Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
20 – 29 June 2022

Virtual Hearing

Name of registrant:	**Marian Catherine Blenkiron**
NMC PIN:	73D0166E
Part(s) of the register:	Nursing, Sub Part 2 RN2: Adult nurse, Level 2 (2 June 1975) Nursing, Sub Part 1 RN1: Adult nurse, Level 1 (9 September 1984) Midwives part of the register RM: Midwife (4 November 1992)
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, lay member) Manjit Darby (Registrant member) Tracey Chamberlain (Registrant member)
Legal Assessor:	John Caudle
Hearings Coordinator:	Tyrena Agyemang
Nursing and Midwifery Council:	Represented by Louis Maskell, Case Presenter
Mrs Blenkiron:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 4, 6, 7, 8 in relation to charge 6, 9 and 10
Facts not proved:	Charges 5a and 5b and 8 in relation to charge 7a,
Fitness to practise:	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 Mrs Blenkiron was not in attendance and that the Notice of Hearing letter had been sent to Mrs Blenkiron's registered email address by secure delivery on 9 May 2022.

Mr Maskell, on behalf of the Nursing and Midwifery Council (NMC), submitted that it 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.

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

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

The panel next considered whether it should proceed in the absence of Mrs Blenkiron. It had regard to Rule 21 and heard the submissions of Mr Maskell who invited the panel to continue in the absence of Mrs Blenkiron. He submitted that Mrs Blenkiron has voluntarily absented herself.

Mr Maskell submitted that there had been limited engagement from Mrs Blenkiron with the NMC in relation to these proceedings and, as a consequence, there was no reason to

believe that an adjournment would secure her attendance on some future occasion. He referred the panel to an email dated 13 June 2022 in which Mrs Blenkiron states:

> *Thank you for your letter. However, I have told you that I have retired, I am no longer nursing and I am no longer bound by your regulatory body. Because of your amorous restrictions I have never been able to secure my career and so it has ended. Please treat this letter as a formal letter of resignation. I do not wish to hear from you again and any further communications from you will be destroyed unread.*

Mr Maskell told the panel that Mrs Blenkiron has made it clear she will not attend a hearing.

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'*.

The panel has decided to proceed in the absence of Mrs Blenkiron. In reaching this decision, the panel has considered the submissions of Mr Maskell, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R* v *Jones (Anthony William)* [2002] UKHL 5 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Blenkiron;
- Mrs Blenkiron has had limited engagement with the NMC and has stated that she will not attend an NMC hearing.
- There is no reason to suppose that adjourning today would secure her attendance at some future date;
- A number of witnesses are due to attend to give live evidence during this hearing,

- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients and/or patients who need their professional services;
- The charges relate to events that occurred in 2018 and 2019;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

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

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

Details of charge

That you, a registered nurse:

1. Between 22 November 2018 and 5 December 2018, failed to comply with your conditions of practice whilst working at Beggarwood Practice, in that:

    a. You were not under direct supervision;

    b. You did not formulate a personal development plan;

2. Between 22 November 2018 and 5 December 2018, took smear samples at Beggarwood Practice without having a sample taker code / PIN number;

3. On 29 November 2018, told Dr A that your sample taker training was up to date so that they would sign the sample taker declaration form for you;

4. Your conduct at charge 3 was dishonest, in that you knew you had not completed said training, but intended for Dr A to believe that you had;

5. Between 22 November 2018 and 5 December 2018;

    a. Failed to make records of the care and treatment you provided to at least 21 patients;

    b. Failed to make adequate patient records in relation to at least 27 patients;

6. Between 8 October 2018 and 18 April 2019, failed to disclose to Hampshire Hospitals NHS Foundation Trust that you were subject to conditions of practice order, in breach of condition 8 of your conditions of practice order;

7. Between 18 April 2019 and 23 April 2019;

a. Failed to disclose to Hampshire Hospitals NHS Foundation Trust that you were subject to a suspension order;

b. Continued to practice at Hampshire Hospitals NHS Foundation Trust despite being subject to a suspension order;

8. Your conduct at charges 6 and 7a were dishonest, in that you knew you had to disclose the fact of your conditions of practice and/or suspension but wilfully withheld this information;

9. On 18 April 2019, at a Substantive Order Review hearing, told the panel that, on your first day working at Hampshire Hospitals NHS Foundation Trust, had discussed your conditions of practice and your need to fulfil said conditions when you had not;

10.Your conduct at charge 9 was dishonest, in that you knew that you had not discussed your conditions of practice as charged above but intended for the panel to believe you had;

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Maskell, on behalf of the NMC, to amend the wording of charges 1a and 6.

The proposed amendment to charge 1a was to remove the word ‘direct’. Mr Maskell told the panel that removing this word would better reflect the supervision Mrs Blenkiron received as she was not required to have a nurse with her at all times, but she was required to have a nurse with her on the same shift.

Mr Maskell told the panel that the proposed amendment to charge 6 was to correct a typographical error, as the charge incorrectly refers to 8 when it should refer to condition 12. It was submitted by Mr Maskell that the proposed amendment would provide clarity and more accurately reflect the evidence before the panel. He submitted that there would be no injustice or prejudice towards Mrs Blenkiron as the content of both charges remained the same. The amendments are as follows:

That you, a registered nurse:

1. Between 22 November 2018 and 5 December 2018, failed to comply with your conditions of practice whilst working at Beggarwood Practice, in that:
   a. You were not under ~~direct~~ supervision;

   and

6. Between 8 October 2018 and 18 April 2019, failed to disclose to Hampshire Hospitals NHS Foundation Trust that you were subject to conditions of practice order, in breach of condition ~~8~~ **12** of your conditions of practice order;

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Blenkiron and no injustice would be caused to either party by the proposed amendments being allowed.

The panel considered the amendment to charge 1a would make it less onerous for Mrs Blenkiron. It also considered that the amendment does not change the substance of the

charge. The panel was also satisfied that the amendment to charge 6 was to correct a typographical error and that it does not change the substance of the charge. The panel concluded, it was therefore appropriate to allow the amendments as applied for, to ensure clarity and accuracy.

Decision and reasons on applications to admit hearsay evidence of Witnesses 8, 9 and 10

The panel heard an application made by Mr Maskell under Rule 31 to allow the written statements of Witness 8, 9 and 10 into evidence. He told the panel that none of the three statements were the sole and decisive evidence in this case.

Mr Maskell outlined that Witness 8 had intended to attend the hearing, but due to a family bereavement the day before she was due to give her evidence, she is now unable to attend.

Mr Maskell told the panel that Witness 9 was the front of house receptionist and was the person responsible for booking agency staff. He told the panel that Witness 9 does not recall the telephone call with the agency about Mrs Blenkiron's conditions of practice order. Mr Maskell also informed the panel that Witness 9 was a reluctant witness, who also had health issues. He told the panel that the NMC had taken all reasonable steps to ensure her attendance and had even offered to postpone the hearing in order to secure her attendance, but her response was that she would not attend the hearing, even if it was postponed to another date for her convenience. Mr Maskell told the panel that a letter was also sent to her address but returned undelivered as the addressee had gone away.

Mr Maskell then moved on to address Witness 10. He informed the panel that this witness was an NMC Investigator and that his evidence provides the panel with undisputed background factual context to the case. Mr Maskell told the panel that Witness 10's evidence explains the history of Mrs Blenkiron's interim orders, and also provides

correspondence between himself and Mrs Blenkiron in which she explains she was unaware she was suspended from practice.

Mr Maskell outlined that Mrs Blenkiron had been emailed in May 2022, informing her that the witness statements of Witnesses 8 and 9 were to be read in the hearing and invited comments from her, but there was no response.

Mr Maskell referred the panel to the case of *Thorneycroft v NMC [2014] EWHC 1565* and submitted that the panel must consider relevance and fairness when making its decision. He submitted that there was no reason to suggest fabrication by any of the witnesses as they had all spoken highly of Mrs Blenkiron.

Mr Maskell told that panel that the charges are serious and relate to dishonesty. He told the panel that all reasonable steps had been taken to secure the witnesses, but due to the reasons already stated they were unable to attend the hearing. He submitted that if the panel were to admit the three statements, it must in due course give the evidence the weight that it deemed appropriate.

In the preparation of this hearing, the NMC had indicated to Mrs Blenkiron that it was the NMC's intention for Witnesses 8 and 9 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 8 and 9, Mrs Blenkiron made the decision not to attend this hearing. On this basis Mr Maskell advanced the argument that there was no lack of fairness to Mrs Blenkiron in allowing Witness 8 and 9's written statement into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application, which included Rule 31. He also took the panel to *Thorneycroft v NMC [2014] EWHC 1565.*

Decisions and Reasons for Admitting Witness 8's Evidence

The panel gave the application in regard to Witness 8 serious consideration. The panel noted that Witness 8's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge, and belief' and signed by her.

The panel considered whether Mrs Blenkiron would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 8 to that of a written statement.

The panel considered that as Mrs Blenkiron had been provided with a copy of Witness 8's statement and, as the panel had already determined that Mrs Blenkiron had chosen to voluntarily absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered that Witness 8's evidence was not contentious and was not the sole and decisive evidence being relied on to prove the charges. As Witness 8 had the intentions of attending the hearing, but due to bereavement was now unable to attend, the panel came to the view that it would be fair and proportionate to accept into evidence the written statement of Witness 8, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decisions and Reasons for Admitting Witness 9's Evidence

The panel gave the application in regard to Witness 9 serious consideration. The panel noted that Witness 9's statement had also been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge, and belief' and signed by her.

The panel considered whether Mrs Blenkiron would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 9 to that of a written statement.

The panel considered that as Mrs Blenkiron had been provided with a copy of Witness 9's statement and, as the panel had already determined that Mrs Blenkiron had chosen to voluntarily absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered that Witness 9's evidence was also not contentious and although it would have given the panel some background and contextual information, it was not the sole and decisive evidence being relied on to prove the charges. the panel came to the view that it would be fair and proportionate to accept into evidence the written statement of Witness 9, but would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

Decisions and Reasons for Admitting Witness 10's Evidence

The panel gave the application consideration and had regard to Witness 10's evidence and noted that it had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge, and belief' and was signed by him.

The panel, again, considered whether Mrs Blenkiron would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 10 to that of a written statement.

The panel considered that as Mrs Blenkiron had been provided with a copy of Witness 10's statement and, as the panel had already determined that Mrs Blenkiron had chosen to voluntarily absent herself from these proceedings, she would not be in a position to

cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered that Witness 10's evidence was a public record and open to the public. The panel did not consider his evidence to be contentious but a factual record of the communication with Mrs Blenkiron. The panel determined that it would be fair and proportionate to accept into evidence the written statement of Witness 10, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

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

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Practice Manager of Beggarwood and Rooksdown Practice;

- Witness 2: Clinical Support Officer at Beggarwood and Rooksdown Practice
- Witness 3: PHE Screening & Immunisation Manager for NHS England and NHS Improvement in the South East Region (Hampshire, Isle of Wight);
- Witness 4: Clinical Director at Cedar Medical Practice and General Practitioner
- Witness 5: Senior Sister in the Diagnostic and Treatment Centre ("DTC")
- Witness 6: Head of Flexible Staffing and E-Rostering at Hampshire Hospitals Foundation Trust
- Witness 7: Deputy Sister in the Diagnostic and Treatment Centre ("DTC")

Background

The charges arose whilst Mrs Blenkiron was employed as a registered nurse at Cedar Medical Centre, Beggarwood and Rooksdown Practice ("the Practice") and Basingstoke and Hampshire Hospitals Foundation Trust ("the Trust"). The NMC received a referral regarding Mrs Blenkiron from Witness 1 who was concerned Mrs Blenkiron had not informed the Practice that she was subject to restrictions on her practise.

On 17 July 2017 Mrs Blenkiron came before an NMC Fitness to Practice Panel which resulted in a substantive suspension order being imposed on her practice for 12 months. On 12 July 2018, the NMC reviewed and varied the order to a conditions of practice order for 9 months and on 25 October 2018, the NMC reviewed the order again and continued the order with the conditions of practice. Mrs Blenkiron was present at the review hearing on 25 October 2018.

On 22 November 2018 Mrs Blenkiron started working agency shifts for the Practice through Locum Medics, but it is alleged she did not disclose to the Practice that she was subject to conditions of practice order. Further to this, during her employment concerns were raised in relation to her record keeping and administration of flu vaccines and immunisations.

It is also alleged, between 22 November 2018 to 5 December 2018 Ms Blenkiron took smear samples at the Practice without having a sample taker code. On 29 November 2018 Witness 4 signed the sample taker declaration form based upon the assurances given by Ms Blenkiron that her training was up to date and that her paperwork to prove this had been sent to her agency.

On 8 October 2018 Mrs Blenkiron commenced work at the Trust. On commencement of her employment Mrs Blenkiron failed to disclose to the Trust that she was subject to conditions of practice.

After the referral by Witness 1, a Fitness to Practise Panel on 23 January 2019 Mrs Blenkiron's interim conditions of practice order was reviewed and varied to an interim

suspension order. Mrs Blenkiron did not attend this hearing. Subsequently, Mrs Blenkiron attended a substantive hearing on 18 April 2019 where a Fitness to Practise Panel imposed a suspension order for a period of 12 months. Mrs Blenkiron did not inform the Trust until 23 April 2019 that her substantive order had been varied and a suspension order was due to come into effect on 16 May 2019.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC.

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

Charge 1

1. Between 22 November 2018 and 5 December 2018, failed to comply with your conditions of practice whilst working at Beggarwood Practice, in that:

a. You were not under ~~direct~~ supervision;

b. You did not formulate a personal development plan;

These charges are found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witnesses 1, 2, 3, 4, the written evidence of Witness 8 and Mrs Blenkiron's response bundle. The panel also referred to the Conditions of Practice Order dated 25 October 2018 which are as follows:

The panel decided that the public would be suitably protected as would the reputation of the profession by the implementation of the following conditions of practice:

1. *At any time that you are employed or otherwise providing nursing services, you must place yourself and remain under the supervision of a workplace line manager, mentor or supervisor nominated by your employer, such supervision to consist of:*

    i. Working at all times on the same shift as, but not necessarily under the direct observation of, a registered nurse of band 6 or above who is physically present in or on the same ward, unit, floor or home that you are working in or on.

    ii. Weekly meetings for the first 3 months following the commencement of employment as a nurse or midwife to discuss your management of your clinical caseload.

2. *You must work with your line manager, mentor or supervisor (or their nominated deputy) to create a personal development plan designed to address the concerns about the following areas of your practice:*
    i. Medicines Management
    ii. Assessment of risk and management of patients
    iii. Prioritisation of workload
    iv. Record keeping and use of clinical systems

3. *You must provide to the reviewing panel a reflective piece detailing how your insight into your misconduct has developed. This should consist of the following:*
    i. The impact of your failings on your patients
    ii. The impact of your failings on the wider profession
    iii. The impact of your failings on your employer

4. *You must meet with your line manager, mentor or supervisor (or their nominated deputy) at least every month to discuss the standard of your performance and*

your progress towards achieving the aims set out in your personal development plan.

5. *You must forward to the NMC a copy of your personal development plan within 28 days of the date on which you take up an appointment as a nurse or midwife.*

6. *You must send a report from your line manager, mentor or supervisor (or their nominated deputy) setting out the standard of your performance and your progress towards achieving the aims set out in your personal development plan to the NMC every 3 months and at least 14 days before any NMC review hearing or meeting.*

7. *You must allow the NMC to exchange, as necessary, information about the standard of your performance and your progress towards achieving the aims set out in your personal development plan with your line manager, mentor or supervisor (or their nominated deputy) and any other person who is or will be involved in your retraining and supervision with any employer, prospective employer and at any educational establishment.*

8. *You must disclose a report not more than 28 days old from your line manager, mentor or supervisor (or their nominated deputy) setting out the standard of your performance and your progress towards achieving the aims set out in your personal development plan to any current and prospective employers (at the time of application) and any other person who is or will be involved in your retraining and supervision with any employer, prospective employer and at any educational establishment.*

9. *You must tell the NMC within 14 days of any nursing or midwifery appointment (whether paid or unpaid) you accept within the UK or elsewhere, and provide the NMC with contact details of your employer.*

10. *You must tell the NMC about any professional investigation started against you and/or any professional disciplinary proceedings taken against you within 14 days of you receiving notice of them.*

11. *a) You must within 14 days of accepting any post or employment requiring registration with the NMC, or any course of study connected with nursing or midwifery, provide the NMC with the name and contact details of the individual or organisation offering the post, employment or course of study.*

    b) You must within 14 days of entering into any arrangements required by these conditions of practice provide the NMC with the name and contact details of the individual/organisation with whom you have entered into the arrangement.

12. *You must immediately tell the following parties that you are subject to a conditions of practice order under the NMC's fitness to practise procedures, and disclose the conditions listed at (1) to (11) above, to them.*

    1 Any organisation or person employing, contracting with, or using you to undertake nursing or midwifery work.

    2 Any agency you are registered with or apply to be registered with (at the time of application) to provide nursing or midwifery services.

    3 Any prospective employer (at the time of application) where you are applying for any nursing or midwifery appointment.

    4 Any educational establishment at which you are undertaking a course of study connected with nursing or midwifery, or any such establishment to which you apply to take such a course (at the time of application).

The panel considered the evidence of the witnesses that the Practice where Mrs Blenkiron was working, was failing and that all substantive staff had left employment. The panel heard in evidence from Witnesses 2 and 4, that the surgery was being supported by temporary staff and that on various occasions Mrs Blenkiron was the only nurse on duty as all other practice nurses were no longer working at the Practice. It also heard that the nurses who were practicing at the surgery were not qualified to carry out supervision of her.

The panel heard in evidence due to the circumstances of the Practice, Mrs Blenkiron did not have a line manager. She would report to the Practice Manager, but he was not considered as her line manager. There was a doctor on site, for some of the time and he would be available for clinical queries only. Witness 4 confirmed that he was not Mrs Blenkiron's line manager and was not providing any clinical supervision.

The panel acknowledged the evidence that Witness 1 was sent a copy of Mrs Blenkiron's conditions by the agency, which was contained within an attachment to an email, but he did not read them and therefore was not aware of her restrictions. The panel noted the evidence of Mrs Blenkiron that she informed staff on her first day at the practice of her conditions of practice order, but this evidence was not corroborated by any of the live witnesses. Witness 8 in her written evidence recalled that Mrs Blenkiron told her of the conditions of practice on the third or fourth day after commencing her employment. Witness 8 was not her line manager. Witness 1 and 2 had no recollection of Mrs Blenkiron escalating the matter to them as advised by Witness 8. The panel was of the view that Witness 1 should have been aware of the conditions, but based on the status of the surgery and the evidence that Mrs Blenkiron was the only nurse on site on various occasions, it was clear that she would not have been supervised as per her conditions.

In light of the evidence, it was also clear that she did not comply with condition 2 and complete a Personal Development Plan (PDP) with her line manager. The panel noted the PDP that Mrs Blenkiron sent to the NMC before starting at the practice, but it is aware that this was not completed with her line manager as required by her conditions of

practice. The panel noted that she did approach Witness 8 when she wanted to complete a learning plan, but this does not substitute the required PDP. The panel noted there was no evidence from any witnesses that they assisted or helped Mrs Blenkiron complete her PDP.

The panel was of the view that Mrs Blenkiron had a duty to inform the practice where she worked as per condition 12. It is clear she did inform the agency, but she relied on the agency to inform the practice of her conditions and therefore she failed to ensure the conditions were complied with in respect of supervision and preparation of a PDP.

The panel was satisfied that in these circumstances, Mrs Blenkiron failed to comply with conditions 1 and 2 of her order and therefore the panel find these charges proved.

Charge 2

2. Between 22 November 2018 and 5 December 2018, took smear samples at Beggarwood Practice without having a sample taker code / PIN number;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3, 4 and Mrs Blenkiron's response bundle.

The panel acknowledged Mrs Blenkiron's admissions that she had taken a number of smear samples without having a sample taker code/PIN number, which is documented in emails between Mrs Blenkiron and the laboratory dated 3 December 2018. In the emails it is clear she was chasing her PIN.

The panel also considered the sample taker declaration form Mrs Blenkiron signed on 29 November 2018, and one of the requirements on the form which clearly states, the form is

to be completed by nurses who have taken cervical samples in the past 12 months. She would have been aware at the time of signing this form that she had been suspended for the previous 12 months and that she would require retraining in order to receive her PIN and also that she should not be taking samples without it.

In light of this evidence, the panel therefore find this charge proved.

Charge 3

On 29 November 2018, told Dr A that your sample taker training was up to date so that they would sign the sample taker declaration form for you;

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witness 3 and 4. The panel accepted the evidence of Witness 4 when he explained he had asked Mrs Blenkiron for evidence of her training, and she told him that it was an administrative issue with the agency. Mrs Blenkiron told him she was unable to provide him Witness 4 the paperwork to demonstrate she had completed the necessary sample taker training as it had been submitted to the agency.

Witness 4 told the panel that Mrs Blenkiron has assured him, her training was up to date and that is how he came to sign the form.

The panel was satisfied that Mrs Blenkiron told Witness 4 that her training was up to date when it was not, in that as she had not practiced and therefore had not undertaken any smear samples for the previous 12 months and she did not meet the requirements of the declaration. The panel therefore finds this charge proved.

Charge 4

4. Your conduct at charge 3 was dishonest, in that you knew you had not completed said training, but intended for Dr A to believe that you had;

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witnesses 3 and 4. It also took into account the NHS Cervical Screening Programme Guidance for the training of cervical sample takers. The sample taker declaration form signed by Mrs Blenkiron clearly stated a requirement to have taken smears in the last 12 months. Witness 3 also confirms there was ready access to support and advice by the helpline and an email address should practitioners have any queries with regard to training.

Having found charge 3 proved, the panel considered whether Mrs Blenkiron's conduct was dishonest. The panel considered the reason Mrs Blenkiron would have intended for Witness 4 to believe she had completed the necessary training when she had been suspended was in order for her to receive a new PIN so that she could continue to practice. There was no other valid reason. Mrs Blenkiron assured and misled Witness 4 into believing she was fully trained in the taking of smear samples when it should have been clear to her that she was not. Guidance readily available to her clearly indicates that further training was required after her substantial break in practise, during her suspension.

The panel considered that to an ordinary member of the public, it would be clear that Mrs Blenkiron misled Witness 4 in order for her to obtain her PIN and that this was dishonest behaviour. The panel acknowledged Mrs Blenkiron would have access to the guidance and therefore as a professional nurse she should have been aware she was not being honest.

In light of this, the panel therefore finds this charge proved.

Charge 5

5. Between 22 November 2018 and 5 December 2018;

a. Failed to make records of the care and treatment you provided to at least 21 patients;

b. Failed to make adequate patient records in relation to at least 27 patients;

These charges are found NOT proved.

In reaching this decision, the panel took into account the Root Cause Analysis Report dated November 2019. The panel noted none of the witness give evidence in relation to this charge and Mrs Blenkiron does not offer any evidence either. The panel did raise the absence of supporting evidence with the NMC, during the hearing, but no further evidence was provided to the panel.

The panel also noted the absence of the process of obtaining this report, the steps Mrs Blenkiron should have taken, her responsibilities in relation to these patients and where she failed in this incident. The panel also acknowledged it was not provided with the Trust's record keeping policy and where in this instance Mrs Blenkiron's records were inadequate. As this document has been exhibited as an item and not by a specific witness there is also no one to question in relation to its contents.

The panel considered that there was no evidence before it to outline, of the number of patients provided what Mrs Blenkiron's responsibilities were and what information she should have documented. There was also no indication of who the author of the report was.

The panel considered in light of all the missing information that it would be unfair to find this charge proved and whilst there is nothing to indicate this document was not reliable, there is no other evidence to corroborate this document and no information to supports its reliability. In this instance the panel could not place any weight on this document and therefore finds both charge 5a and 5b not proved.

Charge 6

6. Between 8 October 2018 and 18 April 2019, failed to disclose to Hampshire Hospitals NHS Foundation Trust that you were subject to conditions of practice order, in breach of condition 8 of your conditions of practice order;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5, 6, 7, 9 and the exhibited Conditions of Practice Order date 25 October 2018.

The panel considered all the evidence before it and that it was not provided with any evidence by the NMC regarding colleagues or supervisors that Mrs Blenkiron worked with between 8 October 2018 to 8 January 2019 while employed at the Trust. The panel did consider the evidence from 8 January 2019 onwards and determined that there was sufficient evidence for it to consider this charge in relation to those dates.

The panel acknowledged the evidence of Witness 6 who told the panel that he started working at the Trust on 9 January 2019 and at that point, he was not aware Mrs Blenkiron was subject to a conditions of practice order. The panel accepted evidence from all of the live witnesses, who told the panel none of the staff at the Trust were aware Mrs Blenkiron was subject to the conditions of practise. This is also supported by the written evidence of Witness 9, who at the time was responsible for the booking of agency staff. As the panel has already determined, Mrs Blenkiron did tell the agency, but it is clear from the evidence

that she failed disclose her conditions to the Trust directly and that she relied on the agency to tell the Trust.

Witness 5 met with Mrs Blenkiron on both her first and second day on the ward. On the second day had a detailed induction discussion with her and Mrs Blenkiron disclosed that she had not worked on a surgical ward for some 15 years and would require support. Witness 5 is clear that during this discussion there was no mention of conditions of practise and the restrictions placed on her by the NMC.

Witness 7 worked closely with Mrs Blenkiron and undertook her clinical assessments at the start of her placement, but confirmed that at no time had Mrs Blenkiron mentioned her conditions of practise.

The panel noted from Mrs Blenkiron's reflective piece that she states she wished she had been more open, suggesting that she was not open with the Trust at the time:

> *I relied on my agency when I should have been open and honest with staff, it was my responsibility, I should have not been afraid, but I had such problems finding any nursing position.*

This supports the evidence that no one at the Trust was aware of her restrictions.

The panel noted condition 12 of her conditions of practice order and that Mrs Blenkiron had a responsibility to disclose the conditions to the Trust. As the panel have found this was not complied with, the panel therefore find this charge proved.

Charge 7a

7. Between 18 April 2019 and 23 April 2019;

a. Failed to disclose to Hampshire Hospitals NHS Foundation Trust that you were subject to a suspension order;

This charge is found proved.

In reaching this decision, the panel took into account the Substantive Review hearing minutes dated 18 April 2019 at which Mrs Blenkiron was present and represented by Mr Conell Loggenberg. It also took into account the evidence of Witness 6.

The panel had sight of a telephone note from Witness 10 dated 18 April 2019 in which it is documented Mr Loggenberg was informed that Mrs Blenkiron had been suspended on 23 January 2019 for a period of 15 months. There was also a letter dated 24 January 2019 sent to Mrs Blenkiron's home address informing her that the order had been varied and a suspension order had come into force. The panel is aware Mrs Blenkiron did not receive that letter due to moving house, but it was of the view that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address information with the NMC.

The panel are relying on the balance of probabilities that Mr Loggenberg having been present on 18 April 2018 at the review hearing with Mrs Blenkiron, would have informed her that she was suspended at that point. The panel note there was no communication from Mrs Blenkiron or the agency until 23 April 2019. When the agency emailed Witness 6 informing him that Mrs Blenkiron was suspended. It was after receiving that email that Witness 6 confirms *"We took Marian off her shifts".*

The panel noted that Mrs Blenkiron had a duty to tell the Trust, but at no point did she directly inform the them that she was subject to a suspension order. The panel also noted that there was no information from Mrs Blenkiron to suggest she was not aware that she had been suspended. The panel therefore find this charge proved.

Charge 7b

7. Between 18 April 2019 and 23 April 2019;

b. Continued to practice at Hampshire Hospitals NHS Foundation Trust despite being subject to a suspension order;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it and considered the definition of "*Continued to practice".* It considered Mrs Blenkiron's status that as an agency nurse you are only paid for the days that you work. The panel acknowledged that she was not contracted to work between 18 April 2019 and 23 April 2019, neither was she being paid, she did not carry out any shifts and she did not have any shifts booked within this period.

The panel determined that Mrs Blenkiron, did not continue to practice during this time and find this charge not proved.

Charge 8

8. Your conduct at charges 6 and 7a were dishonest, in that you knew you had to disclose the fact of your conditions of practice and/or suspension but wilfully withheld this information;

This charge is found proved. in relation to charge 6, but is found NOT proved in relation to charge 7a.

In reaching this decision, the panel took into account its findings at charge 6 and 7a.

Having found charge 6 proved in relation to the period between 9 January and 18 April 2019, the panel is satisfied Mrs Blenkiron knew she had a duty to disclose the restrictions on her practice to the Trust. It noted an email from Mrs Blenkiron to the NMC dated 2 July 2019, in which she stated:

> *I insisted that the agency informed the GP practise in Basingstoke and the Basingstoke hospital of my conditions to practise prior to commencement of my contracts and both had replied that they did that.*

It was clear to the panel, Mrs Blenkiron was reliant on the agency informing the Trust and that she did not disclose her restrictions directly. The panel considered by not telling the Trust, Mrs Blenkiron was able to continue to practice. Complying with her conditions would have meant that she would have to attend weekly meetings with her line manager and complete a PDP. The witnesses before the panel gave evidence that this did not occur.

The panel was concerned at Mrs Blenkiron's conduct, as she had in the past experienced issues with remaining compliant to her conditions of practice order. The panel expected that because of her previous experience of undertaking conditions of practise, Mrs Blenkiron should have been extra vigilant and taken extra care to adhere to her conditions to ensure she could still practice.

In relation to charge 7a, the panel considered its findings and that Mrs Blenkiron as an experienced nurse would have been aware that any changes to her ability to practice should be communicated to her employer as soon as possible. The panel noted there was a delay in the Trust being made aware of the suspension, it is also aware the during the period between 18 – 23 April 2019, Mrs Blenkiron was not contracted to work, nor did she carry out any shifts. She was an agency nurse, which meant that if she did not work, she would not be paid.

The panel considered that although she did not promptly inform the Trust directly, she did not wilfully withhold the information. The panel therefore finds this charge proved in relation to charge 6 and not proved in relation to charge 7a.

Charge 9

9. On 18 April 2019, at a Substantive Order Review hearing, told the panel that, on your first day working at Hampshire Hospitals NHS Foundation Trust, had discussed your conditions of practice and your need to fulfil said conditions when you had not;

This charge is found proved.

In reaching this decision, the panel took into account the transcript of the Substantive Review Hearing dated 18 April 2019.

The panel noted from the transcript three occasions during the hearing when Mrs Blenkiron told the panel that she discussed her conditions of practice order with a 'Sister' on her first day and of her need to fulfil said conditions:

> *"Q. Okay. So moving on from where you said to the agency now in January, "can you please make sure that they know about the conditions," do you want to move on from there?*
> *A. Well, on the first day I met with the sister"*
>
> *"Q. Did you show a copy of the conditions to the sister?*
> *A. Yes, I always carried one with me.*
> *Q. So the sister was also aware of what the NMC required?*
> *A. Yeah.*
> *Q. At what point did you show the conditions to the sister?*
> *A. On the first day.*

Q. On day one, okay. Was the sister also made aware of the charges that were found proved against you?
A. Yeah."

"Q. So when you started work at this hospital, who did you meet with initially, your very first day?
A. The sister on the ward.
Q. Was that the senior sister, the junior sister?
A. I guess she is a junior sister but she's been there 30 years on the same ward.
Q. Right, okay. And was she aware of your Conditions of Practice Order?
A. Yeah, I took the conditions with me, and the agency informed her as well before I started."

The panel heard from both possible Sisters, Witnesses 5 and 7 of whom Mrs Blenkiron could have been referring to in live evidence, that no such conversation took place on the first day of her employment and that the witnesses were not aware of Mrs Blenkiron's conditions of practice order. The panel also heard from Witness 6 who confirmed the Trust was not aware of her conditions.

The Witnesses all corroborated each other's accounts and were consistent in their evidence. The panel noted that there was no connection between the witnesses and they each set out a clear timeline of events. There was no reason for either of them to fabricate their account. The panel also noted the witnesses had referred to Mrs Blenkiron as a good nurse and Witness 7 was impressed that she had approached her for help when she said others would not have.

The panel further acknowledged the witness statements were made close to the events, ensuring better witness recollection. The panel also acknowledged Mrs Blenkiron's admission that she should have been more transparent with the staff.

In light of this, the panel finds this charge proved.

Charge 10

10. Your conduct at charge 9 was dishonest, in that you knew that you had not discussed your conditions of practice as charged above but intended for the panel to believe you had;

This charge is found proved.

In reaching this decision, the panel took into account its finding at charge 9, Mrs Blenkiron's response bundle and the evidence of Witness 5, 6 and 7.

The panel found Mrs Blenkiron had not discussed her conditions of practice and her need to fulfil said conditions when she said that she had. The panel noted from Mrs Blenkiron's evidence during the substantive review on 18 April 2018, where she explained she had difficulties in securing work whilst subject to the conditions:

> *"Well, in the October I was unable to find any work. I would tell them about the conditions; I did get to a couple of interviews but I wasn't successful…"*

The panel considered Mrs Blenkiron withheld the information as she was concerned about receiving a more severe sanction and her ability to practice. The panel was satisfied after hearing from all the witnesses that Mrs Blenkiron did not disclose her restrictions. It was also satisfied that on 18 April 2019 at the NMC review hearing, she acted dishonestly in misleading the panel into determining that she had, when she knew she had not.

The panel considered the opinion of a member of the public, aware of all the facts of this case, would conclude Mrs Blenkiron had acted dishonestly. There was no other reason for her to mislead the panel at that review, than to be misleading.

In light of this, the panel finds this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Blenkiron's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

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.'*

Mr Maskell also referred the panel to the cases of Calhaem v GMC [2007] EWHC 2006 (Admin), Mallon v General Medical Council [2007] ScotCS CSIH 17 and Nandi v GMC

[2004] EWHC 2317 (Admin). He invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

Mr Maskell identified the specific, relevant standards where Mrs Blenkiron's actions amounted to misconduct. He submitted that that the charges proved amount to misconduct and the charges relating to dishonesty are serious. He further submitted that Mrs Blenkiron's actions fell far below what is expected of a reasonable, experienced and competent nurse.

Mr Maskell told the panel that Mrs Blenkiron took smear samples without a sample taker code, she was dishonest with colleagues, senior staff and patients and had a complete disregard for her regulator in that she continued to practise freely when she knew she had restrictions on her practice.

Submissions on impairment

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

Mr Maskell submitted that Mrs Blenkiron took smear samples without the necessary sample taker code, meaning there was no way for the laboratory to conduct its normal and necessary checks or confirm Mrs Blenkiron's training status and competence. He told the panel that Mrs Blenkiron was also taking samples whilst she had not completed the relevant training.

Mr Maskell told the panel that Mrs Blenkiron was subject to a conditions of practice order as a result of concerns with her practise, but she continued to practise without abiding by these, namely treating patients without supervision when this requirement was clearly deemed necessary.

Mr Maskell submitted that Mrs Blenkiron's actions brought the nursing profession into disrepute and breached the expectations of a registered nurse, in that she showed a blatant disregard for her regulator and by not being open and honest with her employer about the restrictions on her practice. He submitted that the fundamental tenets of the nursing profession have been breached by Mrs Blenkiron. He further submitted that charges 4, 8 and 10, which the panel found proved relate to dishonesty and are serious. He told the panel that although all actions of dishonesty are serious, being dishonest about completing training and with her regulator are particularly grave.

Mr Maskell submitted that the panel need to uphold proper standards and public confidence in the profession, and that they would be undermined if impairment were not found today. He submitted that there is a risk of repetition in this case as the incidents took place of a period of time, with two different employers. He told the panel that Mrs Blenkiron now claims to be retired and there is no evidence that she has worked since these incidents. Therefore, she has not had the opportunity to remediate or strengthen her practice. He told the panel that her retirement must not be a factor in the panel's decision as Mrs Blenkiron could return to practice tomorrow if she so wished. He invited the panel to find Mrs Blenkiron impaired as a result of her misconduct.

The panel accepted the advice of the legal assessor which included references to relevant judgments. These included: *Grant [2011] EWHC 927 (Admin)* and *Johnson & Maggs [2013] EWHC 2140 (Admin).*

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

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

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.6 share information to identify and reduce risk

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.5 complete the necessary training before carrying out a new role

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

To achieve this, you must:

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

23 Cooperate with all investigations and audits

To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Blenkiron's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

The panel considered the charges, particularly the ones relating to dishonesty and determined that they do amount to serious misconduct. The panel considered the impact Mrs Blenkiron's actions had on her colleagues, in that she sought to deliberately mislead Witness 4 and others into thinking she was free to practice whilst her training was not up to date. She continued to practice without restrictions whilst she was subject to a conditions of practice order and then a suspension order. Mrs Blenkiron's colleagues were not aware that there were concerns with her practice, therefore putting them at risk also.

The panel considered the impact Mrs Blenkiron's actions had on the numerous patients she had treated and the risks her conduct had on them. It also had regard to the patients that had to be recalled to have their smear tests repeated and the inconvenience this would have caused to the staff and patients.

The panel considered that the misconduct took place over a period of time, involving two employers and that Mrs Blenkiron disregarded the processes put in place to protect patients. It considered that by not adhering to her restrictions, Mrs Blenkiron demonstrated a lack of integrity.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that patients were put at risk as a result of Mrs Blenkiron's misconduct. Mrs Blenkiron's misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find the charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that Mrs Blenkiron has demonstrated limited insight and an understanding of how her actions put patients at a risk of harm. It noted that she did apologise and she also stated that if she were faced with the same situation again, that she would not repeat her actions.

The panel was not satisfied that due to the dishonesty elements of Mrs Blenkiron's misconduct in this case, that her conduct was capable of being remediated and strengthened. The panel carefully considered the evidence before it in determining whether or not Mrs Blenkiron has strengthened her practice. However, it was not provided with any evidence of remediation, as Mrs Blenkiron has not practised since 2019. The panel is of the view that there is a high risk of repetition based on Mrs Blenkiron's limited insight, lack of evidence of strengthened practice and her admissions. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel was satisfied that a fully informed reasonable member of the public aware of the charges in this case would lose confidence in the profession should a finding of impairment not be imposed. The panel therefore also finds Mrs Blenkiron's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC.

Submissions on sanction

Mr Maskell informed the panel that in the Notice of Hearing, dated 9 May 2022, the NMC had advised Mrs Blenkiron that it would seek the imposition of a striking off order if it found Mrs Blenkiron's fitness to practise currently impaired. He told the panel that there are

number off aggravating features, including, three findings of dishonesty, attitudinal issues, a lack of engagement and that this was not an isolated incident to name a few. He also took the panel through the mitigating factors, which he submitted, aside from the smear samples, were that there were no concerns with Mrs Blenkiron's clinical practice; the contextual matters with the practice in that it was a chaotic working environment and that Mrs Blenkiron had demonstrated limited insight in her 2019 reflective piece.

Mr Maskell referred the panel to the charges found proved at Mrs Blenkiron's previous Fitness to Practise Hearing. He highlighted that those charges also involved Mrs Blenkiron being dishonest by not disclosing her conditions of practice order to her agency at that time and submitting a false document during to the Fitness to Practice hearing.

Mr Maskell submitted that the NMC are seeking a sanction of strike off as Mrs Blenkiron's conduct displays serious concerns. He further submitted that her conduct is incompatible with remaining on the nursing register.

Mr Maskell told the panel, that in conjunction with the strike off order, the NMC will also seek to impose an interim suspension order to cover the 28-day appeal period.

The panel accepted advice from the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- There were three findings of dishonesty;
- Deep seated attitudinal issues;
- Not an isolated incident;
- Continued and repetitive dishonesty;
- A pattern of misconduct over a period of time, with two employers;
- Not adhering to her NMC restrictions;
- Conduct which put patients at unwarranted risk of harm;
- Mrs Blenkiron practised without the necessary supervision;
- Previous NMC history involving dishonest conduct;
- Lack of engagement;
- Lack of duty of candour;
- Lack of acknowledgment and reflection on the impact Mrs Blenkiron's actions had on colleagues, patients and the wider nursing profession.

The panel also took into account the following mitigating features:

- Reports from her colleagues of being a good nurse;
- Chaotic and critical working environment at the GP Practice;
- Problems with effective governance for agency staff at the GP Practice and Hospital Trust;
- Limited insight;
- Mrs Blenkiron did inform the agencies that she was subject to a conditions of practice order.

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

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

The panel next considered whether placing conditions of practice on Mrs Blenkiron's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining.

Furthermore, the panel was not satisfied, given Mrs Blenkiron's lack of adherence to previous conditions and her intentions to retire, that the placing of conditions on her registration would adequately address the seriousness of this case and would not protect the public.

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

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

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

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

Finally, in 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?*

The panel determined that Mrs Blenkiron's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register.

The panel considered the level of deception displayed by Mrs Blenkiron in this case was high. Mrs Blenkiron deliberately covered up her NMC restrictions in order to continue working. Patients had to be recalled for repeated treatment as Mrs Blenkiron was not qualified to conduct the smear samples. The panel considered that there was risk of harm to patients as Mrs Blenkiron was not trained and was not adhering to her conditions of practice order by being supervised. Further the panel considered that Mrs Blenkiron's conduct was premeditated with there being three instances of dishonesty in three separate settings. Mrs Blenkiron lied to Witness 4, to her employers and to her regulator in order

for her to continue working resulting in personal gain. The panel considered her actions to be deliberate and repeated and in view of this, the panel determined that Mrs Blenkiron's actions were so serious that to allow her to continue practising, would undermine public confidence in the profession and in the NMC as a regulatory body.

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 effect of Mrs Blenkiron's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Mrs Blenkiron in writing.

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 Mrs Blenkiron's own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Maskell. He submitted that given the sanction determined by the panel, an interim suspension order is both necessary and proportionate in this case. He invited the panel to impose the order for a period of 18 months, which he stated will cover the twenty-eight-day appeal period in the event Ms Blenkiron chooses to appeal the panel's decision. Mr Maskell submitted that the order was necessary for both public protection and the wider public interest.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the twenty-eight-day appeal period.

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

That concludes this determination.