Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
20 January 2021

Virtual hearing

Name of registrant:	Alison Jane Watts
NMC PIN:	98C0259E
Part(s) of the register:	Registered Nurse – Sub Part 1: RNA: Adult Nurse, Level 1 (27 February 2001)
Area of registered address:	West Yorkshire
Type of case:	Misconduct
Panel members:	Helen Potts (Chair, lay member) Angela O'Brien (Registrant member) Tricia Breslin (Lay member)
Legal Assessor:	James Holdsworth
Panel Secretary:	Rob James
Nursing and Midwifery Council:	Represented by Rakesh Sharma, Case Presenter
Ms Watts:	Not in attendance nor represented
Consensual Panel Determination:	Accepted
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Currently Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Watts was not in attendance and that the Notice of Hearing letter had been sent to her registered email address on 5 November 2020. It was also sent to Ms Watts' representative at the RCN on this date.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and the original venue of the hearing and, amongst other things, information about Ms Watts' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Sharma, on behalf of the Nursing and Midwifery Council (NMC), referred the panel to correspondence from the RCN dated 19 January 2020 that confirmed that Ms Watts was aware that the hearing will be taking place virtually rather than at the NMC hearing centre as initially stated in the notice of hearing. He submitted that 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 Ms Watts has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Watts

The panel next considered whether it should proceed in the absence of Ms Watts. It had regard to Rule 21 and heard the submissions of Mr Sharma who invited the panel to continue in the absence of Ms Watts. He referred the panel to the final paragraph of her reflective statement dated 18 January 2020 in which Ms Watts wrote:

"I am willing to engage with the NMC for the purposes of concluding the CPD agreement, however I will not attend any NMC hearing as I feel this would be too detrimental to my own wellbeing."

Mr Sharma submitted that Ms Watts has made her feelings clear in that statement. He further submitted that Ms Watts' representative at the RCN has also stated that she will be available should the panel have any questions that need to be answered. Mr Sharma submitted that there would be no prejudice to Ms Watts in proceeding in her absence where there was an agreed CPD and he would be making no further submissions.

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 has decided to proceed in the absence of Ms Watts. In reaching this decision, the panel has considered the submissions of Mr Sharma, the correspondence from Ms Watts, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Ms Watts has engaged with the NMC and has signed a provisional CPD agreement which is before the panel today;
- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Ms Watts.

Details of charge

That you, a registered nurse:

1) *Between June 2015 and 27 November 2017 carried out 461 cervical screening procedures when you were not qualified to do so.*

2) *Between 14 September 2015 and 27 November 2017 failed to notify your employer, Undercliffe Surgery, that you had failed the cervical screening assessment when you knew or ought to have known you had not passed.*

3) *Your actions in charge 2 lacked integrity in that you:*

    a) *You were never awarded the qualification*
    b) *It was your duty to check if you had been awarded the qualification and you did not*
    c) *You continued to undertake cervical screening procedures.*

4) *Between June 2015 and 27 November 2017 failed to complete a personal audit of samples taken by you as required by the best practice standards in Public Health England's NHS cervical screening programme guidance.*

5) *Between June 2015 and 27 November 2017 failed to keep an audit of your RAG score (rating of red, amber and green) on the Cervical Screening Database as required by your employer, Undercliffe Surgery.*

6) *At a date between June 2015 and November 2017 you informed your employer that your RAG rating was green.*

7) *Your actions in charge 6 above were dishonest in that you knew you had not been assessed as green on the Cervical Sample Taker Database.*

8) *On 8 January 2018 you submitted to a panel of the Investigating Committee of the Nursing and Midwifery Council;*

    a) *A reference purportedly from nurse PG dated 04 January 2018 in the knowledge that PG had not written the purported reference;*
    b) *A reference purportedly from health care assistant DW dated 05 January 2018 in the knowledge that DW had not written the purported reference.*

9) *Your actions in charge 8 above were dishonest in that you submitted the purported references with intent to deceive the panel of the Investigating Committee of the Nursing and Midwifery Council*

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

Consensual Panel Determination

At the outset of this hearing, Mr Sharma informed the panel that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the NMC and Ms Watts.

The agreement, which was put before the panel, sets out Ms Watts' full admissions to the facts alleged in the charges, that her actions amounted to misconduct, and that her fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that the appropriate sanction in this case would be a striking-off order.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

"Consensual panel determination: Provisional agreement

Ms Alison Jane Watts ('the Registrant') PIN 98C0259E is aware of the CPD hearing. The Registrant does not intend to attend the hearing and is content for it to proceed in her and her representative's absence. The Registrant is represented by the Royal College of Nursing ('the RCN') who will endeavour to be available by telephone should clarification on any point be required.

The Nursing and Midwifery Council ('the NMC') and the Registrant ('the Parties') agree as follows:

The Charges

1. *The Registrant admits the following charges:*

    That you, a registered nurse:

    10) *Between June 2015 and 27 November 2017 carried out 461 cervical screening procedures when you were not qualified to do so.*

    11) *Between 14 September 2015 and 27 November 2017 failed to notify your employer, Undercliffe Surgery, that you had failed the cervical screening assessment when you knew or ought to have known you had not passed.*

    12) *Your actions in charge 2 lacked integrity in that you:*

        d) *You were never awarded the qualification*

e) *It was your duty to check if you had been awarded the qualification and you did not*

f) *You continued to undertake cervical screening procedures.*

13) *Between June 2015 and 27 November 2017 failed to complete a personal audit of samples taken by you as required by the best practice standards in Public Health England's NHS cervical screening programme guidance.*

14) *Between June 2015 and 27 November 2017 failed to keep an audit of your RAG score (rating of red, amber and green) on the Cervical Screening Database as required by your employer, Undercliffe Surgery.*

15) *At a date between June 2015 and November 2017 you informed your employer that your RAG rating was green.*

16) *Your actions in charge 6 above were dishonest in that you knew you had not been assessed as green on the Cervical Sample Taker Database.*

17) *On 8 January 2018 you submitted to a panel of the Investigating Committee of the Nursing and Midwifery Council;*

c) *A reference purportedly from nurse PG dated 04 January 2018 in the knowledge that PG had not written the purported reference;*

d) *A reference purportedly from health care assistant DW dated 05 January 2018 in the knowledge that DW had not written the purported reference.*

18) *Your actions in charge 8 above were dishonest in that you submitted the purported references with intent to deceive the panel of the Investigating Committee of the Nursing and Midwifery Council*

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

The Agreed Facts

2. *The Registrant appears on the register of nurses and midwives maintained by the NMC as a Registered Nurse.*

3. *On 13 December 2017, the NMC received a referral from the Registrant's employer, Undercliffe Surgery (the 'Referrer'). The referral related to the Registrant's failure to complete training for a specialist procedure (cervical screening) but despite this, that she had still carried out that procedure over a period of 27 months. The Registrant also falsified testimonials to a panel of the Investigating Committee of the Nursing and Midwifery Council. The Referrer dismissed the Registrant on 22 March 2018 after a local level investigation into these matters.*

4. *The regulatory concerns identified in this case are as follows:*

    - *Performing smear tests without the required qualifications and associated dishonesty;* ***(Charges 1 to 3)***

    - *Failure to follow local policies and procedures;* ***(Charges 4 to 7)***

    - *Falsification of references and associated dishonesty.* ***(Charges 8 and 9)***

Background

5. *In April 2015, the Registrant started a cervical screening module ("the Course") at the University of York. The Registrant attended the required study days in*

April 2015, underwent training in her place of work and performed observed smear tests and submitted these results.

6. *On 27 November 2017, the Cervical Sample Taker Database ("CSTD") notified NHS England that the Registrant had failed the Course in September 2015 but continued to take unsupervised cervical samples until November 2017. The ensuing investigation identified that 461 women had been involved and, in order to ensure that all the women involved were provided with the opportunity to have a quality assured sample taken in adherence with national guidance, the decision was taken to identify all 461 women and invite them for repeat screening.*

7. *During the period when the Registrant was taking cervical samples, she should have undertaken a personal audit of all samples taken to determine her technique and maintained an audit of her 'RAG rating' (the quality of the samples taken).*

8. *An NMC interim order hearing took place on 8 January 2018 for which the Registrant provided "recycled" references. Interim Conditions of Practice were put in place. Once it was discovered that the Registrant had provided misleading references, the order was changed to an Interim Suspension Order on 16 April 2018.*

9. *As part of its investigation the NMC has received and assessed all of the relevant evidence obtained during the local investigations.*

10. *Witness statements have been obtained from:*

- *Ms 1, Advanced Nurse Practitioner at Undercliffe Surgery*
- *Ms 2, Course Module Leader*
- *Ms 3, Practice Nurse at Undercliffe Surgery*

- *Ms 4, Practice Manager at Undercliffe Surgery*
- *Ms 5, Community Nurse*
- *Ms 6, Healthcare Assistant at Undercliffe Surgery*

The Charges

Charges 1 to 3:

11. *As part of the Course, the Registrant was required to obtain five smear samples under the direct supervision of her external mentor (Practice Nurse, Ms 3), followed by 20 samples taken under the indirect supervision of the Registrant's in-house mentor (Advanced Nurse Practitioner, Ms 1). These should have been recorded on the Registrant's electronic portfolio (e-portfolio).*

12. *The Registrant was initially observed by Ms 3 and then performed supervised smears with no concerns. Ms 3 then waited for the Registrant to contact her with details of a further 10 unsupervised samples. However, Ms 3 could not get hold of the Registrant, despite trying a number of methods and, on contacting the Surgery, was advised that (PRIVATE). Ms 3 advised her own line manager and the Surgery, Ms 4, that she had not been able to contact the Registrant with regard to the unsupervised smears.*

13. *On 14 September 2015, Ms 2 wrote to the Registrant to notify her that she had failed her first attempt at completing the Course as she had not submitted any information on her e-portfolio. The Registrant was given the option of a resubmission up to 19 October 2015, or to contact the university with any mitigating factors. The university did not receive any communication from the Registrant and two further letters were sent to the Registrant's home address on 30 November 2015 to advise her that she had failed the course.*
14. *Although the university contacted the Registrant about her failure to submit the required written work for the Course, the Registrant did not notify her employer*

of this, nor did the university. The Surgery became aware that the Registrant had not successfully completed the course after being contacted by NHS England in November 2017, to confirm that she had completed her training. The Registrant was prevented from undertaking any further screening on 27 November 2017.

15. *An investigation was conducted by the National NHS Cervical Screening Programme (Yorkshire and the Humber). The summary of that incident identifies multiple factors that contributed to this incident being able to occur. These include a lack of communication between all parties involved in the Course and systemic failings.*

16. *There is a database called CSTD where all cervical samplers are registered and this allows each cervical sample to be recorded and monitored to check the effectiveness of the sample taking. As a student, the Registrant was registered on this database and was given a sample code to access her electronic portfolios and record her sampling. Students have a "T" on their codes to indicate they are in training.*

17. *When a student passes the Course the "T" is removed by the database administrators and the student continues to sample using their code which no longer has the "T" attached to it. If a student does not complete the Course the system should record the student as not completed. It appears that the "T" was removed from the Registrant's sample code in error, which indicated that she had satisfactorily competed the Course. No explanation for this error was identified.*

18. *Despite the presence of contributory factors identified by NHS England, Ms 2 communicated the Registrant's failure of the Course to the Registrant on three separate occasions, using two email addresses and a postal address.*

19. *The Registrant's position is that, (PRIVATE), she was not looking out for a letter confirming she had passed the Course. The Registrant was of the view that she had performed well in those parts of the Course she had attended but she was aware that she had not completed the Course.*

20. *It was incumbent upon the Registrant to ensure that she was suitably qualified to conduct smear tests. It was the Registrant's duty to check if she had been awarded the qualification and she did not. Furthermore, the Registrant continued to undertake cervical screening procedures despite this.*

Charges 4 to 7:

21. *The Registrant failed to complete a personal audit of all samples taken between June 2015 and 1 January 2017, to determine their sampling technique. This is in accordance with best practice standards in Public Health England guidance NHS Cervical Screening Programme: Guidance for the training of cervical sample takers.*

22. *The Surgery had a robust cervical screening protocol which was commended by the CQC. Part of this protocol requires smear takers to keep an audit of their 'RAG rating' (a means to assess the quality of the samples taken), which the Registrant accepts, on the basis of the evidence of Ms 1, that she indicated was green (and therefore good). The Registrant believes she undertook some but not all audits. However, the Registrant did not provide any evidence to support this. The Registrant knew that she had not been assessed as green on the Cervical Sample Taker Database and therefore her actions were dishonest.*

Charges 8 and 9:

23. *In light of the concerns referred to the NMC, an interim order hearing was held on 8 January 2018. As part of the Registrant's response to the NMC, she submitted a testimonial, purportedly written by community nurse, Ms 5, and dated 4 January 2018. Ms 5 did not write this reference, although she does not dispute its content and says this is how she would describe the Registrant. It is indicated that the content of the reference was taken from an earlier reference Ms 5 had provided for the Registrant in support of a job application.*

24. *The Registrant also submitted a reference, purportedly written by healthcare assistant Ms 6 and dated 5 January 2018. Ms 6 did not write this reference and had never seen it before being shown it by her employer as part of the NMC investigation. Ms 6 had previously provided a reference for the Registrant, which consisted of approximately three lines of text, confirming that she had worked with the Registrant and that the Registrant was reliable and trustworthy.*

25. *The Registrant had submitted these references with the intent to deceive the panel of the Investigating Committee of the Nursing and Midwifery Council and her actions were therefore dishonest.*

26. *All facts as detailed in the charges are admitted by the Registrant.*

Misconduct

27. *In the case of Roylance v General Medical Council (No.2) [2000] 1 AC 311, Lord Clyde stated that:*

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

28. *The Registrant admits that her conduct fell seriously short of the standards of behaviour expected of Registered Nurses. Moreover, the Registrant accepts that her actions breached the following paragraphs of the 2015 NMC Code of Conduct:*

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice.

7 Communicate clearly

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must:

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

13.5 complete the necessary training before carrying out a new role

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times

29. *The actions of the Registrant had the potential to put patients at significant risk of harm, although it is accepted that there is no evidence of actual harm having occurred. The Registrant's failings involve a serious departure from expected standards. Keeping a personal audit is described as best practice and there is no evidence that the Registrant complied with her employer's expectations in this regard. The risks associated with the Registrant failing to monitor her own practice in taking smears include the potential for missed diagnoses and associated patient harm. This is especially the case for those nurses who are learning to perform smears and working without supervision.*

30. *By continuing to carry out cervical smear tests despite the Registrant's knowledge that she had never completed and passed the relevant course shows a concerning lack of integrity. These elements amount to a breach of the duty of candour. This also clearly has the potential to impact on patients in the Registrant's care.*

31. *The Registrant wilfully and deliberately submitted falsified documents in support of her character as part of the NMC investigation into the concerns raised. This was done to mislead a panel of the Investigating Committee and amounts to dishonesty for personal gain. Although the gain may not have been directly financial, it was a deception with the intent to gain professional credibility. This behaviour was also premeditated and had the potential for the panel to reach a decision based on false information.*

32. *The Registrant accepts that the facts, individually and collectively, amount to misconduct.*

Current Impairment

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

> *Do our findings of fact in respect of the 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.*

34. *The Parties agree that the admitted facts do amount to the Registrant putting patients at unwarranted risk of harm. The Registrant accepts that she has brought the reputation of the nursing profession into disrepute by acting in a dishonest way on a number of separate occasions. The Parties also agree that*

the Registrant has breached fundamental tenets of the profession through her dishonesty.

35. *In considering the question of whether the Registrant's fitness to practise is currently impaired, the Parties have considered Cohen v GMC [2007] EWHC 581 (Admin), in which the court set out three matters which it described as being 'highly relevant' to the determination of the question of current impairment:*

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

36. *The Parties agree that the clinical failings in this case are capable of being remedied. However, the failings in this case also involve a lack of integrity, dishonest behaviour and attitudinal issues on the part of the Registrant and the Parties agree that such conduct could not be described as easily remediable.*

Remediation and insight

37. *There is no evidence that the Registrant has attempted to remediate her practice, nor that she has demonstrated an appropriate level of insight through reflection. The Registrant has however provided a signed statement dated January 2021, attached as 'AJW 1', which confirms the following:*

    37.1. her admissions to facts, misconduct and impairment;

    37.2. a more detailed explanation of the impact of her bereavement upon her at the time the events that led to this referral occurred;

    37.3. she has not worked as a nurse since her dismissal by the Referrer and that she wishes to leave the profession;

37.4. she is willing to engage with the NMC to conclude Consensual Panel Disposal but she will not attend any NMC hearing as she feels this would be too detrimental to her own wellbeing.

38. In light of the above, the Parties agree that the misconduct has not been remedied and will not be remedied in the future as a result of the Registrant's decision to leave the profession. Accordingly, a risk of repetition remains. A finding of impairment is therefore necessary to:

38.1. protect the public;

38.2. uphold the reputation of and to maintain public confidence in the profession;

38.3. declare and uphold proper professional standards and protect the reputation of the nursing profession in accordance with the comments of Cox J in Grant at paragraph 101:

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

Sanction

*39. The appropriate sanction in this case is a **striking-off order**. The Parties considered the NMC Sanctions Guidance, bearing in mind that it provides guidance not firm rules.*

40. *The aggravating features of this case are agreed as follows:*

- *The high number of patients involved*
- *The failings occurred over a prolonged period of time*
- *The potential for serious harm to patients*
- *The additional inconvenience and additional invasive procedures required by all 461 patients*
- *Dishonesty in the course of regulatory proceedings*

41. *The parties agree that the relevant mitigating factors in this case include the difficult personal circumstances the Registrant experienced at the time of the incidents in charges 1 to 7.*

42. *In considering what sanction would be appropriate the Parties began by considering whether this is a case in which it would be appropriate to take no further action. The Parties agree that this would leave the public exposed to an unwarranted risk of harm, given the risk of repetition of the misconduct. The Parties also agree that such a sanction would not be sufficient to maintain public confidence.*

43. *The Parties next considered whether a caution order would be appropriate. A caution order would not restrict the Registrant's practice and would therefore be insufficient to protect the public given the risk of repetition of the misconduct. The Parties also agree that such a sanction would not be sufficient to maintain public confidence.*

44. *The Parties considered the imposition of a conditions of practice order. The Parties agree that there are serious failings, including dishonesty, in this case. The Parties agree that workable conditions of practice that provide sufficient protection to the public cannot be formulated. In addition, the Parties agree that*

the wider public interest would not be satisfied by the imposition of a conditions of practice order due to the very serious nature of the dishonesty concerns.

45. *The Registrant has not demonstrated remediation for her clinical failings, nor has she shown any significant remorse and/or detailed reflection regarding her misconduct. In the context of the lack of insight and remediation and the impact the Registrant's failings had upon 461 patients, the Parties agree that a suspension order is neither sufficient nor appropriate in this case. Further, the Parties agree that a suspension order is not sufficient to address the wider public interest.*

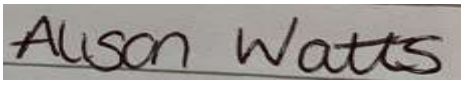
46. *In relation to a striking-off order, the Parties agree that this case involves fundamental concerns about the Registrant's trustworthiness as a registered professional and that the Registrant's conduct is fundamentally incompatible with continued registration. It is agreed that a striking-off order is the necessary and appropriate sanction in this case.*

Interim order

47. *Finally, the Parties agree that an interim order is required in this case. The order is necessary for the protection of the public and is otherwise in the public interest (for the reasons given above). The order should be for a period of 18 months to guard against the risk to the public in the event that the Registrant seeks to appeal against the substantive order. The interim order should take the form of an interim suspension order.*

The Parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The Parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of

facts set out above, may be placed before a differently constituted panel that is determining the allegations, provided that it would be relevant and fair to do so.

Signed  *Dated: 18 January 2021*

Alison Jane Watts

Signed: R. Sharma

(Rakesh Sharma, CPP Lawyer) *Dated: 18 January 2021*

(For and on behalf of the NMC)

Here ends the provisional CPD agreement between the NMC and Ms Watts. The provisional CPD agreement was signed by Ms Watts and the NMC on 18 January 2021.

Decision and reasons on the CPD

The panel decided to accept the CPD.

The panel heard and accepted the legal assessor's advice. He referred the panel to the 'NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. He reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Ms Watts. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

Ms Watts admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of Ms Watts' admissions, as set out in the signed provisional CPD agreement.

Decision and reasons on misconduct and impairment

The panel then went on to consider whether Ms Watts' fitness to practise is currently impaired by reason of misconduct. Whilst acknowledging the agreement between the NMC and Ms Watts, the panel has exercised its own independent judgement in reaching its decision on misconduct and impairment.

In respect of misconduct, the panel had regard to the fact that Ms Watts' actions had taken place over a significant period of time and had put a large number of patients in her care at an unwarranted risk of harm. Further, her actions involved a high level of dishonesty and amounted to behaviour that fellow practitioners would consider to be deplorable.

In this respect, the panel endorsed paragraphs 27 to 32 of the provisional CPD agreement in respect of that misconduct.

The panel then considered whether Ms Watts' fitness to practise is currently impaired by reason of misconduct. The panel determined that Ms Watts' fitness to practise is currently impaired. It concurred with the CPD agreement that, while her clinical failings are capable of remedy, her dishonesty and deep-seated attitudinal issues are not easily remediable. Further, it agreed that she has not shown an appropriate level of insight into her actions which involved risk to a significant number of patients and the falsification of documentation and her colleagues' signatures. These actions brought her colleagues' integrity into question and will inevitably have also had an effect on the public perception of the nursing profession. The panel agreed with the CPD agreement that Miss Watts' misconduct has not been remedied and a risk of repetition remains. Accordingly, the panel found impairment on both public protection and public interest grounds. In this respect the panel endorsed paragraphs 33 to 38 of the provisional CPD agreement.

Decision and reasons on sanction

Having found Ms Watts‘ fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account and was in agreement with the aggravating and mitigating factors as outlined in the CPD agreement.

The panel first considered whether to take no action but concluded that this would be inappropriate in that it would leave the public exposed to an unwarranted risk of harm and would not reflect the seriousness of Miss Watts' dishonesty. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Watts' practice would not be appropriate. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Watts' misconduct was not at the lower end of the spectrum. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Watts' registration would be a sufficient and appropriate response. The panel was in agreement with the CPD that there were no workable conditions that would ensure that the public remained sufficiently protected. Furthermore, the panel concluded that the placing of conditions on

Ms Watts' registration would not adequately address the public interest in light of the serious nature of Miss Watts' dishonesty.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

This was not a single instance of misconduct but involved 461 patients over a two year period. There is evidence of sustained dishonesty and deep-seated attitudinal issues and the panel considered that Ms Watts lacks insight into her misconduct and a risk of repetition remains. Accordingly, the panel agrees with the CPD that a suspension order is neither sufficient nor appropriate. Further, the panel considered that a suspension order would not meet the wider public interest.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of 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?*

Ms Watts' actions were significant departures from the standards expected of a registered nurse. She carried out cervical screening procedures on 461 patients in the knowledge that she had failed the assessment which would have qualified her to do so. In the context of these proceedings before her regulatory body, she dishonestly submitted false references to the NMC. The panel was in no doubt that these actions are fundamentally incompatible with her remaining on the register. The panel was of the view that to allow her to continue practising would put patients at risk of harm and undermine public confidence in the profession and in the NMC as a regulatory body.

The panel agreed with the CPD that the appropriate and proportionate sanction is that of a striking-off order. The panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary not only to protect the public but 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.

This will be confirmed to Ms Watts in writing.

Decision and reasons on interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Watts' own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

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

facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel agreed with the CPD that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to ensure protection of the public during the possible appeal period

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

That concludes this determination.