Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
24 – 27 February 2020
Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Sarah Alexandra Noelle Brewer
NMC PIN:	70G0746E
Part(s) of the register:	Registered Nurse – Sub part 1 and Sub part 2 RN3: Mental Health – 23 October 1998 RN4: Mental Health – 31 July 1970
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Tim Skelton (Chair, Lay member) Catherine Lamb (Registrant member) James Hurden (Lay member)
Legal Assessor:	James Holdsworth
Panel Secretary:	Rob James
Registrant:	Mrs Brewer not in attendance nor represented
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Facts proved:	1, 2, 3, 4b, 5
Facts not proved:	4a, 4c
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim Order:	Interim suspension order (18 months)

Details of charge:

That you, a registered nurse, on the night shift of 5-6 July 2018:

1. Slept on duty;

2. Removed or arranged to have removed pressure mats from one or more residents' rooms and/or failed to return such mats to their rooms;

3. Moved or arranged to have moved alarm bells from residents’ reach and/or failed to return the alarm bells to within their reach;

4. Recorded incorrectly-timed entries in the following documentation for one or more residents:
    a. observation charts;

    b. fluid balance charts;

    c. position charts;

5. Your actions at charge 4 above were dishonest in that you were seeking to represent you had carried out the recorded action when you knew you had not done so.

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

Decision on Service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Brewer was not in attendance and that written notice of this hearing had been sent to Mrs Brewer's registered address by recorded delivery and by first class post on 24 January 2020.

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

Mr Edwards submitted the NMC had complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules").

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mrs Brewer 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.

Decision on proceeding in the absence of the Registrant

The panel next considered whether it should proceed in the absence of Mrs Brewer. The panel had regard to Rule 21 (2) which states:

> (2) Where the registrant fails to attend and is not represented at the hearing, the
> Committee—

(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;

(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or

(c) may adjourn the hearing and issue directions.

Mr Edwards invited the panel to continue in the absence of Mrs Brewer. He referred the panel to a bundle of documents which evidenced various attempts made by the NMC to contact Mrs Brewer by post, phone and email which had been unsuccessful. Mr Edwards confirmed that the Case Officer had tried to call Mrs Brewer on 21 February 2020 but had only managed to get through to her voicemail. He also explained that a trace, to confirm her address, had taken place which included a check via the land registry and electoral roll.

Mr Edwards submitted that this was a serious case and that there was a public interest in proceeding. He further submitted that there were two witnesses that were due to give evidence and that the NMC had made several attempts to get in touch with Mrs Brewer over the last few months.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised "with the utmost care and caution" as referred to in the case of R. v Jones (Anthony William), (No.2) [2002] UKHL 5. The panel further noted the case of R (on the application of Raheem) v Nursing and Midwifery Council [2010] EWHC 2549 (Admin) and the ruling of Mr Justice Holman that:

“...reference by committees or tribunals such as this, or indeed judges, to exercising the discretion to proceed in the person's absence "with the utmost caution" is much more than mere lip service to a phrase used by Lord Bingham of Cornhill. If it is the law that in this sort of situation a committee or tribunal should exercise its discretion "with the utmost care and caution", it is extremely important that the committee or tribunal in question demonstrates by its language (even though, of course, it need not use those precise words) that it appreciates that the discretion which it is exercising is one that requires to be exercised with that degree of care and caution.”

The panel has decided to proceed in the absence of Mrs Brewer. In reaching this decision, the panel has considered the submissions of the case presenter, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *Jones.* It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- no application for an adjournment has been made by Mrs Brewer;
- Mrs Brewer has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- Mrs Brewer has not provided the NMC with details of how she may be contacted other than her registered address;
- there is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness has attended today to give live evidence, another is due to attend via video link tomorrow;
- not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- the charges relate to events that occurred in 2018;
- further delay may have an adverse effect on the ability of witnesses accurately to recall events;

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

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

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

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Mr Edwards, on behalf of the NMC.

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

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 the facts will be proved if the panel was satisfied that it was more likely than not that the incidents occurred as alleged.

Background

Concerns were raised relating to Mrs Brewer's practice when she was working as a Registered Nurse at St Luke's Nursing Home ("the Home"). The concerns were raised by a whistle-blower and led to an unannounced visit to the Home by the Managing Director of the Home, Mr 2, Mrs 1, Deputy Home Manager, and Ms 3, the Home Manager. Mrs Brewer was working on the night shift when the visit took place on 5/6 July 2018 at around 01:20hrs.

When Mrs 1 and Mr 2 and Ms 3 arrived at the Home, it is said that they found observation charts had been completed to state that observations had taken place at 02:00hrs despite it only being 01:20hrs. Having checked rooms 1-5 as a team, they then allocated the remaining rooms and each of the team members checked a number of rooms individually. Mrs 1 and Mr 2 went on to check more rooms in relation to this and found more observation charts with similar recordings.

Mr 2 took pictures of a clock next to some of the incorrectly documented charts. Mrs 1 did not take any pictures but entered resident's rooms to check on their welfare. When checking on patients, she noticed that alarm call bells had been placed a distance away from residents when they should have been within their reach. Both Mr 2 and Mrs 1 noted that several pressure mats, which ought to have been placed beside particularly vulnerable resident's beds, had been removed from their rooms and placed in the corridor with bedroom doors closed. These pressure mats are part of an alarm system to alert staff of a resident's potential fall risk.

Having completed the room inspections, Mrs 1, Mr 2 and Ms 3 met in the lounge of the Home. It was there that they are said to have found Mrs Brewer asleep in a dimly lit room in a reclining chair. It is said that Mrs Brewer was snoring, covered in a blanket, wearing slippers and (PRIVATE). Two Care Assistants were sat behind Mrs Brewer

observing her. Mrs 1, Mr 2 and Ms 3 observed Mrs Brewer for around ten minutes before was she awoken by a cough by Ms 3. When awoken, Mrs Brewer stated that she had been "resting" rather than sleeping.

Mrs Brewer was instantly dismissed and handed the keys of the Home back, having not contested what had happened.

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

The panel heard oral evidence from two witnesses tendered on behalf of the NMC.

Witnesses called on behalf of the NMC were:

- Mrs 1 – Deputy Manager of the Home
- Mr 2 – Managing Director of the Home

The panel first considered the overall credibility and reliability of the witnesses it had heard from.

The panel found Mrs 1 to be very clear in her evidence and considered that it was consistent with her written statement. It had regard to the fact that she did not take pictures when she entered the Home with Mr 2 and Ms 3 as she was concerned for the wellbeing of the residents. The panel was of the view that Mrs 1 did not embellish on her evidence at all and assisted the panel in understanding the culture that was ongoing at the Home.

The panel considered Mr 2's evidence to be helpful although it took account of inconsistencies in his evidence such as his confirmation of Mrs Brewer's handwriting followed by a later admission that he had not seen a great deal of her handwriting previously. The panel was, however, of the view that Mr 2 was not trying to mislead the panel with these comments.

Application to hear evidence via video link

Mr Edwards made an application to hear the evidence of Mr 2 via video link. He informed the panel that it had not been the NMC's intention for Mr 2 to give evidence via video link. However, there had been some difficulties with listing the case and Mr 2 had professional commitments that meant that he could not attend in person on the date as planned. Mr Edwards submitted that there would be no prejudice to Mrs Brewer and stated that she had been asked, in an email one week prior to the hearing, if she had any objections to Mr 2 attending via video link and had not responded. Mr Edwards submitted that the panel would be able to assess the demeanour of Mr 2 on video link.

The panel accepted the advice of the legal assessor.

Having regard to the Mr 2's difficulties in attending in person and the fact that there would be no prejudice to Mrs Brewer in this arrangement, the panel agreed to the application.

The panel considered each charge and made the following findings:

Charge 1:

Slept on duty

This charge is found proved.

The panel had regard to the fact that Mrs 1, Mr 2 and Ms 3 had been alerted to the situation at the Home and undertook an unannounced visit at 01:20am on 5/6 July 2018. Mrs 1 described Mrs Brewer as being "fast asleep in one of the reclining chairs" and noted that she had her shoes off with a blanket wrapped around her and was snoring. She also noticed that Mrs Brewer had slippers on and (PRIVATE).

Mr 2 also confirmed that Mrs Brewer was lying on a reclining chair fast asleep.

The panel also noted Mrs 1's evidence that she, Mr 2 and Ms 3 had observed Mrs Brewer while she was asleep for ten minutes before she was awoken by a cough from Ms 3. In their oral evidence, both Mr 2 and Mrs 1 described Mrs Brewer as being "*startled*" when she was awoken. The panel accepted the evidence of Mrs 1 and Mr 2.

The panel was of the view that the evidence heard from Mrs 1 and Mr 2 during the hearing was consistent with what they had recorded in their witness statements. Further, it noted that Mrs Brewer had taken several pre-mediated steps prior to going to sleep such as (PRIVATE), putting her slippers on, wrapping herself in a blanket and dimming the lights. These did not appear to be the actions of a lady resting her eyes but those of someone who had pre-planned sleep during her shift.

The panel therefore found the charge proved.

When considering charges 2, 3 and 4, the panel was mindful of the fact that Mrs Brewer had clearly pre-planned an uninterrupted period of sleep.

Charge 2:

Removed or arranged to have removed pressure mats from one or more residents' rooms and/or failed to return such mats to their rooms;

This charge is found proved.

The panel noted that the charge was split into two parts. It therefore determined to assess the two sections of the charge separately.

The panel had regard to the evidence of Mrs 1. She had told the panel that when she finished her shift at 16:00hrs, the pressure mats were not outside the residents rooms.

The panel had regard to the fact that Mrs Brewer had prepared herself to sleep and it appeared that she did not wish to be disturbed. It noted that she had taken several pre-meditated actions before going to sleep such as dimming the lights and removing her shoes (PRIVATE). The panel concluded that, although there was no direct evidence of Mrs Brewer removing the pressure mats, it was more likely than not that Mrs Brewer had moved or arranged to have moved the pressure mats as part of her preparation for sleep, to prevent the alarm from disturbing her.

Moreover, the panel was of the view that Mrs Brewer had a responsibility to ensure that the mats were in the correct place next to resident's beds and not outside their rooms. Both Mrs 1 and Mr 2 told the panel, in their oral evidence, that the nurse in charge was responsible for the correct use of pressure mats.

On the balance of probability, the panel determined that Mrs Brewer either removed or arranged for the pressure mats to be removed from resident's rooms.

In its consideration of the second part of the charge, the panel recognised that Mrs Brewer had a duty, as the nurse in charge, to return the pressure mats to the resident's rooms if she saw them out of place.

The panel took account of Mrs 1's evidence, in her witness statement, she stated that there were five or six residents who had required pressure mats at this time and specifically identified the residents in rooms eight and nine as two examples of those that were at high risk of falls.

The panel therefore found the charge proved in its entirety.

Charge 3

Moved or arranged to have moved alarm bells from residents' reach and/or failed to return the alarm bells to within their reach;

This charge is found proved.

The panel again noted the charge was split into two parts and determined to consider each part separately.

The panel had regard to the evidence of Mr 2 that he did not enter the resident's rooms and that it was Mrs 1 who had noticed the alarm bells were out of the residents' reach. Mrs 1 had stated that she did not take any photographs of what had happened as she was concerned for the wellbeing of the residents and that, when checking on them, she had noticed the alarm bells were out of reach of the residents. Mrs 1 was very descriptive in what she found stating that, in one case, the alarm bell was wrapped to the wall and was out of the reach of the resident.

The panel again considered the actions that Mrs Brewer had taken before going to sleep. It noted Mrs 1's clear evidence and took the view that Mrs Brewer had moved the alarm bells as part of her pre-sleeping preparations.

In considering the second part of the charge, the panel considered that Mrs Brewer had a duty in ensuring that the residents in her care were able to reach the alarm bells in order to inform staff that they were in need of assistance. They were unable to do this.

The panel therefore found the charge proved in its entirety.

Charge 4

Recorded incorrectly-timed entries in the following documentation for one or more residents:

a. observation charts;

b. fluid balance charts;

c. position charts;

This charge is found proved in relation to charge 4b and not proved in relation to charges 4a and 4c.

In considering these charges, the panel took account of the evidence of Mr 2. In his witness statement he said:

> *"I observed the charts for the first resident in room 1. I was shocked to find that the observations had been recorded as being carried out at 2am, despite it being approximately 1:20.*
>
> *I then preceded to check the charts on the doors for rooms 2, 3, 4 and 5. I then took the chart off the door of room 4 and decided to take a picture on my mobile phone of it against the radio controlled clock located in the foyer. I took a further picture of the chart at room 2…The observations had been recorded as being taken at 2:00am when the clock on the wall showed the time as 1:28am. The registrant could have taken these at any point from the commencement of her shift until the point at which I entered the Home."*

In their evidence, both Mrs 1 and Mr 2 confirmed that observations should never be recorded in advance of them being taken.

In her evidence, Mrs 1 confirmed that she was very familiar with Mrs Brewer's handwriting having had to "*decipher*" it before. She also informed the panel that Mrs Brewer used her own pen to make the notes and had a particular style of handwriting.

The panel noted that Mrs 1 had not photographed any of the charts as she had been more concerned for the wellbeing of the residents, consistent with her own responsibilities as a Registered Nurse. Mrs 1, in her oral evidence, identified examples of Mrs Brewer's handwriting from the evidential bundle.

The panel had regard to the exhibit bundle which included several examples of the fluid balance charts being documented prior to 02:00hrs as stated. In particular, it noted the fluid balance charts for rooms 2 and 4 which were photographed with the radio controlled clock prior to 02:00hrs as recorded. The panel accepted the evidence of Mrs 1 that these entries were in Mrs Brewer's handwriting.

The panel noted the evidence that Mrs Brewer had documented observations in relation to the fluid balance charts in advance. However, there was no documentary evidence presented to the panel of incorrect timed entries in relation to the observation or position charts. Due to this lack of evidence, the panel found charges 4a and 4c not proved. However, it found charge 4b proved.

Charge 5

Your actions at charge 4 above were dishonest in that you were seeking to represent you had carried out the recorded action when you knew you had not done so.

This charge is found proved.

The panel accepted the advice of the legal assessor who, in addressing the panel in relation to the issue of dishonesty, referred to the case of Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67:

> *"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often*

in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards dishonest".

The panel noted that, following its findings in relation charge 4, this charge could only be considered in relation to charge 4b.

The panel took account of the fact that Mrs Brewer had prepared herself to go to sleep. She had situated herself in a reclining chair in a dimly lit room and had covered herself in a blanket having (PRIVATE). The panel had also taken a view that she had facilitated the removal of the pressure mats from the relevant resident's rooms and taken steps to ensure that their alarm bells were out of reach of the residents. The panel had no doubt that, in completing the observation charts in advance, Mrs Brewer understood entirely that she was acting incorrectly; as she was misrepresenting that she had carried out these important observations at the times listed on the assessment sheet, when in fact she knew she would be asleep.

The panel also considered the view of a reasonable person having had regard to Mrs Brewer's actions and took the view that they would see her actions as clear acts of dishonesty.

Mrs Brewer's actions related to several patients and were undertaken to ensure that she was not disturbed while she slept.

The panel therefore found the charge proved.

Submission on misconduct and impairment:

Having announced its finding on all of the facts, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Brewer's fitness to practise is currently impaired. There is no statutory definition of fitness to practise, however, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

In his submissions Mr Edwards invited the panel to take the view that Mrs Brewer's actions amount to a breach of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code"). He then directed the panel to specific paragraphs and identified where, in the NMC's view, Mrs Brewer's actions amounted to misconduct.

Mr Edwards referred the panel 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.'

Mr Edwards submitted that Mrs Brewer's sleeping whilst on duty was very serious, particularly so when, as the witnesses explained, she should have been awake for the whole shift. This is defined in her job description. Further, he outlined the panel's finding that Mrs Brewer had taken extra steps to ensure that she was not interrupted by removing residents' alarms. Mr Edwards told the panel that colleagues on shift with Mrs Brewer would not know if residents at the Home needed assistance or had come to harm. This was compounded by the fact that the residents' doors were shut.

Mr Edwards further submitted that the inaccurate completion of the fluid balance charts was done with the intention of demonstrating that she had done observations when she had not. These actions, he submitted, put herself first ahead of those in her care. Mr Edwards submitted that honesty and integrity are most important for a Registered Nurse and that the public would consider Mrs Brewer's actions to be deplorable.

He then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Mr Edwards referred the panel to the cases of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).

Mr Edwards submitted that there is no evidence before the panel that suggests that Mrs Brewer has taken any steps to remediate or address the charges that she has faced. Further, he submitted, she has failed to engage with the NMC and has demonstrated no insight or remorse. Mr Edwards submitted that, given the findings of dishonesty, there are clearly attitudinal issues that Mrs Brewer needs to address and that it was “sheer luck” that nothing happened to the residents at the Home. Mr Edwards submitted that to not make a finding of impairment in this case would undermine the NMC as the regulator.

The panel has accepted the advice of the legal assessor which included reference to a number of judgments which are relevant.

The panel adopted a two-stage process in its consideration, as advised. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Brewer’s fitness to practise is currently impaired as a result of that misconduct.

Decision on misconduct

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of the Code.

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that Mrs Brewer's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code. Specifically as captured in the four headings of the Code as follows:

> ***Prioritise People***
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> *You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.*
>
> ***Practise Effectively***
>
> *You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.*

In particular:

10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

Preserve Safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

Promote Professionalism and Trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Brewer's actions which included sleeping while at work, allowing pressure pads to be placed outside residents' rooms, disabling residents' ability to contact staff and falsifying fluid balance charts put several vulnerable patients at a serious risk of harm. Her actions would be considered

deplorable by both her nursing colleagues and the general public. The panel was of the view that Mrs Brewer's actions demonstrated premediated conduct which displayed attitudinal problems coupled with a lack of integrity. She put her own interests first ignoring the safety of the residents in her care. Further, Mrs Brewer falsified information in a dishonest manner in order to mislead her colleagues. This action could also have put residents at risk of harm as incorrect clinical information may have resulted in inaccurate clinical decision making.

The panel found that Mrs Brewer's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the panel considered the judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) in reaching its decision, in paragraph 74 she said:

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

Mrs Justice Cox went on to say in Paragraph 76:

> I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for

panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

> Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
>
> a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
>
> b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
>
> c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
>
> d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.

The panel found that Mrs Brewer's actions engaged all four parts of the Grant judgment in that she put the patients in her care at risk of harm and in doing so brought the nursing profession into disrepute. Further, Mrs Brewer breached fundamental tenets of the nursing profession namely those relating to integrity, trust and dishonesty.

Regarding insight, the panel noted that, on the night in question, Mrs Brewer understood that she could be dismissed from her role for sleeping while on duty. The panel had regard to Mr 2's comments that Mrs Brewer asked him if she had "*lost her job*" before handing over the keys and leaving the Home. Since the incident, Mrs Brewer has provided no evidence of remorse or insight regarding her actions. Furthermore,

there is no evidence to suggest that Mrs Brewer has reflected on how her actions put her residents at serious risk of harm, let down her colleagues and damaged the reputation of the profession.

In addition, the panel had not been provided with a reflective account of how Mrs Brewer's misconduct and dishonesty impacted on her colleagues, the residents in her care, the profession and the wider public.

The panel took the view that the only aspect of Mrs Brewer's misconduct which could be deemed to be remediable were the inaccuracies in record keeping. However, these inaccuracies were deliberately undertaken to mislead colleagues.

In the round, all of Mrs Brewer's failings were rooted in serious attitudinal failings which would be difficult to remediate.

The panel is of the view that there is a risk of repetition based on the lack of insight, remediation and remorse. It took the view that that Mrs Brewer's actions were very serious, included dishonesty and put vulnerable patients at risk of harm. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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, in this case, a finding of impairment on public interest grounds was also required. It was of the view that a member of the public would be horrified by Mrs Brewer's actions and would be concerned if a finding of impairment was not made.

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

Determination on sanction:

The panel has considered this case carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Brewer off the register. The effect of this order is that the NMC register will show that Mrs Brewer has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case. 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. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

Mr Edwards informed the panel that the sanction bid for this case was that of a striking off order. He submitted what the NMC perceived to be the aggravating and mitigating factors of the case and stated that there is evidence of deep seated attitudinal issues and, for that reason, temporary removal from the register would not be sufficient.

The panel considered the following to be aggravating factors in the case:

- Mrs Brewer's pre-meditated actions presented a serious risk of harm to the very vulnerable patients in her care;
- Mrs Brewer's actions included an act of dishonesty;
- Mrs Brewer has demonstrated no evidence of remorse, insight or remediation.

The panel considered the following to be mitigating factors in the case:

- Mrs Brewer's misconduct took place over one shift.

The panel had regard to the NMC guidance entitled “Considering sanctions for serious cases” and especially the section relating to cases involving dishonesty. The panel acknowledged that there was a spectrum of dishonesty and determined that this case fell at the higher end of the spectrum and included the following factors:

- vulnerable victims
- direct risk to patients
- premeditated, systematic … deception

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

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 Mrs Brewer’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 Mrs Brewer’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.

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 substantive nature of the misconduct identified in this case was not something that can be addressed through

retraining. Further, it took into account Mrs Brewer's lack of engagement with the NMC and noted it therefore had no information that could assist it in reaching a conclusion that Mrs Brewer would engage with any conditions that were put in place.

The panel concluded that the placing of conditions on Mrs Brewer'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 SG indicates that a suspension order would be appropriate where (but not limited to):

- 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 Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour

The panel had regard to the fact that, although, Mrs Brewer's actions had taken place over one shift, it was serious misconduct characteristic of a deep seated attitudinal problem which involved pre-meditated action that could have led to serious harm to the residents in her care. The panel noted that it had no information to suggest that Mrs Brewer had continued to work in the healthcare sector following her dismissal from the Home. Further, it was the panel's view that Mrs Brewer had demonstrated no insight into her actions.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Brewer's actions is fundamentally incompatible with her remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in considering a striking-off order, the panel took note of the following guidance from the SG:

- Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?
- Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?
- Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?

Mrs Brewer's actions 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 misconduct was serious and to allow her to continue practising, especially in the light of the lack of engagement with the NMC, insight and any evidence of any attempts to remediate, would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel was of the view that Mrs Brewer's behaviour demonstrated deep seated attitudinal issues which showed a lack of care for the residents at the Home putting them at serious risk of harm and also involved an attempt to deceive her colleagues. Further, Mrs Brewer's behaviour showed disregard to the fundamental tenets of nursing including integrity, trust and dishonesty.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the

effect of Mrs Brewer’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 order 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.

Determination on Interim Order

The panel has considered the submissions made by Mr Edwards 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 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 Mrs Brewer is sent the decision of this hearing in writing.

That concludes this determination.