Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

3 – 10 February 2020

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

Name of registrant:	Andrew Thomas Johnson
NMC PIN:	12D0047E
Part(s) of the register:	Adult nurse (23 November 2012)
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Michael Murphy (Chair, Registrant member) Helen Eatherton (Registrant member) Gregory Hammond (Lay member)
Legal Assessor:	John Donnelly
Panel Secretary:	Kelly O'Brien Sam Headley (7 February 2020)
Registrant:	Present and represented by Ray Short, UNISON
Nursing and Midwifery Council:	Represented by Siobhan Caslin, Case Presenter, Counsel instructed by the NMC
Facts proved:	**1a), 1b), 1c), 1d), 2a), 2b), 2c), 2d), 2e), 3b)ii) 3c)iii)**
Facts proved by admission:	**3c)i), 3c)ii)**
Facts not proved:	**3a), 3b)i)**
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**

Interim order: **Suspension order (18 months)**

Details of charge

That you, a registered nurse, employed by Mid Essex Services Hospital Trust:

1. On 9 January 2018 provided inadequate care to Patient A in that you:
   a) Did not recognise neutropenic sepsis as a potential reason for her high temperature
   b) Did not advise her to attend the A & E department immediately when she reported a high temperature
   c) Did not escalate the situation to an appropriate senior member of staff
   d) Did not mark her file to be followed up

2. On 2 March 2018 provided inadequate care for patient B in that you:
   a) Did not take sufficient details of his medical history
   b) Did not take sufficient details regarding his current symptoms
   c) Did not advise him of the dose of codeine required
   d) Did not follow up the referral to the GP with the GP
   e) Did not put a follow up plan in place

3. Between 1 January 2017 and 2 March 2018 Failed to keep adequate records in that:
   a) You recorded notes that were illegible
   b) In relation to Patient A:
      i. You did not document your telephone consultation with her
      ii. You did not record Patient A's responses to advice
   c) In relation to Patient B:
      i. You did not complete a new triage form for Patient B
      ii. You did not record his medical history on the form
      iii. You did not record details of his symptoms

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

Decision and reasons on application under Rule 19

At the outset of the hearing Ms Caslin made a request that parts of the hearing of your case be held in private on the basis that proper exploration of your case may involve reference to your health. The application was made pursuant to Rule 19 of the Rules.

Mr Short indicated that he supported the application to the extent that any reference to your health should be heard in private.

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

Rule 19 states

> 19.—(1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.
>
> (2) Subject to paragraph (2A), a hearing before the Fitness to Practise Committee which relates solely to an allegation concerning the registrant's physical or mental health must be conducted in private.
>
> (2A) All or part of the hearing referred to in paragraph (2) may be held in public where the Fitness to Practise Committee—
>
> (a) having given the parties, and any third party whom the Committee considers it appropriate to hear, an opportunity to make representations; and
>
> (b) having obtained the advice of the legal assessor, is satisfied that the public interest or the interests of any third party outweigh the need to protect the privacy or confidentiality of the registrant.

(3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied—

(a) having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and

(b) having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.

(4) In this rule, “in private” means conducted in the presence of every party and any person representing a party, but otherwise excluding the public.

Having heard that there may be reference to your health, the panel determined to hold such parts of the hearing in private. The panel determined to rule on whether or not to go into private session in connection with your health as and when such issues are raised.

Background

The charges arose whilst you were employed as a Registered Nurse by Mid Essex Services Hospital Trust (the Trust). You were employed as a Band 6 chemotherapy nurse and worked on the Chemotherapy Day Unit (the Unit), at Broomfield Hospital (the Hospital).

The Trust raised concerns regarding your clinical practice. It is alleged that you were involved in two serious incidents with chemotherapy patients. The Trust has stated that as a result of your omissions in these incidents, were it not for the timely intervention of other senior nursing staff, these failings could have resulted in serious patient harm or death.

In January 2018 you were working in the capacity of a Band 6 Chemotherapy Practitioner. It is alleged that you took a telephone triage of Patient A who was receiving chemotherapy and known to be at risk of myelosuppression. Patient A reported a high temperature of 39.8C, which is a symptom of suspected neutropenic sepsis. It is alleged that you advised the patient to take oral antibiotics, but you did not advise that patient to attend the Accident and Emergency Department (A & E), nor did you seek senior advice or mark her file to be followed up. A Senior Sister overheard a conversation about the patient after the event and requested further information and intervened. It is alleged that the patient then attended A & E. This forms the basis of charge 1.

In March 2018, while you were working in the capacity of a Band 6 Chemotherapy Practitioner, you took a telephone triage of a patient receiving chemotherapy. It is alleged that the patient reported having diarrhoea, which is a known side effect of chemotherapy. It is alleged that you did not take sufficient details of the patient's medical history or their symptoms, and advised the patient to contact their own GP to request a prescription for Codeine Phosphate. It is also alleged that you did not contact the patient's GP yourself. The patient was left to contact their GP themselves which potentially could have resulted in the patient receiving an

inadequate dose for the diarrhoea. The usual practice is for a patient to be followed up; you filed the patient's records away instead of placing the file in the follow up box. It is alleged that the triage documentation was not found for a further five days, which resulted in the patient receiving no follow up call. This forms the basis of charge 2.

It is also alleged that between 1 January 2017 and 2 March 2018 you failed to keep legible or adequate records. This forms the basis of charge 3.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Caslin, on behalf of the NMC, and those made by Mr Short on your behalf.

Ms Caslin submitted that the three NMC witnesses gave clear and consistent evidence to the panel, and invited the panel to find them to be credible and reliable witnesses. Ms Caslin submitted that, by contrast, your evidence was so inconsistent and incredible that she invited the panel to find it unreliable.

Ms Caslin submitted that there is overwhelming documentary and oral evidence that suggests the facts as set out in the charges are found proved.

In relation to charge 1, Ms Caslin submitted that there is evidence that you provided inadequate care to Patient A. She submitted that a temperature of 39.8 degrees is a medical emergency and a life or death situation. She submitted that had Ms 2 not intervened on 9 January 2018 the consequences for Patient A could have been fatal. Ms Caslin submitted that it is the NMC's case that you did not recognise the risk of neutropenic sepsis and that is why you did not tell the patient to attend A & E immediately.

Ms Caslin submitted that the panel had two conflicting accounts, between you and Ms 2, as to what happened towards the end of the shift. She invited the panel to prefer the account of Ms 2, and for the panel to accept that Ms 2 insisted you call Patient A back and tell them to attend A & E. Ms Caslin submitted that your various different accounts of events were not plausible.

In relation to charge 2, Ms Caslin submitted that the panel had conflicting accounts between you and Mr 3 as to what happened. You told the panel that you were instructed by Mr 3 to file the notes as the case did not need to be followed up, and he refutes this. Ms Caslin submitted that you have accepted that you did not start a new triage form or record the dose of the codeine the patient should take. Ms Caslin said that it was Ms 1 and Ms 2's evidence that the dose required for Patient B was unusual and would not be something a GP would be familiar with, and therefore they would expect you to follow this up with the GP directly.

Ms Caslin submitted that your varying accounts in relation to charge 2 are not credible or plausible, and invited the panel to find the entirety of charge 2 proved.

In relation to charge 3, Ms Caslin submitted that the panel had a number of your record entries in documentary evidence before it. She invited the panel to consider the notes and whether it considers them legible.

Mr Short commended your written statements and invited the panel to consider your positive testimonials. He submitted that the common element of your evidence is the refusal of the patients to accept the advice to attend A & E. Mr Short submitted that you took care to make sure the patients received treatment despite this. He submitted that you feel great sympathy and empathy for all your patients.

Mr Short submitted that you feel great remorse for the outcomes in each of these cases.

Mr Short submitted that it does seem that charges 1 and 2 are the main charges relating to the incidents, and charge 3 is somewhat of a catch all or safety net charge.

The panel heard and accepted the advice of the legal assessor which included reference to; *Suddock v NMC 2015 EWHC 3612 (Admin), Lavis v Nursing & Midwifery Council (2014) EWHC 4083 (Admin), Wisson v HPC [2013] EWHC 1036 (Admin)*, *R v Lucas (Ruth) [1981] QB 720.*

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.

The panel heard oral evidence from three witnesses called on behalf of the NMC:

Ms 1– *Oncology Clinical Nurse Specialist / Lead Nurse Chemotherapy at the Hospital*;
Ms 2 – *Senior Sister at the Chemotherapy Day Unit at the Hospital*;
Mr 3 – *Macmillan Lead Nurse, Cancer and Palliative Care at the Hospital*;

The panel also heard evidence from you under oath.

The panel found Ms 1 to be a credible and reliable witness. The panel found that Ms 1 presented as a highly knowledgeable and experienced professional with a patient focused approach. Her evidence was clear, and her written and oral evidence was consistent. The panel noted one minor inconsistency in her oral evidence but attributed this to the passage of time. The panel noted that Ms 1 stated when she could not recall events. The panel found that Ms 1 was fair to you, and appeared balanced in her evidence. The panel noted that although Ms 1 was an indirect witness to some of the events, she evidently runs the department well and therefore still had a good knowledge of the events. The panel considered that Ms 1’s evidence was compelling. The panel

was greatly assisted by Ms 1's helpful contextual information, particularly regarding what should have happened.

The panel found Ms 2 to be a credible and reliable witness. The panel found that her oral and written evidence was consistent. It noted minor inconsistencies within her oral evidence but these were not of sufficient magnitude to undermine her evidence. Ms 2 was clear when she could not recall events, and admitted to having a vague recollection of some of the details. The panel found that Ms 2 came across as a passionate and patient focused nurse. She presented a very detailed account of what should have happened. The panel considered that Ms 2 appeared fair and balanced in her evidence and did not appear to bear you any personal animosity.

The panel found Mr 3 to be a credible and reliable witness. Mr 3 presented as highly professional and experienced. The panel considered that Mr 3's written evidence contained a lot of hearsay. However, Mr 3 provided helpful contextual evidence. Whilst his recall of events was not complete he was upfront and honest in admitting when he could not remember a detail. The panel found that Mr 3 was careful to provide the panel with factual evidence only, and was careful not to speculate or provide an opinion. Mr 3 stated when he did not know an answer, and his oral evidence was consistent with the documentary evidence.

The panel found you to be a wholly unreliable witness. The panel considered that there were numerous inconsistencies between your written reflective statements. There were also a large number of inconsistencies between your written and your oral evidence, and internally within your oral evidence. The inconsistencies were on central, not peripheral, points and went to the heart of the evidence. The panel found it impossible to decipher which version of events presented by you was the truth. You accepted that your third reflective statement was untrue as you claimed you had been told what to put in it. The panel considered the guidance provided by the case of Lucas where a witness makes an admission of having been untruthful on a previous occasion. However, it noted that crucially here the inconsistencies arose within several different parts of your

evidence and did not centre on one point. The panel found that your evidence was not clear and was vague at times. The panel concluded that it could not place any reliability on the evidence you provided. The only evidence from you on which the panel placed any weight was your contemporaneous notes on the triage forms for Patient's A and B.

At the start of this hearing you admitted the following charges:

Charge 3

3. Between 1 January 2017 and 2 March 2018 Failed to keep adequate records in that:

c) In relation to Patient B:

i. You did not complete a new triage form for Patient B

ii. You did not record his medical history on the form

These were therefore announced as proved.

The panel then went on to consider the remaining charges and made the following findings:

Charge 1a)

1. On 9 January 2018 provided inadequate care to Patient A in that you:

a) Did not recognise neutropenic sepsis as a potential reason for her high temperature

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it.

The panel noted the absence of any documentary evidence to support your assertions that you recognised neutropenic sepsis as a reason for Patient A's high temperature. The panel had regard to Patient A's telephone triage record completed by you dated 9 January 2018. The panel noted that you recorded the patient's temperature as 39.8. The panel also noted that you recorded Patient A's risk factor of "Fever (and receiving chemo)" as green, when it should have been recorded as red, and you conceded that this was an error. The panel had regard to the oral evidence of each of the NMC witnesses who consistently stated that a temperature of 39.8 on a patient receiving chemotherapy was an indicator of neutropenic sepsis. The witnesses added that as Patient A was known to be at risk of myelosuppression the high temperature was a medical emergency. Your account of the matter varied in all three of your reflections and in your personal statement.

The panel was aware of the telephone call exchange commenced with Patient A at 14.42 on 9 January 2018, and thereafter calls were made at 16.20, 17.25, and 17.40.

The panel considered that you did not refer to the potential of neutropenic sepsis in your oral evidence until you were discussing your telephone call to Patient A at 17:40, which is the telephone call following Ms 2's intervention. The panel considered that your records in Patient A's case do not evidence any sense of urgency or a medical emergency but included notes such as "stable" and "feels ok". Your entries in the Actions Taken section of the form state "start in case [antibiotics] over 5 days" and "check before office closes". The notes do not refer to advising the patient to attend the Unit or A & E department until the fourth telephone call at 17:40.

The panel considered Ms 1 and Ms 2's evidence that suspected neutropenic sepsis is a known medical emergency. The panel considered that on the basis of the evidence before it, it was more likely than not that you did not recognise neutropenic sepsis as a potential reason for Patient A's high temperature. Had you recognised this, as a chemotherapy nurse, you should have acted differently, and recorded matters differently. Accordingly, the panel found this charge proved.

Charge 1b)

b) Did not advise her to attend the A & E department immediately when she reported a high temperature

This charge is found proved.

The panel did not accept your evidence that you advised Patient A to attend A & E earlier in the afternoon but she refused. The panel had regard to Patient's A telephone triage record completed by you dated 9 January 2018. It noted that there is no mention of asking Patient A to attend A and E until the note at 17.40, which was following Ms 2's intervention.

The panel noted its previous finding that you incorrectly recorded Patient A's risk factor as green (meaning lower risk), when it should have been red (high risk), and that you did not recognise neutropenic sepsis as a potential reason for Patient A's temperature of 39.8. The panel considered that you did not record that you advised Patient A to attend A & E in the "Action Taken" box of the triage form. The panel considered that it was more likely than not that you did not recognise the seriousness of Patient A's condition and therefore did not advise her to attend A & E. Accordingly, the panel found this charge proved.

Charge 1c)

c) Did not escalate the situation to an appropriate senior member of staff

This charge is found proved.

The panel considered that the inconsistencies in your oral evidence on your various escalation attempts were so vast and complex that they were not credible. The panel

considered that these explanations had not been referenced in any oral or documentary evidence and only emerged during cross examination. The panel noted that it is accepted by you that you did not successfully escalate Patient A's situation to a senior member of staff. This is supported by the three NMC witnesses, all senior members of staff, who confirmed that you did not seek them out to escalate Patient A's situation to them.

Ms 2 told the panel that she learnt of the situation with Patient A as she attended the office at the end of the day to enquire how your day had been, and another colleague, sat near to you, mentioned that you were worried about a patient. Having found Ms 2 to be a credible and reliable witness, the panel preferred her evidence.

Accordingly, in all the circumstances, the panel found this charge proved.

Charge 1 d)

d) Did not mark her file to be followed up

This charge is found proved.

The panel had regard to all the documentary evidence before it. It had careful regard to Patient A's triage notes. The panel noted the absence of any indication that this case was intended to be handed over to another member of staff, or followed up. The panel considered the time line of the four telephone calls with Patient A between 14:42 and 17:40 and noted that you had followed up with Patient A throughout the day, but made no mention of the need to hand over to the out of hours nurse.

However, the panel had regard to Ms 2's oral evidence that you did not volunteer the information about Patient A and that she had to coax this out of you. The panel accepted the evidence of Ms 2.

The panel found that you did not mark Patient A's file to be followed up. Accordingly, the panel found this charge proved.

Charge 2 a)

2. On 2 March 2018 provided inadequate care for patient B in that you:
   a) Did not take sufficient details of his medical history

This charge is found proved.

The panel noted the point raised by the legal assessor earlier in the proceedings that charges 2a) and 2b) were similar to charges 3c)ii) and 3c)iii) although not duplicitous or "double charged". Both parties were given the opportunity to comment on this and neither party made any application in this regard.

In its consideration of this charge, the panel noted that charge 3c)ii) is admitted.

The panel had regard to all of the documentary evidence before it, in particular Patient B's notes, and your entry dated 2 March 2018 which states:

> *"Diarrhoea continues even after stopping cepatine. Advised to get script from GP for codeine phos and commence this"*

The panel considered Ms 1 and Ms 2's evidence that it would be expected that if a new telephone call was received after a gap of three days since the last contact with the patient, that the triage nurse would complete a new telephone triage form, which includes a medical history. The panel, having found both witnesses to be credible and reliable, accepted their evidence. The panel had regard to a telephone triage record on Patient A's file which was completed by another nurse on 26 February 2018 and which included a medical history.

The panel found that on the basis of the documentary evidence, your short note did not include a medical history. The panel also found that, on the basis of Ms 1 and Ms 2's oral evidence, not including a medical history meant that the note was inadequate, as this should have been treated as a new patient contact.

The panel therefore found this charge proved.

Charges 2 b) 2 c) and 2 d)

b) Did not take sufficient details regarding his current symptoms
c) Did not advise him of the dose of codeine required
d) Did not follow up the referral to the GP with the GP

These charges are found proved.

The panel had regard to all of the documentary evidence before it, in particular Patient B's notes, and your entry dated 2 March which states:

> *"Diarrhoea continues even after stopping cepatine. Advised to get script from GP for codeine phos and commence this"*

The panel compared your notes regarding Patient B to notes written by another nurse on Patient B's record, and considered that your note was brief and inadequate by comparison. The panel accepted the evidence of Ms 1 and Ms 2 that your advice and record thereof amounted to inadequate care. The panel noted that you did not start a new triage form, and therefore did not go through the appropriate check lists.

The panel considered that your notes were brief and the only symptom that is stated is “Diarrhoea continues”. There is no elaboration on any other symptoms, or assessment of the diarrhoea.

The panel considered that you did not give Patient B’s symptoms the gravitas they warranted. The panel considered the evidence of each of the NMC witnesses that Patient B’s diarrhoea could have led to dehydration, infection, colitis or perforation of the bowel and was therefore potentially serious.

The panel found that there is no documentary evidence that you told Patient A which dose of codeine was required, nor is there any documentary evidence that you made follow up calls to the GP. The panel considered that your evidence regarding your advice to Patient B was inconsistent and unreliable.

In all of the circumstances, the panel found each of charges 2b), 2c), and 2d) proved for the reasons stated.

Charge 2 e)

e) Did not put a follow up plan in place

This charge is found proved.

The panel noted that there is conflicting evidence between you and Mr 3. You told the panel that you queried Patient B’s case with Mr 3 and he told you it did not require any follow up. Mr 3 refutes this and said that, given Patient B’s symptoms, he would have told you to put the notes in the follow up box. The panel preferred the evidence of Mr 3. The panel had regard to Patient B’s triage notes. It noted the absence of any reference to a plan or any follow up, as had been made in previous entries by another nurse. In all the circumstances, the panel found charge 2 e) proved.

Charge 3

3. Between 1 January 2017 and 2 March 2018 Failed to keep adequate records in that:

a) You recorded notes that were illegible

This charge is found NOT proved.

The panel considered the documentary evidence. In particular it had regard to your telephone triage call records for Patient A and Patient B. The panel considered that whilst your handwritten was not completely clear it could be read and was therefore not illegible.

The panel noted that the issue of your handwriting had been raised with you by Ms 1 and Ms 2 and you began writing in block capitals to attempt to remedy this. The panel also noted a difference of opinion on the legibility of your handwriting between Ms 1 and Ms 2.

The panel considered that the examples of your handwriting seen by the panel were legible. No other evidence was provided and the panel therefore found this charge not proved.

Charge 3 b) i)

3. Between 1 January 2017 and 2 March 2018 Failed to keep adequate records in that:

b) In relation to Patient A:

i. You did not document your telephone consultation with her

This charge is found NOT proved.

The panel had regard to Patient's A telephone triage record completed by you dated 9 January 2018. The panel considered that this clearly evidenced that you did document your telephone call with Patient A and that you completed the relevant triage form. Therefore the panel found this charge not proved.

Charge 3 b) ii)

3. Between 1 January 2017 and 2 March 2018 Failed to keep adequate records in that:

b) In relation to Patient A

ii. You did not record Patient A's responses to advice

This charge is found proved.

The panel had regard to Patient's A telephone triage record completed by you dated 9 January 2018. The panel noted the complete absence of any reference to Patient A's responses, in particular her apparent refusal to attend A & E. Accordingly, the panel find this charge proved.

Charge 3c)

3. Between 1 January 2017 and 2 March 2018 Failed to keep adequate records in that:

c) In relation to Patient B:

iii. You did not record details of his symptoms

This charge is found proved.

The panel had regard to Patient B's notes, and your entry dated 2 March 2018. The panel considered that whilst you recorded the symptom of "Diarrhoea", this was not

adequate. Your record did not go into further details of his symptoms such as the frequency and severity. Accordingly, the panel found you did not record details of Patient B's symptoms and found this charge proved.

Submissions on misconduct

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

Ms Caslin invited the panel to take the view that the facts found proved amount to misconduct. She reminded the panel that it must use its professional judgement in determining whether the facts found proved amount to misconduct. She referred the panel to terms of *'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)'* (the Code) in making its decision and identified the specific, relevant standards where your actions amounted to misconduct.

Ms Caslin submitted that your failings found proved at the facts stage demonstrated repetition of failures and that each failing is serious enough to amount to misconduct.

Mr Short on your behalf submitted that you recognise that your actions did amount to misconduct as they fell below the standards parties involved in your case expect of a registered nurse. He told the panel that you were sorry that you came across as not credible and you acknowledged that your documentation was a major fault, for which you expressed remorse. Mr Short also submitted that you were sorry that patients were failed on these occasions.

Submissions on impairment

Ms Caslin moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of

Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin).

In referring the panel the panel to the case of Grant, Ms Caslin drew the panel's attention to paragraph 76, where Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

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

She submitted that limbs a) – c) of the Grant test were engaged in your case and that your fitness to practise is currently impaired on the grounds of public protection. She submitted that the panel may be drawn to conclusions that you have attitudinal issues in your abject refusal to adopt responsibility for any failings over and above record keeping, and your attempts to blame others for your failings.

Ms Caslin further submitted that you have not remediated your failings and that you have significant lack of insight into these failings, demonstrated by your limited attempts at remediation. She submitted that, although the clinical concerns are remediable, your reluctance to accept your clinical failures is attitudinal and therefore not easily remediable. Ms Caslin also submitted that your lack of insight and minimisation of your failings demonstrates that there is a high risk of repetition if you were permitted to practise without restriction.

Ms Caslin also submitted that your fitness to practise is impaired on the grounds of public interest to uphold proper standards of conduct in the nursing profession, as well as to uphold public confidence in the nursing profession.

Mr Short submitted that you could not deny that your fitness to practise is impaired on the grounds of public interest. He referred to your testimonials from a number of people who have knowledge of your case.

Mr Short submitted that there is not a pattern of behaviour but that there are two distinct and separate events. Mr Short told the panel that you have not worked as a nurse for some time now and that you have done as much remediation as you can.

The panel accepted the advice of the legal assessor, which included reference to the judgements in the cases of *Grant* and *Cohen* v *General Medical Council* [2008] EWHC 581.

Decision and reasons on misconduct

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

The panel, 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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern… their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

- 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, and
- 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

- 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

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice. 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.

8 Work cooperatively

- 8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
- 8.2 maintain effective communication with colleagues
- 8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff
- 8.5 work with colleagues to preserve the safety of those receiving care
- 8.6 share information to identify and reduce risk, and

- 9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

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.

- 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

Preserve safety

You make sure that patient and public safety is protected.

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

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 profession from patients, people receiving care, other healthcare professionals and the public.

20 Uphold the reputation of your profession at all times

- 20.1 keep to and uphold the standards and values set out in the Code
- 20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
- 20.8 act as a role model of professional behaviour…

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 your actions in all of the charges found proved amounted to misconduct.

The panel considered all of the sub charges found proved in charge 1), charge 2) and charge 3) as a whole as they related to two separate occasions when the allegations arose.

In relation to charge 1a), charge 1b), charge 1c) and charge 1d), the panel considered that your failings are serious enough to amount to misconduct. The panel determined

that your actions were deplorable and resulted in a serious risk of harm and death to Patient A.

In relation to charge 2a), charge 2b), charge 2c), charge 2d) and charge 2e) the panel also determined that your failings were again serious and amounted to misconduct. It considered that there was only a three line entry in Patient B's records when there should have been a full medical history. The panel concluded that, similarly to the other charges, there was evidence of an accumulation of failings that add up to inadequate care which put the patient at a risk of significant harm.

In relation to charge 3b) and charge 3c), the panel took into account that there were significant risks of harm to Patient A and Patient B. It determined that your failures to keep adequate records fell so seriously short of the standards of a registered nurse as to amount to misconduct.

The panel found that your actions overall did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, your 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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

The panel considered that limbs a) – c) of the *Grant* test were engaged in your case.

The panel determined that patients were put at risk of harm and even death as a result of your misconduct. The panel also considered that your misconduct also breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel noted Mr Short's submission that you are remorseful. However, the panel considered that you have not demonstrated any insight into your failings and concluded that you demonstrated deep seated attitudinal issues in not accepting most of your failings. The panel considered that you were attempting to minimise your misconduct and blame your colleagues for most of your failings. The panel noted that you had made some admissions at the outset of the hearing, but you have only demonstrated a limited understanding of how your actions put the patients at risk of harm. The panel considered that you have not fully demonstrated an understanding of why what you did was wrong and how this impacted negatively on the reputation of the nursing profession.

The panel was satisfied that the misconduct in this case is capable of remediation. The panel carefully considered the evidence before it in determining whether or not you have remedied your practice. The panel took into account your training, which addressed one aspect of your failings, namely your record keeping. However, there was

no evidence of course details, the duration of the course, or the result of an assessment.

The panel considered that, in the absence of any full remediation, there is a risk of repetition based on the lack of remediation of your failings and lack of insight into the repercussions of your misconduct as a registered nurse. The panel considered that you are liable to put patients at a risk of serious harm in the future. The panel therefore concluded that a finding of impairment is necessary on the grounds of public protection.

The panel was mindful that you had detailed your own health and personal circumstances. However, the panel bore in mind that the overarching objectives of the NMC to protect, promote and maintain health, safety, and wellbeing of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required to uphold proper standards of conduct in the nursing profession.

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

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Submissions on sanction

In her submissions on sanction, Ms Caslin informed the panel that the NMC sanction bid communicated to you in the notice of hearing was a conditions of practice order, but she said that this is subject to ongoing review. In light of the panel's findings at fact and impairment the NMC has revised the sanction bid to a suspension order for a period 12 months, with a review before expiry.

Ms Caslin outlined what the NMC considered to be the aggravating and mitigating features of this case. Ms Caslin submitted that no further action or a caution order would be inappropriate as the panel have found that you are liable in future to place patients at a serious risk of harm.

Ms Caslin submitted that conditions of practice would not be appropriate in this case as the panel have found deep-seated attitudinal issues. She further submitted that conditions require a willingness to respond positively to re-training and, as the panel are aware, these incidents occurred in a supportive environment, which allowed you to work as a Band 5 nurse whilst receiving a Band 6 salary. She said that conditions are also inappropriate in view of your lack of insight.

Ms Caslin submitted that a suspension order is the appropriate and proportionate sanction. She submitted that the misconduct is capable of remediation, and a suspension order would afford you time to reflect on your failures, develop insight, and demonstrate to a future panel that you have made efforts to remediate.

Mr Short informed the panel that you have been subject to an interim conditions of practice order. He said that whilst you have not been working under the conditions, you have been offered an interview for an outpatient role working as a Band 5.

Mr Short submitted that the risk to the public could be addressed by a conditions of practice order, particularly given your understanding that you need to work as a Band 5.

Mr Short submitted that this would give you the chance to come to terms with the panel's judgments.

Mr Short submitted that there were two specific incidents, and they had in common the rare event of an ill patient refusing to accept advice. These coincided with health and family issues. You have accepted that you are guilty of misconduct. You accept that you were not proactive in respect of Patient A and Patient B and you deeply regret this. You also recognise that you need to be extremely careful with your recording and reporting, and that you need to be assertive for your patients and their immediate need at the time. You accept that you do not have the skills for telephone triage work, and that, given your health concerns, you need to be open and receptive to support.

Mr Short invited the panel to impose a conditions of practice order, which would allow you to start on the process of remediation. Mr Short submitted that you are extremely sorry and remorseful for the care that was afforded to Patient A and Patient B.

Decision and reasons on sanction

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

In reaching this decision, the panel had regard to all the evidence that has been adduced in this case. The panel accepted the advice of the legal assessor. The panel bore 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 published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel had regard to the aggravating and mitigating features in this case.

The panel considered the aggravating features to be as follows:

- There was a real risk of serious patient harm, even death;
- You displayed a lack of insight into your failings;
- There are deep seated attitudinal issues in your not accepting most of your failings, and your attempting to deflect blame onto colleagues and external influences;
- The incidents occurred despite a level of support being in place; and
- There were two incidents, the second of which occurred whilst you were under informal supervision.

The panel considered the mitigating features to be as follows:

- You self-referred to the NMC, although the panel noted that there was also an employer referral;
- You made some minor admissions at the outset;
- You have an otherwise unblemished career; and
- Your health and personal circumstances, although the panel was mindful of the NMC guidance that personal circumstances do not outweigh its duty to protect the public.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the risk of repetition identified and the seriousness of the case. The panel decided that it would be neither proportionate nor protect the public, nor be in the public interest to take no further action. The panel decided that a caution order would be inappropriate for the same reasons, noting that this case is not at the lower end of the spectrum of impaired fitness to practice.

The panel next considered whether placing conditions of practice on your 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 Sanctions Guidance, in particular:

> Conditions may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):
>
> - no evidence of harmful deep-seated personality or attitudinal problems
> - identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining
> - …
> - potential and willingness to respond positively to retraining
> - …
> - patients will not be put in danger either directly or indirectly as a result of conditional registration
> - the conditions will protect patients during the period they are in force
> - it is possible to formulate conditions and to make provision as to how conditions will be monitored

The panel considered that whilst there were identifiable areas of your practice in need of retraining, given the circumstances the panel was not satisfied that any conditions could be formulated that would protect patients for the period in which they are in force. The panel considered that you have expressed a willingness to respond to re-training, but Ms 1 said that this willingness had not changed your practice. The panel noted that during the time of the incidents you were under informal supervision. The panel considered that due to your lack of insight, the evidence of deep-seated attitudinal problems, and your willingness to blame others, there are no practicable or workable conditions that could be formulated to protect the public.

The panel considered that the clinical failures in your misconduct are in principal capable of remediation. However, it found that the attitudinal concerns which came to light during the course of this hearing are not.

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

Key things to weigh up before imposing this order include:

- whether the seriousness of the case require temporary removal from the register?
- will a period of suspension be sufficient to protect patients, public confidence in nurses and midwives, or professional standards?

Use the checklist below as a guide to help decide whether it's appropriate or not. This list is not exhaustive:

- 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 noted that this was not a single incident of misconduct, there is evidence of deep-seated attitudinal problems, and, given your lack of insight, you do pose a significant risk of repeating the behaviour.

The panel considered that, with reference to the above guidance, a suspension order was not appropriate or proportionate. The panel considered the inconsistencies in your evidence and your tendency to repeatedly blame your other health care professionals and a complete failure to recognise your responsibility, makes you a liability to your patients and your work colleagues. The panel considered your own evidence that you effectively fabricated your third reflective piece, and that you repeatedly embellished your account during your oral evidence. By submitting documents which are not a true and accurate reflection, and by altering your account during oral testimony, the panel considered that you could not be trusted not to fabricate submissions to any future reviewing panel. These concerns raise fundamental questions about your professionalism. Therefore, in this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

This sanction is likely to be appropriate when what the nurse or midwife has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:

- 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?

The panel considered that your original actions and/or omissions were capable of remediation. However, the deep seated attitudinal concerns and lack of professionalism which have come to light at this hearing are not capable of remediation, and are fundamentally incompatible with your remaining on the register. The panel was

concerned that you do not appear to be capable of genuine honest reflection. It noted your three attempts at drafting a reflective piece at the local level, and your admission that the third piece was fabricated. In these circumstances to allow you to continue practising would place patients at risk of harm and undermine public confidence in the profession and in the NMC as a regulatory body. The panel considered that any future reflection from you could not be trusted as a result of the attitudinal concerns identified.

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 your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

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

Determination on interim order

The panel considered the submissions made by Ms Caslin 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 took account of the submissions made by Ms Caslin and Mr Short. Mr Short did not oppose the application.

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 you are sent the decision of this hearing in writing.

That concludes this determination.