefore, there is a continuing risk to the public due to Ms Hill's conduct in this case which is a difficult element to remediate.

<u>Public protection</u>

Ms Hill's failings fall seriously below the standards expected of a nurse, has not provide evidence to address the concerns and she has failed to engage with the NMC by providing a response to the concerns and charges, therefore remains a risk to the public. A finding of impairment is therefore required for the protection of the public.

<u>Public interest</u>

…

The NMC consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour and to maintain confidence in the profession and the NMC as a regulator. The

registrant's conduct engages the public interest because The NMC considers there is a continuing risk to the public due to Ms Hill's actions in this case. Her behaviour raises fundamental concerns about her professionalism as a nurse and is a serious breach of her position as a registered professional.

The NMC therefore consider that Ms Hill's fitness to practise is impaired on both public protection grounds and in the wider public interest."

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 regard to the terms of the Code.

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

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

8 Work cooperatively

To achieve this, you must:

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

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

However, the panel found that Ms Hill's failings were wide-ranging and persistent over the course of two nightshifts. She failed to read Resident A's care plan in full, failed to check the NIPPY machine or its tubing, failed to use the on-call system to escalate concerns, and failed to take or record appropriate observations following Resident A's fall. The panel considered that these failures meant that Resident A did not receive the standard of care required and was caused harm.

The panel noted that Ms Hill's actions were not isolated instances but a repeated failure to carry out fundamental nursing responsibilities. It considered that the NIPPY machine was essential to Resident A's breathing and safety, and therefore, failing to escalate issues or check the equipment represented a serious departure from expected standards of a registered nurse. Moreover, the panel found that failing to take and document observations after a fall was a fundamental issue that had the potential to miss/not identify a clinical deterioration.

The panel also took account of Ms Hill's own admissions during the fact-finding and disciplinary meetings, including that she had not read the care plan in full, had not checked the tubing and had not taken observations. It found that Ms Hill's later police statement was inconsistent with these admissions, and thus the panel found her evidence to be unreliable.

Having considered all of the circumstances, the panel determined that Ms Hill'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, Ms Hill'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. 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* 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;'*

The panel found limbs a, b and c, as set out above, to be engaged in this case. It considered that as a result of Ms Hill's misconduct, namely her failing to read the care plan, to check the NIPPY machine and tubing, to escalate concerns via the on-call system and to take observations following Resident A's fall, Ms Hill caused Resident A significant harm and exposed other residents in her care to a risk of significant harm. The panel found these omissions breached the fundamental tenets of the nursing profession and brought its reputation into disrepute.

Regarding insight, the panel determined that Ms Hill has shown limited insight. While the panel acknowledged that Ms Hill made some admissions during internal processes, it considered that she did not demonstrate any meaningful reflection or acceptance of responsibility for her actions. The panel also noted that Ms Hill has not engaged from the NMC proceedings and has provided no evidence of remorse, remediation or a recognition of the seriousness of her failings.

The panel considered the case of *Cohen v GMC* [2008] EWHC 581 (Admin) and was satisfied that the misconduct in this case is capable of being addressed. However, there was no evidence before the panel to show that Ms Hill has taken steps to strengthen her practice, such as training, reflection or seeking supervision. In the absence of such steps, the panel determined that there remains a risk of repetition of the misconduct. The panel therefore decided that a finding of impairment is necessary on the ground 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 was otherwise in the public interest. It determined that members of the public would be gravely concerned if a nurse who failed to escalate clinical concerns, did not take observations and failed to act in accordance with the Code were permitted to practise without restriction.

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 finds Ms Hill's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Hill'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 6 months. The effect of this order is that the NMC register will show that Ms Hill'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 noted that in the Notice of Meeting, dated date, the NMC had advised Ms Hill that it would seek the imposition of a 6-month suspension order. The NMC submitted:

> *"…The aggravating features in this case include admission during the local investigation.*
>
> *The mitigating feature is that there is no strengthening of practice.*
>
> *No action/imposing a caution order*
> *Taking the least serious sanctions first, it is submitted that taking no action or imposing a caution order would not be appropriate in this case. The NMC Sanctions Guidance ("the Guidance") states that taking no action will be rare at the sanction stage and this would not be suitable where the nurse presents a continuing risk to patients. In this case, the seriousness of Ms Hill's conduct means that taking no action would not be appropriate. A caution order would also not be appropriate as this would not mark the seriousness of the concerns and the case is not at the lower end of the spectrum of impaired fitness to practise. Additionally, neither sanction would restrict Ms Hill from practising.*
>
> *Conditions of Practice Order*
> *The Guidance (SAN-3c) says that a conditions of practice order is appropriate when the concerns can easily be remediated and when conditions can be put in place that will be sufficient to protect the public and address the areas of concern to uphold*

public confidence. In this case, a conditions of practice order would not be sufficient to protect the public and would not be in the public interest. There are no conditions which can be formulated to address the concerns.

Ms Hill has not engaged with the NMC and the NMC is unsure whether she is still working a healthcare setting. Suitable and workable conditions can therefore not be formulated. Moreover, a conditions of practice order would not be sufficient to mark the seriousness of the concerns.

Suspension Order

Reference SAN-3d, this was not a one off and Ms Hill has demonstrated any insight into her actions of not escalating concerns relating to a patient care and the impact of her actions to the wider nursing profession. She therefore poses a significant risk of repetition of this behaviour. Ms Hill has brought the profession into disrepute and trust and confidence in the profession is likely to be seriously eroded by her actions. Taking into account the nature and seriousness of the conduct, temporary suspension would be enough to address the concerns.

Striking- Off Order

SAN-3e states a Striking-Off order is likely to be appropriate when what the nurse, midwife or nursing associate has done is fundamentally incompatible with being a registered professional. The NMC does not believe Ms Hill's conduct in this matter compatible with removal from the register.

Therefore, the NMC considers that a 6 month Suspension Order is the proportionate and appropriate sanction."

Decision and reasons on sanction

Having found Ms Hill'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 following aggravating features:

- Limited insight into failings
- Failure to engage with the NMC
- Inconsistencies in her account as she denies allegations in her statements but partially admits failings in investigatory meeting
- No evidence of strengthening of practice
- Conduct which caused harm and put residents at risk of suffering harm

The panel also took into account the following mitigating features:

- Admissions during the local investigation

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 Ms Hill'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 Ms Hill'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 Ms Hill'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:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *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 is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel considered the relevant factors in the SG and accepted that the concerns in this case could in principle be addressed through retraining. However, given Ms Hill's lack of engagement, absence of any meaningful reflection and the nature of the misconduct, the panel was not satisfied that appropriate conditions could be identified, monitored or enforced. The panel therefore concluded that a conditions of practice order would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

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

The panel was satisfied that the factors listed above were applicable in this case. The panel noted that while Ms Hill has demonstrated limited insight, there was no evidence of attitudinal concerns or repeated misconduct. The panel also considered her lengthy

nursing career without previous regulatory history. In these circumstances, the panel concluded that the misconduct, though serious, was not fundamentally incompatible with remaining on the register.

The panel did go on to consider whether a striking-off order would be proportionate. It reminded itself that this is the most serious sanction, reserved for cases where there is a persistent lack of insight, deep-seated attitudinal issues or misconduct fundamentally incompatible with continued registration. The panel determined that Ms Hill's case did not meet this threshold. It concluded that while there was limited insight and no evidence of remediation, her conduct taken in the context of a long and otherwise unblemished career, could properly be marked by a suspension 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 Ms Hill. However this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 6 months was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by:

- a reflective piece addressing the Registrant's failings found proved and their impact on patients, colleagues and the wider profession;

- evidence of professional development or training, particularly in relation to safe use of clinical equipment and escalation of concerns;
- evidence of a review and understanding of the NMC Code; and
- testimonials or references demonstrating professional conduct in any employment or voluntary role.

This will be confirmed to Ms Hill 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 Ms Hill'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:

> *"If a finding is made that Ms Hill's fitness to practise is impaired on a public protection and public interest basis and a restrictive sanction imposed, we consider an 18-month interim suspension order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest. This is because any sanction imposed by the panel would not come into immediate effect but only after the expiry of 28 days beginning with the date on which the substantive decision letter is sent to Ms Hill or after any appeal is resolved. An interim order of 18 months is necessary to cover any possible appeal period."*

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest.

The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive suspension order. The panel therefore imposed an interim suspension order for a period of 18 months because to do otherwise would be incompatible with its earlier findings. The period of this order is for 18 months to allow for the possibility of an appeal to be made and concluded.

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

That concludes this determination.