Nursing and Midwifery Council
Fitness to Practise Committee
Substantive Meeting
2 October 2019 - 3 October 2019

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

Name of registrant:	Emily Dennison Whitelaw
NMC PIN:	74D0162S
Part(s) of the register:	Registered Nurse – sub part 1 Adult Nursing – 20 June 1977 Children's Nursing – 18 July 1979 Specialist Community Public Health Nursing Health Visitor – 18 November 1998 V100: Community Practitioner Nurse Prescriber 30 May 2000
Area of Registered Address:	Scotland
Type of Case:	Misconduct
Panel Members:	Andrew Harvey (Chair, Lay panel member) Jane Jones (Registrant panel member) Sadia Zouq (Lay panel member)
Legal Assessor:	Charles Conway
Panel Secretary:	Raj Patel
Consensual Panel Determination:	Accepted
Facts proved:	All
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim Order:	Interim suspension order (18 months)

Decision on Service of Notice of Meeting

The panel considered whether notice of this meeting has been served in accordance with Rules 11A and 34 of the *Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (the Rules)* as amended state:

> *'11A.(1) Where a meeting is to be held in accordance with rule 10(3), the [Fitness to Practise] Committee shall send notice of the meeting to the registrant no later than 28 days before the date the meeting is to be held.*
>
> *34.(3) Any other notice or document to be served on a person under these Rules may be sent by—*
> *(a) ordinary post'*

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

The panel was informed that written notice of this meeting had been sent to Miss Whitelaw's registered address by first class post and by recorded delivery on 29 August 2019. The panel also noted the status of this package from the Royal Mail 'Track and Trace' system, which confirmed that notice of this meeting was delivered to Miss Whitelaw's current registered address and was signed for under the name 'WHITELAW' on 30 August 2019 at 14:49 hours. The panel further noted that notice of this hearing was also sent to her representative at Unite the Union on 29 August 2019.

In the light of all of the information available, the panel was satisfied that Miss Whitelaw has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34. It noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Accordingly, the panel determined that notice had been served in accordance with the Rules.

Consensual Panel Determination

The panel was provided with a provisional Consensual Panel Determination (‘CPD’) agreement, signed by Miss Whitelaw and the Nursing and Midwifery Council (‘NMC’) on 5 August 2019 and 27 August 2019, respectively.

The panel was also provided with two appendices to support the CPD agreement, namely, Miss Whitelaw’s reflective statements (signed prior to the CPD agreement) and a testimonial.

The CPD agreement reads as follows:

Fitness to Practise Committee

Consensual panel determination: provisional agreement

The Nursing and Midwifery Council and Ms Emily Dennison Whitelaw (“the parties”) agree as follows:

Charges

1. *Miss Whitelaw admits the following charges:*

That you, a Registered Nurse whilst employed as a Health Visitor by NHS Forth Valley Trust:

1. *On 16 June 2015, upon it being reported to you by Family Support Worker A, that Child C’s mother had disclosed alleged sexual abuse of Child C by her paternal step-grandfather, you:*

    a) *Failed to immediately report this allegation as a child protection concern to social services and/or the police*

b) Inappropriately told Family Support Worker A to take no action as the child had no contact with the grandparents and/or the allegations may be fabricated

c) Failed to document in Child C's visiting record why and/or how you reached the decision that no action should be taken

d) Failed to promptly visit Child C to conduct a welfare check as to her safety

e) Failed to promptly contact Child C's mother to discuss and/or clarify the allegation

2. *On 15 January 2016 following a telephone conversation with a social worker in relation to what had occurred on 16 June 2015, you:*

    a) Inaccurately misquoted the words reported by Child C to a social worker as "Papa told me not to do it" rather than either "Papa does that" or "Papa told me to do that" when you should have sought verification of what was alleged to have been said by referring to Child C's records

    b) Failed to document this telephone conversation in Child C's records

3. *Failed to provide an appropriate level of care to Child C and/or the family in that you:*

    a) Carried out an inadequate number of home visits

    b) Did not visit and/or contact the family following receipt of a Vulnerable Person's Report ("VPR") concerning domestic abuse in or around 25 June 2015

c) Did not adequately supervise and/or oversee the work of Family Support Worker A in relation to her visits to Child C and her family

d) Did not ensure that the 'My World Triangle Assessment' was

i. completed to an adequate standard
ii. reassessed every six months

4. Failed to adequately manage your health visitor caseload in that an audit of 226 patient records revealed:

a) There were delays in making records of your visits in that 57% of your caseload had at least one late entry over a 72 hour period

b) 91.8% of your caseload had only partially completed demographics

c) You did not consistently carry out and/or complete on time, appropriate developmental contacts

d) Only 38% of your caseload had appropriate assessments completed

e) 28% of your caseload had an incomplete SHANARRI assessment

f) 13% of your caseload had inappropriately allocated Health Plan Indicators ("HPIs")

g) You did not clearly identify and/or record in 5% of your caseload what HPI assessment was required

h) 62 planned home visits had not been followed through

i) 68 records did not demonstrate a 'clear child's journey' within them

j) You had inappropriately delegated work to Family Support Worker A and/or did not adequately oversee the work which was being completed

k) In respect of the records of 8 patients who were identified as a vulnerable HPI or should have been allocated a vulnerable HPI:

i. None had fully completed demographics
ii. No records had the name of the Child's Health Visitor under Associated Professionals
iii. None had an up to date HV assessment
iv. Only 3 of the 8 records (36.5%) had a recorded My Wider World Assessment ("MWW") and/or were out of date
v. 4 of the records had no record of a recent assessment having been carried out
vi. None of the 8 records had a current care plan attached to the record
vii. 6 of the 8 records revealed that the child had not been regularly seen as contacts were more than 3 months apart
viii. 7 of 8 records did not evidence timely recording of the contacts within 72 hours

5. In relation to Child One who was on your caseload, you:

a) Did not complete a Health Visitor Assessment or alternatively failed to record your visit in the records
b) Did not carry out regular Health Visitor assessments and/or at least every six months

6. In relation to Child Two who was on your caseload, you:

a) Did not fully engage with the family and/or escalate concerns regarding the family's non-engagement
b) Carried out an inadequate number of home visits

7. In relation to Child Three who was on your caseload, you:

a) Did not follow up a Police Concern Report ("PCR") with the family
b) Did not liaise with the child substance team to discuss potential impact on child welfare
c) Inappropriately delegated a PCR to a Family Support Worker
d) Did not demonstrate a 'clear journey' in respect of contact made with the child's mother
e) Did not complete a new assessment upon being allocated this case

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

Facts

2. *The facts are as follows:*

2.1 Miss Whitelaw appears on the register of nurses and midwives maintained by the NMC as a registered nurse – adult (RN1); registered nurse – children (RN8); Community Practitioner Nurse Prescriber (V100) and registered specialist community public health nurse (HV). Miss Whitelaw first registered with the NMC in July 2001 and commenced work as a Health Visitor with NHS Forth Valley Trust ("the Trust") on 18 October 2004.

2.2 On 11 September 2017, the NMC received a referral from the Trust in relation to Miss Whitelaw's failure to provide appropriate care to a vulnerable child, Child C, and failure to adequately manage her health visitor caseload.

2.3 The concerns against Miss Whitelaw were initially raised when the Chair of Child Protection requested information about Child C, who was one of the children monitored as part of Miss Whitelaw's caseload. It was found that allegations of potential sexual abuse were raised to Miss Whitelaw but that she did not take

these any further. The initial allegations were raised with her in June 2015, whereas the Chair requested documents in December 2016.

2.4 *An audit was undertaken of Miss Whitelaw's work by a Clinical Nurse Manager and a Team Leader for Health Visiting. The audit revealed a considerable number of errors in record-keeping, conducting assessments and improper delegation. These concerns appear to be wide-ranging following an analysis of 226 patient records.*

Charge 1 (a) – (e)

3. *The mother of Child C disclosed alleged sexual abuse of Child C by her paternal step-grandfather on 16th May 2015 to Family Support Worker A. Family Support Worker A was concerned with what she had been told and immediately reported the matter to Miss Whitelaw. Family Support Worker A also recorded the allegations she had received in Child C's health visitor record. Family Support Worker A recorded the following entry: "Mum reports that Child C was playing/touching her private part the other night and when told to stop she said either 'Papa does that' or 'Papa told me to do that.'" Child C at the time of the disclosure was 3 years and 8 months old.*

4. *When the allegation was disclosed to Miss Whitelaw by Family Support Worker A, Miss Whitelaw did not take any action and made no record of why and/or how she reached the decision that no action should be taken. She felt that there was a possibility that the parents were lying, as the relationship between them and the grandparents had been difficult.*

5. *Miss Whitelaw had not acted appropriately and in accordance with NHSFV Child Protection Guidelines to ensure that Child C was safe from harm. The SG document Child Protection Guidance for Healthcare Professionals (2013) states that Health Visitors play a pivotal role in the prevention and early detection of concerns regarding the wellbeing of a child that may include more serious protection and care concerns.*

6. *Regardless of whether Miss Whitelaw thought this was true or false, she should have immediately reported the matter for further investigation. It was her*

responsibility to report such matters so that they could be further investigated by the social services department and/or the police. In situations like this, Miss Whitelaw would also have been expected to promptly visit the child to ensure their safety, undertake a risk assessment and to contact the mother to discuss this issue but failed to do so.

Charge 2 (a) and (b)

7. *Following Miss Whitelaw's decision to take no further action regarding the disclosure of the alleged abuse of Child C, she subsequently misquoted the Mother's allegation to a social work colleague in a telephone call as "Papa told me not to do it", rather than the more accurate "Papa does that", or "Papa told me to do that". Thereby Miss Whitelaw had completely changed the sense of the statement which had been made by the mother, thereby minimising the inference.*

8. *Further, there was no record of this telephone conversation in Child C's records.*

Charge 3 (a)

9. *Miss Whitelaw carried out very few health visits for Child C. During the same period that Family Support Worker A had carried out 73 visits, Miss Whitelaw by comparison had only made 5 visits to Child C. Miss Whitelaw should have carried out more visits as a more senior and experienced member of staff. There was little evidence showing supervision of Family Support Worker A's intervention with this family.*

10. *There were multiple contacts from the Family Support Worker and lots of intervention in terms of assistance for the mother but there was little supervision of these actions on the part of Miss Whitelaw and therefore no analysis as to whether the interventions were making any difference to Child C's circumstances or wellbeing. There were many informal discussions between the support workers and health visitors but not much of this was recorded.*

11. *Miss Whitelaw failed to carry out home visits unless prompted to do so following an incident. These visits tended to be joint visits with the Social Work Department. Miss Whitelaw did joint visits with social work but there was no proper pattern to visit the family. In the clinic, she saw the family around 15 times and also saw them for annual reviews. However, the conditions in the clinic are very different and a more artificial environment compared to the conditions of a family home.*

12. *At the time of the incident, there was no policy in place regarding the number of visits a family must receive. However, any child identified as vulnerable, which Child C was, should be visited regularly. The job of a Health Visitor is to identify child's needs which are not being met and the risks and Miss Whitelaw failed to do this.*

Charge 3 (b)

13. *Miss Whitelaw failed to visit and/or contact the family following receipt of a Vulnerable Person's Report ("VPR") concerning domestic abuse in or around 25 June 2015. Miss Whitelaw should have carried out a visit to conduct a risk assessment and evaluate the safety of Child C. Miss Whitelaw did not visit the family at home until 12 January 2016, over six months after receipt of the VPR.*

Charge 3 (c)

14. *Further, Family Support Worker A's visits to Child C should have been supervised by Miss Whitelaw through discussion and reflection. Miss Whitelaw had the caseload responsibility for Child C but it appeared that Family Support Worker A had been largely managing the cases herself.*

15. *There were many instances when there was no obvious input from Miss Whitelaw when there should have been documented evidence that Family Support Worker A's actions were being supervised, planned and agreed by Miss Whitelaw.*

Charge 3 (d)

16. *The 'My World Triangle Assessment', was incomplete, out of date and never repeated or reviewed. Any child who has additional health issues should have further formal assessment utilising the GIREC National Practice Model. The 'My*

World Triangle Assessment' should be reassessed every six months to ensure no other needs are missed but this was not done. Some planning had taken place, however this was not clear enough for Family Support Worker A to action on her own.

Charge 4 (a)

17. *The audit of Miss Whitelaw's work revealed that 57% of the records reviewed during the audit had at least one late entry over 72 hours.*

18. *Audit results have shown that sometimes entries are recorded after 72 hours, however, this would not be considered as normal practice. A structured programme for HV service audit of records commenced 2016/17. A benchmark for NHSFV would be based on results from the last HV Service audited in January 2018 which evidenced that 69% of contacts had been recorded after 72 hours, meaning that the percentage of late entries was 31%.*

Charge 4 (b)

19. *91.8% of the electronic records reviewed during this audit had partially completed demographics. This figure is higher than what would be expected for an individual Health Visitor. The problem was related to recording these details on the electronic records. Often, the missing information would be available on paper but had not been entered onto the electronic records system.*

20. *It tended to be information about associated professionals that was missing, such as Health Visitors name/contact details or details of any Social Workers or other relevant professionals working with the family.*

Charge 4 (c)

21. *In Scotland, The Universal Health Visiting Pathway ("UHVP") which came into effect in the Trust on 1 May 2016 defines points of contact from antenatal to pre-school and is based on best available research. It indicates that all visits should be*

undertaken by a Health Visitor in the family home. All children born 1 May 2016 within the Trust would be expected to receive pathway visits; these are the appropriate development contacts.

22. *Under UHVP, babies are seen 11 – 14 days after birth then at the following times: 2 visits between 3 – 5 weeks of age; 6 – 8 weeks; 3 months; 4 months; 8 months; 13 – 15 months; 27 – 30 months; 4 – 5 years pre-school. Babies born prior to 1 May 2016 were not cared for under the UHVP and would be required to receive 3 month, 4 months or 8 month visits.*

23. *Details of how Miss Whitelaw performed in relation to these visits are as follows:*

    - ***Notification visits:*** *Miss Whitelaw carried out two of the required notifications late. This was not necessarily a concern as there can be reasons for this (such as the mother not living at her home address immediately after the baby's birth and there was difficulty in making contact). However, she would be expected to be recording the reasons for the delay and the records had no explanation for why these visits were carried out late.*

    - ***6-8 week visits:*** *the visits at 6 – 8 weeks were already part of the core health visiting programme and were not new visits introduced by UHVP. Emily missed three of these visits, although the babies were seen at a baby clinic around this time. There was a pattern of babies who missed pathway visits but were seen at the baby clinic. However, there was minimal information within the electronic record in relation the developmental review.*

    - ***3 months visits:*** *these were introduced by UHVP. There will have been variation in the Health Visitors' caseload as a result of this as some families would have been on the new pathway programme and others would not. 46 of these visits were completed. However, the majority of these babies were seen at the clinic around this time and again, there was a pattern of clinic contacts, rather than home visits.*

    - ***4 month visits:*** *these were introduced by UHVP. 38 children on Miss Whitelaw's caseload did not received a 4 month visit when required. Again,*

however there was a pattern of clinic contacts. Prior to the introduction of the UHVP, babies were often seen at baby drop in clinics at around 3/4 months where contact are generally completed. However, there was routinely little mention of developmental assessments at these contacts.

- ***8 month visits:*** *these were also introduced by UHVP. Three visits were completed late and nine of these visits were not completed; however three of these were due to when Miss Whitelaw was on sick leave.*

- ***13 – 15 month visits:*** *A one year contact had always taken place. Miss Whitelaw did not complete 24 of these contacts. Three babies were seen at the clinic rather than at home.*

24. *There were a number of visits which were not completed or were late. This could be for a number of reasons. However, there was no recorded information in the records providing reasons for the late or missed visits. There were only 110 children with all contacts completed out of 226 children in total.*

25. *Another concern was that Family Support Worker A had carried out seven visits on behalf of Miss Whitelaw. These particular visits should have been Health Visitor contact visits. In terms of the impact of having Family Support Worker A carry out these visits, when records were reviewed there was little evidence of follow up or input from Miss Whitelaw. Miss Whitelaw was responsible for ensuring that appropriate care was being provided and there was a continuum of assessment and care to support early identification and management of concerns.*

Charge 4 (d) and (e)

26. *The Getting It Right For Every Child (GIRFEC) National Practice Model is used for assessment and planning. It provides a framework for structuring and analysing information consistently to identify and understand the child's needs, identify strengths and adversities, and consider what support they might need.*

27. *The Trusts standard for Health Visitors practice at the time of the audit informed that a discussion about the GIRFEC National Practice Model should take place with the parent/s during first visits to the family. Parents must be aware that during these early visits, the Health Visitor is recording and observing the child's wellbeing in relation to the Wellbeing Indicators (SHANARRI). Parents should be invited and encouraged to become fully involved in this process and their views recorded.*

28. *By the time the baby is 6 months old, the SHANARRI observations should be completed. Analysis of the observations should be recorded and this analysis should reference the resilience matrix and demonstrate consideration of strengths and protective factors as well as any vulnerabilities and adversities. Following this, a Health Plan Indicator (HPI) is allocated to the child. In the Trust, the HPI allocated may be Core, Additional or Vulnerable. Any child that had been allocated an HPI of Additional or Vulnerable due to having more complex needs must have a My World Triangle (MWT) Assessment completed. The record must also contain a clear SMART Action Plan which details who is responsible for meeting the particular needs identified. Action Plans and MWT's require regular review and should be repeated at least after six months if the child continues to require additional help.*

29. *Only 38% of Miss Whitelaw's caseload had appropriate assessments carried out. This is a very low number. The Trust's standards inform that SHANARRI assessment must be carried out for all children: this assesses health and wellbeing. 28% of the cases had an incomplete SHANARRI assessment. The first page of a SHANARRI assessment contains well-being observations and the second page contains analysis of findings where you would identify any next steps required. It was the second page that was generally missing from these assessments.*

30. *Patients with more complex needs who had an additional or vulnerable HPI identified would also need a further assessment in a format of a MWT assessment. By not completing these assessments, Miss Whitelaw was failing to complete a robust assessment and analysis of risk and protective factors for her patients. This means that something could have been missed by Miss Whitelaw as, without an assessment, you cannot fully identify what the child/family strengths and needs are, ascertain parents' views, identify outcomes with the family and agree next steps.*

Charge 4 (f)

31. *The national HPI is defined in the Universal Health Visiting Pathway as: an additional HP/indicates that the child (and/or their carer) requires sustained (>3 months) additional input from professional services to help the child attain their health or development potential. Any services may be required such as additional HV support, parenting support, enhanced early learning and childcare, specialist medical input, etc. (Universal Health Visiting Pathway in Scotland, Scottish Government 2015)*

32. *The records show that 29 HPIs were inappropriately allocated by Miss Whitelaw. As a Health Visitor and Practice Teacher, Miss Whitelaw was required to be familiar with HPIs and to apply them appropriately within her caseload. At the Trust, there are three HPIs that can be assigned to patients: core; additional; and vulnerable. There is also an unassigned category. Health Visitors have six months to observe new babies and finalise assessments prior to assigning an HPI, so no baby should be unassigned after that point. The core indicator is for patients who are following the core health visiting pathway. The additional indicator is for patients who have an additional health/development need. The vulnerable indicator is for any patient who is deemed vulnerable. Vulnerable patients can include: children on the child protection register; children with home supervision orders; looked after children; and children with any concerns in relation to vulnerability as identified by the Health Visitor.*

33. *Of the 29 cases where the HPI allocation was deemed appropriate, 14 had been allocated to the core HPI, when they should have been under the additional HPI. By failing to identify that these children had additional needs, there was a risk that they may miss out on help and support to meet those needs. This significant; if a child is allocated as an additional HPI, this can always be reviewed and changed to core without any risk to the child but emphasis seemed to be going the other way. When a child is allocated a Vulnerable HPI they should be seen at least three monthly at home, when they are allocated an additional HPI, they should be seen every six months, or as identified in the child’s plan. Without these regular reviews, something could be missed or not picked up on in a timely fashion.*

Charge 4 (g)

34. *It was recorded that 12 of the children in Miss Whitelaw's caseload (5%) needed further assessment and intervention. These were children who had an identified risk within the caseload. Such risks could include: looked after or accommodated children; substance abuse by a parent; alcohol dependency by a parent; homelessness; or police concern reports. It is recorded that Miss Whitelaw did plan further contact with a number of the children identified as requiring further assessment, however, this was not recorded as part of a child's plan, rather it was an entry made in the continuation section of the record.*

Charge 4 (h)

35. *Miss Whitelaw had 62 planned visits that she did not follow through with. For example, she would write comments such as "plan: see in 2 weeks" but then there would be nothing recorded after that. There were a number of these comments in the notes within her caseload. Several families had two planned visits that were not followed up and one family had three visits that were not followed up. It is not entirely clear whether this was a gap in recording or whether Miss Whitelaw did not carry out these visits. There were also two entries stating "plan: discussion to take place with GP" and nothing further recorded. Again, there was nothing to indicate that the conversation had taken place. If the conversation had in fact taken place, there was no record of the outcome.*

Charge 4 (i)

36. *There were 68 records that did not have a clear journey within them. This mainly refers to gaps in recording by Miss Whitelaw. The records should have been easy to pick and understand, but this was not the case. For example, it was not clear whether there had been any discussions with the patients' GPs. Where Miss Whitelaw had been asked to see a family, it was not clear what the purpose of her contact was and there were no clear outcomes identified. It was also unclear why baby massage referrals had been made. All of which were important to give a clear*

picture of the child's journey. In general, when Family Support Worker A visited families she would provide Miss Whitelaw with relevant updates but there was little evidence of what action Miss Whitelaw took after she received the information relayed to her by Family Support Worker A.

Charge 4 (j)

37. *Miss Whitelaw had also delegated visits to highly vulnerable families to Family Support Worker A. Her rationale for this was not always clear. Where a Family Support Worker has been asked to visit a family, this would be expected to be for a specific piece of work. However, in these cases, Family Support Worker A's role was often unclear. Family Support Worker A was reporting back to Miss Whitelaw following her visits but there is little evidence of Miss Whitelaw overseeing the patients' care and she was not assessing and reviewing the patients' need.*

38. *There were further concerns in relation to the PCR, as the record demonstrated that a Family Support Worker visit was not appropriate following the receipt of a PCR. It therefore should have been Miss Whitelaw visiting the patient instead. There was also one record which had police reports within it but there was no updated assessment and no plan in the records following this significant event.*

Charge 4 (k)

39. *None of the eight vulnerable patient records audited had fully completed demographics. There was no up to date assessment completed on any of the eight vulnerable patients' notes audited. It is also recorded that a MWT Assessment was present in only three of the eight records looked at (37.5%). The Trust's standard states that if a child has complex need and has been allocated an HPI of additional or vulnerable, a MWT assessment must be completed. This is a more detailed assessment which helps to assess the child's needs and what they need to grow and develop. All Health Visitors have been trained in this and everyone had been provided guidance to support completion.*

40. *The three records that had a MWT assessment had all been completed by a Health Visitor Trainee, who was allocated Miss Whitelaw as her Clinical Practice Teacher and was working alongside her. The records were appropriate but were two months overdue to be reviewed. The remaining records did not have a MWT Assessment, and only one had a SHANARRI assessment completed. This assessment is used for all children. However, concerns identified within that should to a MWR Assessment being carried out. This was required but was not actioned by Miss Whitelaw.*

41. *Four of the records had no record of a recent assessment being carried out. One had the most recent assessment five years ago; two had the last assessment four years ago; and, the final one had no record of assessment at all. There was no robust assessment and analysis by Miss Whitelaw. This meant that there was no complete picture of the child's needs and that there was a risk of unmet need, things being missed or not acted upon. There was no clear recognition of how things were for the child without that overview.*

42. *None of the eight electronic records audited had a current care plan attached. Two of the eight records made some cross reference to multi agency plans held in paper records. Not having a care plan in place means that there was no clear outcome identified for the child concerns and time frame for review; the care plan contains the outcome and any further actions needed to be taken.*

43. *Six of the eight records looked at, the child had not been regularly seen by a Health Visitor, meaning that Health Visitor contacts were more than three months apart. A vulnerable child's assessment and plan needs to be reviewed and updated on a regular basis in order to ensure things are improving. If the situation is not improving, there needs to be a contingency plan setting out what needs to be done. Without having an up to date assessment and plan in place, which was reviewed regularly, it would be difficult to measure the difference the current plan making for the child. This presents a risk as there would be no way of knowing whether the child was benefitting from the measures in place or not.*

Charge 5 (a) and (b)

44. *Child One was a child who had four episodes of being looked after and accommodated away from home. The child's mother had a history of dealing with significant mental health problems, such as Post-traumatic stress disorder, self-harm and suicidal thoughts. The mother had input from psychiatric services and the child had intentional injuries. There had been lots of contact between Family Support Worker A and the family but no regular contact with Miss Whitelaw. Miss Whitelaw should have been liaising with the community psychiatric nurse and other support services, especially given the particular vulnerabilities of this child.*

45. *There was no current Health Visitor Assessment, plan or analysis carried for Child One by Miss Whitelaw. There should have been regular contact and ongoing assessment by Miss Whitelaw, particularly when the child was removed from and returned to their home. However, this did not occur. Miss Whitelaw should have completed a Health Visitor Assessment focusing on the impact the circumstances were having on Child One. Such an assessment should have been reviewed at least every six months or more often, if required. Six months is the minimum requirement. Miss Whitelaw failed to meet this.*

Charge 6 (a) and (b)

46. *Child Two was from a family who had transferred into the area. There was a previous history of paternal criminality, substance abuse and violence. Although Social Work Services were not involved with the family within the area, there had been Social Work involvement when the family lived in their previous area as the child was on the Child Protection Register there. The family also had financial issues and were disengaging with Health Visitor Services. Child Two had issues with their behaviours, speech, sleep and toileting. There was no assessment or plan recorded in the child's notes.*

47. *The family transferred in from another area in July 2014 and were initially allocated to another Health Visitor in the team before being transferred to Miss Whitelaw's*

caseload in November 2014. Miss Whitelaw's first contact with the family was in June 2015, although a Health Visitor Trainee working with Miss Whitelaw had seen the family on one occasion since transfer to Miss Whitelaw's caseload, as had the Family Support Worker.

48. *Concerns were also raised by the child's nursery and the GP referred the child to a paediatrician. Although it was evident from the continuation notes within the child's records that Miss Whitelaw did observe and assess Child Two during a home visit, there was no evidence of a Health Visitor Assessment using the national practice model.*

49. *Lack of engagement from the family was part of the concern. Miss Whitelaw should have been working with the family to encourage them to engage and work alongside her. However, there was no evidence within the record of Miss Whitelaw working to establish a therapeutic relationship with this family. Instead, work was directed to two Health Visitor Trainees and a Family Support Worker. Miss Whitelaw only saw the child on two occasions and during the first visit, Child Two was asleep therefore no assessment could take place. There were three planned Health Visits cancelled by the family, however, there were also delays in Miss Whitelaw rescheduling the follow ups. After one failed home visit, Miss Whitelaw's plan was recorded as "recall in three months unless family make contact". The parents were reluctant to engage and it was left to them to make contact with Miss Whitelaw. The next contact was almost four month later and by was done by another Health Visitor Trainee.*

50. *The nursery then raised concerns with Miss Whitelaw and again, there was a delay in following up; this time of over two months. Miss Whitelaw should have explained the purpose of contacts when she first met the family, the role of the Health Visitor and how engagement with the health visiting service would be beneficial to the child, especially as the child had additional health needs identified. She should have worked to build a relationship with the family by allowing the parents the opportunity to get to know her and build confidence in the Health Visitor service. If the family was not engaging and/or accepting support, Miss Whitelaw should have considered engaging with other professionals including Social Services, and worked with*

relevant colleagues to engage the family and identify and manage any potential risks.

51. *By failing to fully engage with the family or escalate concerns regarding the family's non-engagement, Miss Whitelaw was not supporting Child Two to develop and grow to their maximum potential.*

52. *Two Team Around the Child meetings (TACs) were arranged by the nursery and Miss Whitelaw attended on of the meetings where reference was made to parents not being accepting of the child's needs. However, there was very little information within the electronic record regarding outcomes from the meeting, plans or contingencies to inform of the next steps.*

Charge 7 (a) – (e)

53. *Child Three's mother had mental health issues and there were also issues with substance misuse. A Police Concern Report (PCR) was not followed up and a further PCR was followed by the Family Support Worker at Miss Whitelaw's request. This was not an appropriate contact for a Family Support Worker. A Health Visitor contact was required to allow for assessment and analysis of changing family circumstances and consider full impact on the child.*

54. *There was conflicting information contained within Child Three's record. The substance misuse team had left messages asking for a Health Visitor to contact them to discuss the mother's non-engagement and the impact this may have on the child's welfare. However, there was no evidence in Child Three's record to suggest that Miss Whitelaw followed up on this. Conversely, the mother's record showed that Miss Whitelaw did telephone the mother and had a discussion with her regarding her poor engagement. However, there was no cross-reference within the child's record regarding this and nothing within the child's records to evidence that the impact this might have had on the child was considered and assessed.*

55. *Child Three's mother contacted Family Support Worker A twice within a five minute period when Family Support Worker A was visiting another family and left voice*

messages. Family Support Worker A called the officer to report this to Miss Whitelaw. On return to the office, Miss Whitelaw told Family Support Worker A that she had made contact with the mother but there was no entry in the child's record regarding this contact, therefore it looked like it did not occur. However, on the mother's record there was an entry detailing contact made by Miss Whitelaw and actions taken to support the mother. Miss Whitelaw visited the mother the following day. Miss Whitelaw had recorded this on Child Three's records as an "opportunistic" visit ad she was unable to contact the mother by telephone which was not consistent with her having spoken to the mother the previous day. However, on the mother's record there was an entry which gave further detail.

56. *There is conflicting information in the child's record which can only be clarified by reviewing the mother's records and there was no cross-reference made to the mother's record. If cross-reference had been made this would show a clear journey, without this it appears contradictory.*

57. *Further, the plan recorded in Child Three's noted indicated that the mother was not happy with having Health Visitor involvement. This should have been followed up by Miss Whitelaw, particularly as the following day, she was informed by Social Work Services that following the mother's attendance at Accident and Emergency department (A and E) which was alcohol related, A and E staff had a made a referral to Social Work Services regarding child protections concerns. There was no reference at all to this referral in the child's record; it was only evident on the mother's record. Further, Miss Whitelaw would have been expected to be liaising with the substance misuse team to discuss the impact on the child's welfare and there was no evidence within the records of a child centred approach being taken.*

58. *There was no up to date assessment contained within Child Three's notes. The most recent assessment was completed by the Health Visitor allocated to Child Three before Miss Whitelaw, when the case was allocated as a core HPI. Family circumstances had deteriorated for Child Three since that assessment. When Miss Whitelaw was allocated this case and when things began to change for that child, a new assessment should have been completed but Miss Whitelaw failed do this.*

59. *Conducting a new assessment would be the only way to identify the impact of changing circumstances and identify what was required to meet the child's need. By June 2016, Child Three's family circumstances had deteriorated yet visits were still primarily being completed by Family Support Worker A. There was generally evidence of Family Support Worker A reporting back to Miss Whitelaw following her visits but no clear evidence of Miss Whitelaw acting upon this.*

Misconduct

60. *In the case of Roylance v General Medical Council (No.2) [2001] 1 AC 311, Lord Clyde stated that:*

"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by the medical practitioner in the particular circumstances."

61. *It is agreed that the following paragraphs of The Code: Professional standards of practice and behaviour for nurses and midwives 2015 ("the Code"), effective from 31 March 2015 have been breached:*

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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*

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 *work in partnership with people to make sure you deliver care effectively*

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

To achieve this, you must:

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

4 Act in the best interests of people at all times

8 Work cooperatively

To achieve this, you must:

8.2 *maintain effective communication with colleagues*

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

8.6 *share information to identify and reduce risk,*

10 Keep clear and accurate records relevant to your practice

This includes but is not limited to patient records. It includes all records that are relevant to your scope of 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*

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

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*

11.2 *make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and*

11.3 *confirm that the outcome of any task you have delegated to someone else meets the required standard.*

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

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… and use the channels available to you in line with our guidance and your local working practices*

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 *take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

17.2 *share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information*

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*

62. *Not every breach of the Code and not every falling short in the particular circumstances will amount to misconduct. It must be serious, or as Elias LJ put it in the case of R (on the Application of Remedy UK Ltd) v GMC [2010] EWHC 1245 (Admin), "sufficiently serious… that it can properly be described as misconduct going to fitness to practise."*

63. *Ms Whitlaw accepts that the facts in all of the charges are sufficiently serious so as to amount to misconduct as these failings were a significant departure from the standards expected of a registered nurse. Miss Whitelaw's failings were serious and include her not acting appropriately in line with child safeguarding guidelines to ensure Child C was safe from harm. Health visitors play a pivotal role in the early detection of concerns. Further, an audit of her work revealed considerable errors in record keeping, conducting assessments and improper delegation. All these failings had the potential to place the children under her care, particularly Child C, at significant risk of harm.*

64. *Miss Whitelaw asserts that she was managing two caseloads and was not properly supported. However, as an experienced Health Visitor and Clinical Practice Teacher to students, she should have raised any concerns she had and by failing to do so, she fell far below the standards expected of her.*

Impairment

65. *Miss Whitelaw accepts that her fitness to practise is impaired by reason of her misconduct.*

66. *The parties have considered the questions formulated by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of CHRE v Grant & NMC [2011] EWHC 927 (Admin) ('Grant') by Cox J. They are as follows:*

> *Do our findings of fact in respect of the [practitioner's] misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practice 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. ...

67. *The parties have also considered the comments of Cox J in Grant at paragraph 101:*

    The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case.

68. *In light of the above, while there is no evidence that Miss Whitelaw's failings had caused direct harm to the children under her care, her actions and omissions had the potential to place to these children at real risk of harm and in the case of Child C, it clearly had the potential to place Child C at real risk of serious ongoing sexual abuse.*

69. *The parties agree that, due to her misconduct, Miss Whitelaw is liable in the future to put patients at unwarranted risk of harm were she to practise without any restriction.*

70. *The parties also agree that the reputation of the nursing profession would be damaged if Miss Whitelaw were to be permitted to practise unrestricted due to the seriousness of the misconduct and in particular, the potential it had to place Child C at a real risk of serious ongoing sexual abuse.*

71. *The parties agree members of the public appraised of Miss Whitelaw's conduct would also expect a finding of impairment to mark the conduct as unacceptable and*

Miss Whitelaw accepts that a finding of current impairment is necessary to declare and uphold proper standards.

72. *Miss Whitelaw is engaging with the NMC and has demonstrated some insight by way of her full acceptance of the charges and that her fitness to practise is currently impaired by reason of her misconduct. She also provided reflective pieces (**Appendix 1)** in which she expresses remorse and acknowledges her failings. Her insight is developing but has improved since the time of the allegations in question (locally she stood by her decision that not taking any action to report the allegations of sexual abuse was the correct thing to do as she genuinely believed the allegations to be untrue). The registrant's reflections appropriately acknowledge her failings, but do not address how she placed Child C at serious risk of harm nor the public interest implications arising from her misconduct.*

73. *In Cohen v GMC [2007] EWHC 581 (Admin), the court set out three matters which it described as being 'highly relevant' to the determination of the question of current impairment:*

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

74. *The three questions set out in Cohen (above) can be answered as follows:*

    1. *There have been repeated failings in her handling of safeguarding concerns involving extremely vulnerable children. The concerns in this case are serious and wide-ranging and would therefore be difficult to remediate.*

    2. *The misconduct has not yet been remedied as Miss Whitelaw has retired and has taken no steps to remedy her failings. The Trust's investigation recommended that the registrant undergo a period of retraining and mentoring however Miss Whitelaw did not do this.*

3. *At present, the concerns are highly likely to be repeated should Miss Whitelaw be permitted to practise on an unrestricted basis as there is no evidence of remediation.*

75. *For the reasons above, the parties agree that Miss Whitelaw's fitness to practise is currently impaired, both on the grounds of public protection and the wider public interest.*

Sanction

76. *The parties agree that the appropriate sanction in this case is a **striking-off order**.*

77. *In reaching this agreement, the parties considered the current edition of the NMC's Sanctions Guidance ('the Guidance'), bearing in mind that it provides guidance and not firm rules. In coming to this view, the parties have kept in mind the principle of proportionality and the principle that sanctions are not intended to be punitive. It is agreed that the proposed sanction is a proportionate one that balances protecting the public and the public interest with the Registrant's interests.*

78. *The aggravating features of the case are as follows (non-exhaustive):*

    - *No evidence of remediation.*
    - *Child C was extremely vulnerable; the child is now in foster care and requires input from service in relation to emotional and physical health.*
    - *Child C was placed at serious risk of serious harm, namely ongoing sexual abuse. Allegations of suspected sexual abuse should not been dismissed without any investigation, particularly given Miss Whitelaw's level of experience.*
    - *Due to Miss Whitelaw's failure to report or escalate, this concern around alleged sexual abuse was not explored until 18 months later.*
    - *Wide ranging failings revealing inability to handle caseload over a sustained period of time – caseload dealt with a number of vulnerable children.*

79. *The mitigating features of the case are as follows (non-exhaustive):*

- *No other concerns have been raised regarding Miss Whitelaw's practice.*
- *Miss Whitelaw has made full admissions to the charges and accepted current impairment.*
- *Miss Whitelaw provided reflective pieces (**Appendix 1)** and a positive testimonial (**Appendix 2**).*
- *Miss Whitelaw indicates that there was a lack of staffing and that she was struggling with the responsibility of handling two caseloads.*

80. *It is acknowledged that Miss Whitelaw has a previous unblemished career having qualified as a nurse in 2001 with no previous regulatory findings. However the revised Sanctions Guidance makes it clear the fact that a nurse does not have a previous fitness to practise history is not generally a relevant consideration to the decision on sanction. The NMC's guidance states as follows: "Sometimes, panels will have to make decisions on sanction in cases where the nurse or midwife's conduct is so serious that it is fundamentally incompatible with continuing to be a registered professional. If this is the case, the fact that the nurse or midwife does not have any fitness to practise history cannot change the fact that what they have done cannot sit with them remaining on our register. For these reasons, panels should bear in mind there will be usually be only extremely limited circumstances where the concept of a 'previously unblemished career' will be a relevant consideration when they are deciding which sanction is needed, or in giving their reasons."*

81. *The parties first considered whether to take no action or make a caution order. It decided that neither of these would be appropriate in view of the seriousness of the misconduct, the need to protect the public interest and the need to declare and uphold proper standards of conduct.*

82. *With regard to a Conditions of Practice Order, Miss Whitelaw has not expressed any willingness to comply with conditions or undergo training. Instead, she has stated that she is retiring from nursing. In any event, the parties agree that a Conditions of Practice Order would not be sufficient to address the serious nature of the charges*

and the wide-ranging failures in this case. Nor would it be sufficient to satisfy the significant public interest in this case. For these reasons, the parties agree that a conditions of practice order would not be appropriate or proportionate in this case.

83. *The parties went on to consider a Suspension Order. There were repeated failings and numerous errors in record-keeping, conducting assessments and improper delegation over a sustained period of time involving the care and welfare of vulnerable children. Miss Whitelaw neglected her position and her actions displayed a disregard for the children in her care and her colleagues, in that she failed to provide the relevant support.*

84. *Although Miss Whitelaw appears to be developing insight and has provided reflective statements, ultimately, the conduct in this case is fundamentally incompatible with the expectation that a reasonable member of the public would have of the standards of a registered nurse, particularly a nurse tasked with risk assessing and protecting vulnerable children in the community. The seriously aggravating feature of this case is her failure to act appropriately in line with child safeguarding guidelines to ensure Child C was safe from harm, thereby placing Child C at real risk of serious ongoing sexual abuse. The parties therefore agree that a Suspension Order would not be appropriate and proportionate in this case to protect the public and satisfy the public interest.*

85. *Miss Whitelaw's actions and omissions were significant departures from the standards expected of a registered nurse and such serious breaches of the fundamental tenets of the profession are incompatible with her remaining on the register. The parties agree that a Striking-off Order would be the most appropriate and proportionate order in this case.*

86. *The parties acknowledge the adverse impact the loss of her registration may inevitably have on Miss Whitelaw, albeit Miss Whitelaw has indicated she has retired. However, the significant public interest in her removal from the register far outweighs her interest in this matter. To allow Miss Whitelaw to remain on the register would undermine public confidence in the profession and in the NMC as a regulatory body. This order will mark the importance of maintaining public*

confidence in the profession, and will send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

87. *For reasons given above, a Striking-Off order is the only sanction that will adequately protect the public and the public interest.*

88. *Finally, given that the parties agree that there is a risk that patients would be placed at an unwarranted risk of harm and the public interest would be engaged should Miss Whitelaw be permitted to practise without any restrictions, the parties agree that an interim order is necessary in this case.*

89. *It is agreed that the likelihood of Miss Whitelaw appealing this determination is remote, given it has been reached by agreement. Furthermore, the public would not expect a nurse who had admitted the conduct which is the subject of these charges to frustrate the process by appealing the order.*

90. *For these reasons, the parties agree that an Interim Suspension Order is necessary on the grounds of public protection and otherwise in the public interest. In the event no appeal is made, the interim order will fall away once the 28-day appeal period has elapsed, and the substantive order will take effect.*

91. *The parties understand that this provisional agreement cannot bind a panel and that the final decision on findings of fact, impairment and sanction is a matter for the panel. The parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts (set out above) may be placed before a differently constituted panel that is determining the allegation.*

Here ends the provision agreement between Miss Whitelaw and the NMC.

Decision and reasons on the Consensual Panel Determination:

The panel considered and decided to accept the CPD agreement. The panel was aware that Miss Whitelaw had accepted the CPD agreement and made full admissions to the charges. Further, the panel was mindful that this did not bind the panel, and it was still required to make its own determinations on the issues of facts, impairment and sanction.

The panel accepted the legal assessor's advice. He referred the panel to the NMC Sanctions Guidance (SG) and to the NMC's guidance on Consensual Panel Determinations. He reminded the panel that it could only accept or reject the provisional agreement reached between Miss Whitelaw and the NMC, they had no power to amend it other than by the agreement of the parties. Further, the panel should consider whether the provisional agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the profession and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel noted that Miss Whitelaw admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of Miss Whitelaw's admissions as set out in the signed provisional agreement before the panel.

The panel then went on to consider whether Miss Whitelaw's fitness to practise is currently impaired. Whilst acknowledging the agreement between Miss Whitelaw and the NMC, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of misconduct, the panel determined that the allegations and Miss Whitelaw's failings as a registered nurse were serious and included her not acting appropriately in line with child safeguarding guidelines to ensure that vulnerable children were safe from harm. The panel considered that Miss Whitelaw had not carried out the prerequisite visits as required, and that an audit of her work revealed considerable errors in record keeping, conducting assessments and improper delegation.

Further, the panel noted that there were a number of substantial failings in regards to Miss Whitelaw's conduct, namely, in that all her failings had the potential to place a number of vulnerable children under her duty of care at a significant risk of harm. In this respect, the panel endorsed paragraphs 60 to 64 of the provisional agreement.

The panel then considered whether Miss Whitelaw's fitness to practise is currently impaired by reason of her misconduct. Whilst there is no evidence that Miss Whitelaw's failings had caused direct harm to the children under her duty of care, the panel considered that her actions and omissions had the clear potential to place these children at a real risk of harm. The panel acknowledged that reputation of the nursing profession would be severely damaged if Miss Whitelaw were to be permitted to practice unrestricted due to the seriousness of her misconduct, and, in particular, the potential of placing vulnerable people at a real risk of serious harm.

Whilst Miss Whitelaw is engaging with the NMC and its proceedings and has demonstrated some insight by way of her full acceptance of the charges, the panel considered that Miss Whitelaw has not sufficiently addressed all the charges, has not demonstrated any evidence of remediation and therefore lacks sufficient insight into her failings. In this respect the panel endorsed paragraphs 65 to 75 of the provisional agreement.

The panel also considered the aggravating and mitigating factors as agreed by both Miss Whitelaw and the NMC.

The panel noted that Miss Whitelaw has now retired and does not wish to continue or return to practice as a registered nurse.

Having found Miss Whitelaw'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.

Decision and reasons on sanction

Taking into account all of the information before it, including the CPD agreement, the panel decided to make a striking-off order. The panel directs the registrar to strike Miss Whitelaw off the NMC register. The effect of this order is that the NMC register will show that Miss Whitelaw has been struck-off the register.

The panel accepted the advice of the legal assessor.

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 Sanctions Guidance ('SG') published by the NMC and considered the aggravating and mitigating factors. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

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

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Whitelaw's misconduct was not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice on Miss Whitelaw'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 is of the view that there are no practical or workable conditions that could be formulated, given the wide ranging nature of the proven facts. The serious misconduct identified in this case is not something that can be addressed through retraining.

In addition, the panel noted there was a lack of insight and remediation as well as no evidence before it, to suggest that Miss Whitelaw continues to work as a registered nurse. Accordingly, the panel concluded that placing conditions on Miss Whitelaw's registration would not adequately address the seriousness of this case, and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The panel noted the mitigating factors which include Miss Whitelaw's assertion that there was a lack of staffing and that she was struggling with the responsibility of handling two caseloads. The panel also noted Miss Whitelaw's full admissions as to the facts.

The panel also noted the aggravating factors, which include the lack of insight and remediation demonstrated by Miss Whitelaw, raising the issue of potential repetition and the potential serious harm being caused to vulnerable children.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse.

Balancing all of these factors, the panel has determined that a suspension order would not be an appropriate or proportionate sanction, given that it relates to very vulnerable children and their families.

Finally, in considering a striking-off order, the panel took note of the SG.

Miss Whitelaw's actions were a serious breach of the fundamental tenets of the nursing profession which were significant departures from the standards expected of a

registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that her actions were so serious that to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

In view of all of these factors and after taking into account all the evidence before it, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Miss Whitelaw's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was 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.

Decision and reasons on interim order

The panel determined that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension 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. To do otherwise would be incompatible with its earlier findings.

The period of this interim order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by the striking-off order 28 days after Miss Whitelaw is sent the decision of this meeting in writing.

That concludes this meeting.

This determination will be confirmed to Miss Whitelaw in writing.