Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
19- 24 May 2022
26-27 May 2022

Virtual Hearing

Name of registrant:	**Kathryn Mary Jones**
NMC PIN:	07B1081E
Part(s) of the register:	Nursing, Sub part 1 RNA: Registered Nurse- Adult (10 October 2007)
Relevant Location:	Doncaster
Type of case:	Misconduct
Panel members:	Christina McKenzie (Chair, Registrant member) Barry Greene (Lay member) Richard Lyne (Registrant member)
Legal Assessor:	Cyrus Katrak
Hearings Coordinator:	Roshani Wanigasinghe
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Ms Jones:	Not present and unrepresented
Facts proved:	Charges 1b, 4, 5, 6d, 6e, 6f, 7a, 7b, and 8
Facts not proved:	Charges 1a, 1c, 1d, 1e, 1f, 1g, 2, 3, 6a, 6b and 6c.
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 Ms Jones was not in attendance and that the Notice of Hearing had been sent to Ms Jones's registered email address on 5 April 2022.

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

Mr Kennedy, 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.

In the light of all the information available, the panel was satisfied that Ms Jones has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Jones

The panel next considered whether it should proceed in the absence of Ms Jones. It had regard to Rule 21 and heard the submissions of Mr Kennedy who invited the panel to continue in the absence of Ms Jones.

Mr Kennedy referred the panel to the number of emails made to Ms Jones from her NMC case officer enquiring about her attendance at today's hearing, to which Ms Jones replied on 19 April 2022 indicating that she wished to apply for voluntary removal as she wants to *"leave nursing for good".*

Mr Kennedy submitted that, Ms Jones had voluntary absented herself from these proceedings and as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

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 Ms Jones. In reaching this decision, the panel has considered the submissions of Mr Kennedy, the email exchange between Ms Jones and the NMC case officer, and the advice of the legal assessor. It has had particular regard to any relevant case law and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Jones;
- Ms Jones has informed the NMC that she wishes to apply for voluntary removal and therefore was aware that the case was commencing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses have been warned to attended virtually to give live evidence;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018 and 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Jones in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her, she has made no substantive 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 Ms Jones' decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make substantive 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 Ms Jones. The panel will draw no adverse inference from Ms Jones' absence in its findings of fact.

Decision and reasons on application for hearing to be held in private

Mr Kennedy made an application for limited parts of this hearing to be held in private which relate to Ms 5's health. He informed the panel that Ms 5's health would be mentioned briefly in a further preliminary application he intends to make. Mr Kennedy submitted that it is in the interest of Ms 5 that these matters be heard in private. The application was made pursuant to Rule 19 of the Rules.

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

Having heard that there will be reference to Ms 5's health, the panel determined that such matters should be held in private as and when such issues are raised.

Decision and reasons on application pursuant to Rule 31 in respect of admissibility of evidence

The panel heard an application made by Mr Kennedy under Rule 31 of the Rules to allow the hearsay testimony of Ms 5 into evidence.

He referred to *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)* which states:

> [45] For the purposes of this appeal, the relevant principles which emerge from the authorities are these:
>
> "1.1.The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.
>
> 1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.
>
> 1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.
>
> 1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is relevant and that it is fair to admit it."

Mr Kennedy referred the panel to the hearsay bundle in which it includes details of various correspondence between Ms 5 and the NMC case officer. Mr Kennedy referred the panel to a further telephone note dated 16 May 2022, **[PRIVATE].**

Mr Kennedy told the panel that Ms 5's evidence was in relation to charges 4-6. He submitted that hearsay is admissible in civil proceedings and that the test of admissibility is subject to relevance and fairness.

[PRIVATE].

He submitted that Ms 5's evidence is not the sole and decisive evidence with respect to charge 4-5, as the application form itself completed, dated and signed by Ms Jones is before the panel. He further submitted that the panel had before it the form in which Ms Jones ticks 'no' to the question of whether she is subject to any NMC investigations as well as the manuscript statement from Ms Jones herself.

In relation to charge 6, Mr Kennedy submitted that Ms 5's evidence may be the sole and decisive evidence as she was the individual responsible for stating where the observation document was completed incorrectly, any other documents were updated incorrectly and if there were any other documents required to be updated at all. He however referred the panel to a further accident form completed by another senior carer to assist with charge 6 which the panel can place weight on.

Mr Kennedy reminded the panel, that with regard to fairness it could attach less weight to the evidence on the basis that it had not been tested by way of cross-examination.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 of the Rules provides that, so far as it is 'fair and relevant,' a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal

assessor also referred the panel to the relevant considerations as set out in the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*.

From the authority of *Thorneycroft,* the panel took into consideration the various principles derived from this case. It considered whether Ms Jones would be disadvantaged by this application. The panel noted that Ms Jones had been made aware that **[PRIVATE]**, the NMC would be seeking to allow hearsay testimony into evidence. Further the panel had already determined that Ms Jones had chosen voluntarily to absent herself from these proceedings, and the panel if they so wished could test the evidence of the witnesses. There is also a public interest in the issues being explored fully, which supported the admission of this evidence into the proceedings.

The panel was satisfied that the evidence of Ms 5 is relevant, noting that it gave direct evidence of the alleged incident contained in charges 4-6.

With regard to fairness, the panel noted that Ms 5's evidence to the NMC was not the sole and decisive evidence in relation to charges 4-6, there were also other information including forms and statements by Ms Jones that provides evidence in relation to these charges.

[PRIVATE].

The panel was also of the view that the statement of Ms 5 was not contradictory to the other evidence before it and corroborated her contemporaneous statement and interviews made following the incident. Whilst it acknowledged that Ms 5 would have been able to provide further context to charges 4-6, the panel noted that it would attach what weight it deems appropriate to the evidence on the basis that it had not been tested by way of cross-examination.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Ms 5, and would give the hearsay evidence the appropriate weight once the panel had heard and evaluated all the evidence before it.

Details of charge

That you, a registered nurse:

1. On 4 January 2018, failed to provide adequate care for Resident A following their fall, in that you failed to:

    a. Recognise the injury as a head injury **[Charge found NOT proved]**
    b. Complete observations; **[Charge found proved]**
    c. Ensure an accident form was completed correctly; **[Charge found NOT proved]**
    d. Update the mobility care plan; **[Charge found NOT proved]**
    e. Update the falls risk review; **[Charge found NOT proved]**
    f. Notify next of kin; **[Charge found NOT proved]**
    g. Recognise the need for an assessment at A&E; **[Charge found NOT proved]**

2. On 3 October 2018, failed to disclose to Exemplar Healthcare Service that you were subject to a Nursing and Midwifery Council investigation; **[Charge found NOT proved]**

3. Your conduct at charge 2 was dishonest, in that you answered “no” on their application form to the question “have you ever been referred to the NMC?” when you knew the answer was ‘yes’; **[Charge found NOT proved]**

4. On 30 November 2018, failed to disclose to Laureate Court and /or Belmont Agency that you were subject to a Nursing and Midwifery Council investigation; **[Charge found proved]**

5. Your conduct at charge 4 was dishonest, in that you answered “no” on their application form to the question “are you currently under investigation for misconduct?” when you knew the answer was ‘yes’; **[Charge found proved]**

6. On 19 February 2019, failed to provide adequate care for Resident B following their fall, in that you failed to:

    a. Ensure that an observation record was completed correctly; **[Charge found NOT proved]**
    b. Complete an accident and incident form; **[Charge found NOT proved]**
    c. Update the daily care records; **[Charge found NOT proved]**
    d. Complete a fall risk assessment; **[Charge found proved]**
    e. Update the multidisciplinary team and communication record; **[Charge found proved]**
    f. Evaluate Resident B and update their care plan; **[Charge found proved]**

7. On 6 November 2019, in relation to Resident C:

    a. failed to carry out bowel irrigation; **[Charge found proved]**
    b. signed the bowel irrigation chart to suggest that you had carried out the bowel irrigation; **[Charge found proved]**

8. Your conduct at charge 7.b. was dishonest in that you intended anyone reading the bowel irrigation chart to be believe that you had carried out the bowel irrigation when you had not; **[Charge found proved]**

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

Background

The NMC received a referral from Educare Staffing Limited on 23 April 2018 regarding concerns about Ms Jones' practice.

Ms Jones has been a registered nurse since 2007 and was employed by Educare between 25 October 2017 and 05 January 2018. The referral relates to Ms Jones' practice at Adeline House Care Home (the Home) where she allegedly failure to recognise a head injury and failed to seek appropriate medical help following a resident's unwitnessed fall.

It is alleged that at 14.20 on 4 January 2018, a carer found a resident on the floor, with a graze to the right eye and knee. It is alleged that Ms Jones failed to recognise a head injury, had failed to complete an incident form, failed to update care plans and failed to follow post falls protocol.

It is alleged that the Resident was taking regular prescription of Apixaban (anticoagulant). It is alleged that Guidance recommends referral to Accident and Emergency (A&E) within 8 hours for consideration of a computer assisted tomography scan (CAT scan) if potential head injury had taken place for anyone taking Apixaban. Ms Jones had not consulted the British National Formulary (BNF) or sought advice on consequences of the resident taking this medication in the given circumstances. She had failed to contact the resident's daughter. The daughter had called the Home at around 4:20 pm to check on the resident. It is alleged that when she called on 4 January 2018, Ms Jones about the guidance for Apixaban.

It is further alleged that another nurse had called for an emergency ambulance at 21.00 when the Resident had become more unresponsive.

Ms Jones had given her notice on 15 January 2018, prior to a Disciplinary Meeting at Adeline House Care Home on 16 January.

Charges 2-5 relate to failure to inform subsequent employers that Ms Jones was under investigation by the NMC and the dishonesty involved by not informing them of these investigations.

Charge 6 relates to Resident B who had a fall in a second care home, and the alleged failure to record the appropriate documentation and update and complete relevant care plans.

Charges 7 and 8 relate to Resident C in a third care home and the failure to carry out a bowel irrigation, the alleged falsification of records relating to that failure and the associated dishonesty.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Ms Jones.

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:

- Ms 1: Home Manager for Adeline Care Home;
- Ms 2: HR Manager at the time of the concerns at the Home;
- Ms 3: NMC Investigator;
- Mr 4: Home Manager at Chapel Lodge Care Home.

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

Charge 1

In its consideration of charge 1, the panel bore in mind that this was Ms Jones' first shift and only shift at the Home. It noted that Ms Jones was not allowed to return to work following her shift, and she was therefore prevented from the opportunity to update care plans and other documents. Not all care plans needed immediate updating and the panel considered it unreasonable to categorise such incompletions as failures as Ms Jones' was not allowed back to complete any such forms.

Charge 1a

1. On 4 January 2018, failed to provide adequate care for Resident A following their fall, in that you failed to:

    a. Recognise the injury as a head injury.

This charge is found NOT proved.

In reaching this decision, the panel took into account the Interview meeting notes dated 10 January 2018 and the email from Ms Jones to the NMC dated 9 May 2022.

The panel had sight of the interview meeting notes dates 10 January 2018 in which it states:

> *"Kathryn recalls what she believed to have happened, which is as follows – Carer asked Kathryn to go and check on a service user after they had a fall. There were no witnesses of the fall. Kathryn checked service user, no broken bones were found however there were some grazes under the Service User's eye and on her knee. Kathryn also mentioned injuries such as a red mark present on the service user's cheek bone. Kathryn stated that she didn't consider this to be a head injury. Kathryn informed [Ms 1], the home manager about Service User fall and filled out an accident report form and daily logs. When asked by [the Investigator] if Kathryn had completed the service user's medication earlier in the day, Kathryn confirms she had completed the service user's anticoagulant medication in the morning round. Kathryn claims that herself and [Ms 1] at the time didn't think that the service user was on anticoagulant medication."*

The panel considered the contents of Ms Jones' email to the NMC dated 9 May 2022 very carefully. She wrote:

> *"…Also when the incident happened I asked [Ms 1] as a second opinion do you think I should ring an ambulance, and she said NO. "*

The panel then had sight of Ms 1's witness statement dated 11 November 2019 which states:

> *"Resident A was sent to the hospital via a non-emergency ambulance around 21:00 hours or 22:00 hours. She waited 5 hours to be seen and at one point became aggressive, which is unusual for Resident A. She was given diazepam, which is a*

sedative, to clam her down…there were lot of events that had taken place which could have triggered her distressed response but had appropriate help been sought earlier, the experience could've been less traumatic for her. She could've had her scan and been returned to the home without distress.

I don't believe there was any harm caused to her as a result of Kathryn's failings. On 14 January 2018 Resident a went back to hospital and had the CT scan of her head which showed no changes…"

The panel noted that Ms Jones had recognised that there was a graze to Resident A's cheek, however, did not consider it to be anymore serious than that, in order to be considered as a head injury. It recognised from the information before it, that Ms Jones had sought advice from colleagues before contacting emergency services and was advised to call them on a 'non-urgent' basis.

The panel noted the wording of the charge and considered that the term "head injury" is not specific in the charge, therefore the marks identified by Ms Jones could be considered as a "head injury" themselves.

The panel reminded itself that the burden of proof at the fact-finding stage is on the NMC and is on the balance of probabilities. In relation to this charge, the panel determined that the NMC had not discharged the burden of proof and therefore the panel found charge 1a not proved.

Charge 1b

1. On 4 January 2018, failed to provide adequate care for Resident A following their fall, in that you failed to:

b. Complete observations.

This charge is found proved.

In reaching this decision, the panel took into account the Interview meeting notes dated 10 January 2018 and Resident A's daily notes.

The panel had sight of the interview meeting notes dated 10 January 2018 in which Ms Jones accepts that she did not complete the observations. The panel noted that it stated:

> *"[The Investigator] asked Kathryn if she had monitored the Service User after the fall and Kathryn admitted that she didn't, but she should have…"*

The panel further had sight of Resident A's daily notes in which it noted that there were no records to indicate that Ms Jones had carried out any observations.

The panel was satisfied from the evidence before it that Ms Jones, on 4 January 2018, failed to provide adequate care for Resident A following their fall, in that she failed to complete observations.

The panel therefore found charge 1b proved.

Charge 1c

1. On 4 January 2018, failed to provide adequate care for Resident A following their fall, in that you failed to:

    c. Ensure an accident form was completed correctly.

This charge is found NOT proved.

In reaching this decision, the panel took into account the Interview meeting notes dated 10 January 2018, Resident A's accident record and Ms 1's evidence.

The panel noted the interview meeting notes dated 10 January 2018 in which it stated:

> *"Kathryn informed [Ms 1], the home manager about Service User fall and filled out an accident report form and daily logs."*

The panel bore in mind Ms 1's evidence in which she stated that there was space in the back of the form to provide further detail, which had not been done.

The panel then had sight of Resident A's accident report. It noted that all sections of the form has been filled and completed by Ms Jones. The panel was of the view that, perhaps the form was not filled to the standard required by Ms 1, however, the form had all sections completed. Having had sight of the form, the panel noted that any additional information could have been provided at the back of the form, but there is no indication on the form that any such additional information was a requirement.

The panel therefore determined that on 4 January 2018, Ms Jones did ensure an accident form was completed correctly following Resident A's fall.

The panel reminded itself that the burden of proof at the fact-finding stage is on the NMC and is on the balance of probabilities. In relation to this charge, the panel determined that the NMC had not discharged the burden of proof and therefore the panel found charge 1c not proved.

Charge 1d

> 1. On 4 January 2018, failed to provide adequate care for Resident A following their fall, in that you failed to:
>
> d. Update the mobility care plan.

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident A' mobility care plan and the Post Falls Protocol.

The panel had sight of the Post Falls Protocol in which it states, in relation to mobility care plans that:

> *"WRITE A DETAILED ENTRY IN THE MOBILITY CARE PLAN TO INCLUDE – LOCATION OF FALL, TIME OF FALL, WITNESSED OR UNWITNESSED, POSITION OF RESIDENT, ASSESSMENT OR CHECKS UNDERTAKEN, ADVICE SOUGHT, ANY OTHER ACTION, IF THE RESIDENT HAS ANY FALLS PREVENTION EQUIPMENT WAS IT IN PLACE APPROPRIATELY AND WORKING. INCLUDE A REVIEW OF THE LAST 3 MONTHS AND DETERMINE IF ANY NEW ACTION OR REFFERAL IS REQUIRED."*

The panel bore in mind the evidence it had heard that the Post Falls Protocol was hung on the nursing office wall. However it noted that the document it had seen was undated and therefore the panel could not be certain whether this protocol was in place at the time of the events.

The panel further noted that this was Ms Jones' first and only shift at the Home. It reminded itself that Ms Jones was not allowed to return to practice at the Home following this incident, and therefore she was prevented the opportunity to update the mobility care plan. It reminded itself of the evidence it heard, that mobility care plans are reviewed on a monthly basis, unless for ad hoc reasons. In the absence of any time scales that indicated when to review this document, the panel determined that there was no failure on Ms Jones' part. It further noted that the care plan was updated the following day by the Home Manager.

The panel reminded itself that the burden of proof at the fact-finding stage is on the NMC and is on the balance of probabilities. In relation to this charge, the panel determined that the NMC had not discharged the burden of proof and therefore the panel found charge 1d not proved.

Charge 1e

1. On 4 January 2018, failed to provide adequate care for Resident A following their fall, in that you failed to:

e. Update the falls risk review.

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident A' care plan and the Post Falls Protocol.

The panel noted that, similar to charge 1d above, the panel was not provided with any specific time frames in which this ought to have been completed. It noted from the care plan that Ms Jones had recorded "*Falls risk updated and care plan."* However, the panel was not provided with the falls risk documentation or any information regarding it.

The panel reminded itself that the burden of proof at the fact-finding stage is on the NMC and is on the balance of probabilities. In relation to this charge, the panel determined that the NMC had not discharged the burden of proof and therefore the panel found charge 1e not proved.

Charge 1f

1. On 4 January 2018, failed to provide adequate care for Resident A following their fall, in that you failed to:

f. Notify next of kin.

This charge is found NOT proved.

In reaching this decision, the panel took into account an email dated 5 January 2018 from Ms 1 to Educare, an email dated 4 January 2018 from Resident A's daughter to the Home

The panel noted the email dated 5 January 2018 from Ms 1 to Educare, which states:

> *"So on the 4th at Approx 14:20pm Resident A was found on the floor by a carer in her bedroom. Kathryn attended and checked Resident A over. She noted a small graze to her right eye and knee. Kathryn tells me despite the graze to her eye she didn't consider a head injury. Resident A is prescribed Apixaban anticoagulant, guidance recommends any one prescribed apixaban that has a fall and potential head injury should attend A and E for consideration of a CT Head within 8 hours. Kathryn monitored Resident A and approx. 4pm her daughter rang to check how Resident A was, Kathryn informed the daughter Resident A had fallen and was ok."*

The panel also had sight of an email dated 4 January 2018 from Resident A's daughter to the Home, in which it states:

> *"…As usual, I phone today, Thursday 4 January, around 4.20 and spoke to the Bank nurse called Catherine [Ms Jones], to enquire how mam was. Catherine told me she was fine but that she had 'forgotten' to let me know that mam had been found on the floor in her room earlier that day. She said she'd only grazed her knee and her eye but would probably have a black eye tomorrow…*
>
> *I was so concerned that I came to visit mam at Adeline. I spoke to some of the carers who said that she'd fallen around 2-2.30 that afternoon…"*

The panel took all of the information into consideration. It noted that Ms Jones had learned of Resident A's fall and had attended to check on the Resident shortly after 2:30 pm. The panel then bore in mind that Resident A's daughter had spoken to Ms Jones at approximately 4.20pm.

The panel noted that Ms Jones had informed Resident A's daughter about resident A's fall during that phone call and had been open and honest about the details of the fall and had fulfilled her duty of candour. The panel noted that the time frame of when the fall occurred and the updating of the next of kin was approximately 2 hours. The panel heard from Ms 1 that she considered a 2 hour time frame to be a reasonable period to informing next of kin of any incidents. The panel determined that it was satisfied from the information before it that Ms Jones had updated the Resident's daughter about Resident A's fall. The panel considered that 2 hours following a fall for an update was a reasonable time period. Ms Jones was the only nurse on duty and would be concerned about assisting the resident and assessing/ treating any injuries as her priority. She also had to provide nursing care for other home residents.

The panel reminded itself that the burden of proof at the fact-finding stage is on the NMC and is on the balance of probabilities. In relation to this charge, the panel determined that the NMC had not discharged the burden of proof and therefore the panel found charge 1f not proved.

Charge 1g

1. On 4 January 2018, failed to provide adequate care for Resident A following their fall, in that you failed to:

    g. Recognise the need for an assessment at A&E.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Ms 1, her email to Educare on 5 January 2018 and Ms Jones' email to the NMC dated 9 May 2022.

The panel bore in mind Ms 1's oral evidence in which she said that she did not feel it necessary for an assessment at A&E and that a review by an Emergency Care Practitioner (ECP) within primary care was sufficient.

The panel had sight of Ms 1's email to Educare on 5 January 2018, in which she wrote:

> *"So on the 4th at Approx 14:20pm Resdient A was found on the floor by a carer in her bedroom. Kathryn attended and checked Resident A over. She noted a small graze to her right eye and knee. Kathryn tells me despite the graze to her eye she didn't consider a head injury. Resident A is prescribed Apixaban anticoagulant, guidance recommends any one prescribed apixaban that has a fall and potential head injury should attend A and E for consideration of a CT Head within 8 hours. Kathryn monitored Resident A and approx. 4pm her daughter rang to check how Resident A was, Kathryn informed the daughter had fallen and was ok. [Resident A's daughter] advised Kathryn about the Apixaban and the need for checking at A and E. Kathryn called ECP for advice and arranged a non urgent ambulance."*

The panel noted Ms Jones' email dated 9 May 2022 to the NMC in which she stated:

> *"Also when the incident happened I asked [Ms 1] as a second opinion do you think I should ring an ambulance, and she aid NO [sic]"*

The panel bore in mind that Ms Jones had inquired and sought further advice from her senior regarding the necessity for an A&E assessment. The panel was satisfied that she was advised against A&E, which was confirmed by Ms 1 during oral evidence. The panel was therefore of the view that there was no failure on Ms Jones' part to recognise that Resident A needed an assessment at A&E as charged.

The panel reminded itself that the burden of proof at the fact-finding stage is on the NMC and is on the balance of probabilities. In relation to this charge, the panel determined that the NMC had not discharged the burden of proof and therefore the panel found charge 1g not proved.

Charge 2

> 2. On 3 October 2018, failed to disclose to Exemplar Healthcare Service that you were subject to a Nursing and Midwifery Council investigation.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Ms 2.

The panel considered the evidence it had heard from Ms 2, who confirmed to the panel that the form was an automatically generated form used by Agencies. She said that she was unable to see who the form was completed by, but, she could identify that it was not sent by Ms Jones. Ms 2 informed the panel that she was able to positively say so due to the lack of a National Insurance number on the form and the inclusion of an Agency name as a header, which usually indicates that it was completed by an Agency.

The panel noted that it did not have any further evidence in relation to this charge. The panel determined that it did not have sufficient information before it to satisfy it that Ms Jones made or was aware of the assertion on the form that she was not under investigation.

The panel reminded itself that the burden of proof at the fact-finding stage is on the NMC and is on the balance of probabilities. In relation to this charge, the panel determined that the NMC had not discharged the burden of proof and therefore the panel found charge 2 not proved.

Charge 3

3. Your conduct at charge 2 was dishonest, in that you answered “no” on their application form to the question “have you ever been referred to the NMC?” when you knew the answer was ‘yes’.

This charge is found NOT proved.

In reaching this decision, the panel took into account it’s decision at charge 2 above. The panel determined that by virtue of charge 2 not being found proved, this charge is also found not proved.

Charge 4

4. On 30 November 2018, failed to disclose to Laureate Court and /or Belmont Agency that you were subject to a Nursing and Midwifery Council investigation.

This charge is found proved.

In reaching this decision, the panel took into account of a handwritten application form dated 30 November 2018 by Ms Jones, which was signed and dated by Ms Jones the letters from the NMC to Ms Jones dated 30 April 2018 and 27 September 2018. The panel also took into account Ms 5’s witness statement dated 13 September 2019 and a letter from her to the NMC dated 13 September 2019.

The panel had sight of a handwritten application form dated 30 November 2018, which was signed and dated by Ms Jones. The panel noted a section entitled *‘MISCONDUCT’* in which the question of ‘*Are you currently under investigation for misconduct?’* was answered no.

The panel had sight of the NMC letter dated 30 April 2018 which was sent to Ms Jones via recorded delivery, which stated that the NMC had received a referral from Educare Staffing Limited. The letter makes clear that it is sent to her just to inform her that the NMC has a case open and that they were making enquiries.

The panel then had sight of the second NMC letter dated 27 September 2018 which was again sent to Ms Jones via recorded delivery, which stated that the NMC had decided that the concerns about her fitness to practice needed to be considered by the Case Examiners and therefore further investigations will be carried out if necessary.

The panel then noted Ms 5's witness statement dated 13 September 2019 where she said:

> *"I became aware of the NMC referral on 7 February 2019, Kathryn came downstairs into my office and told me that a referral had been made. I asked her what she meant by this, and then asked her when this had taken place. Kathryn said that this happened in her previous role. I asked Kathryn why she had not told me this before and she said she should have. Kathryn said that this lady's daughter said that she would report to the NMC, but she did not think that she had done so. I do not know their names. I told Kathryn that this was not good enough. I thought this was appalling behaviour, it is much better to be open and honest".*

The panel were satisfied that Ms Jones was or should have been aware from letters sent by the NMC on 30 April 2018 and 27 September 2018 that she was under investigation.

The panel further had sight of a letter dated 13 September 2019 sent from Ms 5 to the NMC in which she wrote:

> *"Kathryn Jones commenced work at Laureate Court in Nov 2018, as a Registered Nurse. I have attached a job description which clearly defines the role and responsibility. Kathryn did not disclose the potential hearing. I learned about that on*

the 07/02/2019 when she came into my office to tell me that there had been a concern in another Care home…"

The panel had sufficient evidence to satisfy it that Ms Jones was informed by the NMC that she was subject to an investigation. It heard from Ms 3 who supplied contacts and correspondence between the NMC and Ms Jones, including;

- A notice of referral letter dated 30 April 2018;
- A notice of referral to Case Examiners dated 27 September 2018;
- Telephone call on 16 May 2018 to which Ms Jones responded by email;
- Emails from the NMC on 22 May 2018 requesting the return of her Personal Contacts and Employment Details form (PCED form);
- Email to Ms Jones regarding investigation progression on 8 June 2018;
- NMC letter to Ms Jones regarding her PCED dated 21 December 2018;
- Letter to Ms Jones regarding her PCED dated 23 January 2019;
- Emails regarding the PCED to Ms Jones dated 4 February 2019;
- Email to Ms Jones regarding enquires on 4 and 5 February 2019; and
- Letter to Ms Jones about further investigation on 16 August 2019.

The panel was then satisfied from the evidence before it that on the balance of probabilities, on 30 November 2018, Ms Jones was aware that she was under investigation and she failed to disclose to Laureate Court and /or Belmont Agency that she was subject to a Nursing and Midwifery Council investigation.

The panel therefore found charge 4 proved.

Charge 5

5. Your conduct at charge 4 was dishonest, in that you answered "no" on their application form to the question "are you currently under investigation for misconduct?" when you knew the answer was 'yes'.

This charge is found proved.

The panel took into account the NMC guidance on dishonesty and applied the case of *Ivy v Genting Casinos* [2017] UKSC 67.

In reaching this decision, the panel took into account its decision at charge 4 above. It also took into account Ms Jones statement dated 7 February 2019, the letters sent by the NMC dated 30 April 2018 and 27 September 2018 and the various email communications from the NMC case officer to Ms Jones including an email dated 15 May 2018.

The panel first had sight of Ms Jones statement dated 7 February 2019 in which she stated:

> *The reason I did not mention it at my interview is because I had not heard anything form them, and I was going to tell [Ms 5] when I did. This action did [sic] not meant to be deceitful at all, in any shape or form. I realised I should have informed [Ms 5] earlier.*

The panel further noted that the NMC letter dated 27 September 2018 sent to Ms Jones via recorded delivery, stated that the NMC had decided that the concerns about her fitness to practice needed to be considered by the Case Examiners and therefore further investigations will be carried out if necessary. The letter also mentioned what the particular regulatory concerns were.

The panel further had sight of an email dated 15 May 2018 from a NMC case officer to Ms Jones, in which it stated the following:

> *“I write further to my email below as we are yet to receive a response from you.*
>
> *I would like to remind you of:*

Section 23 of The Code: Professional standards of practice and behaviour for nurses and midwives requires to you cooperate with this investigation, and that failure to do so may result in the NMC taking action against you.

I would appeal to you provide us with necessary information and or an update why they is a delay in acknowledging receipt of our request."

The panel bore in mind its determination at charge 4 above that it was satisfied from the evidence before it that on 30 November 2018, Ms Jones failed to disclose to Laureate Court and /or Belmont Agency that she was subject to a Nursing and Midwifery Council investigation. The panel found that it had evidence before it to indicate that Ms Jones had been sent multiple letters and correspondence via different means to inform her that she was subject to investigation. The panel found this evidence reaffirms its position that Ms Jones answered "no" on Laureate Court and /or Belmont Agency's application form to the question "are you currently under investigation for misconduct?" when she knew the answer was 'yes'.

The panel was not persuaded by Ms Jones statement to Ms 5 that she was not trying to be deceitful. The panel found that Ms Jones actions at charge 5 would be considered dishonest by the standards of ordinary reasonable people.

The panel therefore found charge 5 proved.

Charge 6

The panel noted that the evidence in Ms 5's statement related mostly to charge 6 and it's sub charges. The panel noted that Ms 5 was unable to give live evidence due to health reasons, which meant that her evidence remained untested. The panel bore in mind that it was unable to explore what the normal culture and practices of the Home were during the time of these events.

Charge 6a

6. On 19 February 2019, failed to provide adequate care for Resident B following their fall, in that you failed to:

a. Ensure that an observation record was completed correctly.

This charge is found NOT proved.

In reaching this decision, the panel took into account the written evidence from Ms 5 dated 13 September 2019 and Resident B's observation record.

The panel noted that Ms 5 wrote in her witness statement dated 13 September 2019:

"The Observation Chart that was completed was done using the incorrect form. Kathryn should have overseen this and not let the carers do it. The correct Observation Record has not been completed by Kathryn, all the entries up until 13:30 hours and the same up until 23:00 ours are from [another colleague] the Senior Carer."

The panel noted that Ms 5 indicated that Ms Jones had completed the observation records incorrectly, in that she used the wrong form. The panel has sight of Resident B's observation chart and noted that it had been completed correctly and regularly. The panel have not had an opportunity to test Ms 5's evidence as to why she states that Ms Jones had completed the wrong form. The panel was unable to identify any gaps in the observation record.

The panel reminded itself that the burden of proof at the fact-finding stage is on the NMC and is on the balance of probabilities. In relation to this charge, the panel determined that the NMC had not discharged the burden of proof and therefore the panel found charge 6a not proved.

Charge 6b

6. On 19 February 2019, failed to provide adequate care for Resident B following their fall, in that you failed to:

b. Complete an accident and incident form.

This charge is found NOT proved.

In reaching this decision, the panel took into account the Accident and Incident report and Investigation Policy and Resident B's daily care record between 18 February 2019 and 24 February 2019.

The panel noted that the Accident and Incident report and Investigation Policy states the following:

"Named Nurse/Team Leader is responsible for completing Accident & Incident Reports when necessary and for documenting the appropriate information legibly and in sufficient detail."

The panel then had sight of Resident B's daily care record between 18 February 2019 and 24 February 2019, which indicated that two other members of staff were Resident B's keyworker and named nurse on those dates. The panel were therefore not satisfied from the evidence that Ms Jones was the named nurse or team leader and therefore found that she did not have a duty to complete the Accident & Incident form.

The panel reminded itself that the burden of proof at the fact-finding stage is on the NMC and is on the balance of probabilities. In relation to this charge, the panel determined that the NMC had not discharged the burden of proof and therefore the panel found charge 6b not proved.

Charge 6c

6. On 19 February 2019, failed to provide adequate care for Resident B following their fall, in that you failed to:

c. Update the daily care records.

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident B's daily care records and Ms 5's witness statement.

The panel noted that Ms 5 states in her witness statement dated 13 September 2019 that:

"The Daily Care Record has been completed. The fall was documented by a carer and not by Kathryn as the nurse on duty. The carer was right here but it is the responsibility of the nurse to complete these records."

The panel also noted that the daily care record for Resident B within the bundle is missing pages 2, 3, 4 and 5. The panel was of the view that it was unable to determine with the limited information before it, whether Ms Jones on 19 February 2019, failed to provide adequate care for Resident B following their fall, by failing to update the daily care records.

The panel reminded itself that the burden of proof at the fact-finding stage is on the NMC and is on the balance of probabilities. In relation to this charge, the panel determined that the NMC had not discharged the burden of proof and therefore the panel found charge 6c not proved.

Charge 6d

6. On 19 February 2019, failed to provide adequate care for Resident B following their fall, in that you failed to:

d. Complete a fall risk assessment.

This charge is found proved.

In reaching this decision, the panel took into account Ms 5's witness statement, Falls Risk Assessment chart.

The panel had sight of Ms 5's witness statement dated 13 September 2019 in which she said:

> *"The Falls Risk Assessment is filled in monthly but if there is a fall then this should be documented on the evaluation and Falls Risk Assessment because this could create a higher risk score. There is nothing documented about the fall on 19 February 2019 and Kathryn should have done this. The last review was on 21 February 2019 and before that was on 12 February 2019. There is no risk review of Resident B on the 19th."*

The panel had sight of the Falls Risk Assessment in which it identified that there were monthly entries from December 2018 until February 2019 on falls recorded on the same day. The panel noted that other members of staff updated the Risk Assessment Form on the days that a fall had occurred. There was no entry for the 19 February 2019 when this fall occurred. The panel was able to confirm that Ms Jones was the nurse on duty on that day through her signature on the GP and Multidisciplinary team visit and communication record.

The panel bore in mind the nature and needs of Resident B, and was of the view that a fall should have been risk assessed immediately and notes made on the chart on the day for any resident, particularly when the resident is known to be vulnerable and frail. The panel

was satisfied from the information before it, that Ms Jones, on 19 February 2019, failed to provide adequate care for Resident B following their fall, in that she failed to complete a fall risk assessment.

Charge 6e

> 6. On 19 February 2019, failed to provide adequate care for Resident B following their fall, in that you failed to:
>
> > e. Update the multidisciplinary team and communication record.

This charge is found proved.

In reaching this decision, the panel took into account Ms 5's witness statement and the multidisciplinary team and communication record.

The panel noted that Ms 5 stated in her witness statement dated 13 September 2019 that:

> *"We use the Multidisciplinary Team and Communication Record when we have visits from the Long Term Conditions Nurse (LTCN). The LTCN would come after 08:00 hours to check the residents' daily blood pressure levels. This is because a lot of our residents' have low blood pressure. There is no record of the fall that took place on 19 February 2019, which would have been information that the LTCN should have known, so they have a full picture."*

The panel had sight of the multidisciplinary team and communication record and noted that there were no entries in relation to that fall. Given the lack of any such entries and the confirmation that Ms Jones was the nurse on duty, the panel was satisfied that Ms Jones, on 19 February 2019, failed to provide adequate care for Resident B following their fall, in that she failed to update the multidisciplinary team and communication record.

The panel therefore found charge 6e proved.

Charge 6f

> 6. On 19 February 2019, failed to provide adequate care for Resident B following their fall, in that you failed to:
>
> f. Evaluate Resident B and update their care plan.

This charge is found proved.

In reaching this decision, the panel took into account Ms 5's witness statement and the multidisciplinary team and communication record.

The panel noted that Ms 5 states in her witness statement dated 13 September 2019 that:

> *"If there has been a fall by a resident, you would expect to see this added to the Care Plan Evaluation. The evaluation of the resident moves from 12 February 2019 to 22 February 2019, again there is no record of Resident B's fall on 19 February 2019. Resident B's health was deteriorating, not because of the fall, but because his general health was worsening as he was a dying man. This resident passed away on 24 February 2019 due to his illness. Kathryn should have been checking and documenting properly following a fall for this kind of resident, even though he only suffered a cut to the hand."*

The panel had sight of Resident B's care plan and noted that there were no entries in relation to the fall. Given the lack of any such entries and the confirmation that Ms Jones was the nurse on duty, the panel was satisfied that Ms Jones, on 19 February 2019, failed to provide adequate care for Resident B following their fall, in that she failed to evaluate Resident B and update their care plan.

The panel therefore found charge 6f proved.

Charge 7a and 7b

7. On 6 November 2019, in relation to Resident C:

a. failed to carry out bowel irrigation;
b. signed the bowel irrigation chart to suggest that you had carried out the bowel irrigation.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the Probationary Meeting dated 12 November 2019, the Investigation meeting dated 7 November 2019 and the signed Bowel Irrigation chart.

Within the Probationary Meeting dated 12 November 2019 between Mr 4 and Ms Jones, the panel noted the following:

"[Mr 4]: A more serious incident that took place was Resident C's bowel irrigation. As you know I asked you if you had completed the irrigation and you said it had been done. I asked you if it had been documented to which you said yes. When I told you that I had asked about it, you still maintained that it had been done. That day you left work at 2000hrs therefore you had time to complete the task which meant you not only falsified documentation you lied to me and you implied that a resident had lied.

[Ms Jones]: I understand that it was really stupid, I shouldn't have lied and I know that I have lost your trust."

The panel had sight of the signed the bowel irrigation chart in which Ms Jones noted the following:

"16/11/19 Bowel irrigation done
Excessive wind
1000 ml in- good result"

The panel took into account that Ms Jones accepted during her Probationary Meeting dated 12 November meeting that she had not carried out a Bowel Irrigation for Resident C. Further, the panel noted the detail of the entry had noted on the irrigation chart.

The panel was satisfied from the information before it that Ms Jones, on 6 November 2019, in relation to Resident C, failed to carry out bowel irrigation and had signed the bowel irrigation chart to suggest that she had carried out the bowel irrigation.

The panel therefore found charge 7 in its entirety, proved.

Charge 8

8. Your conduct at charge 7.b. was dishonest in that you intended anyone reading the bowel irrigation chart to be believe that you had carried out the bowel irrigation when you had not.

This charge is found proved.

The panel took into account the NMC guidance on dishonesty and applied the case of *Ivy v Genting Casinos* [2017] UKSC 67.

In reaching this decision, the panel took into account its decision at charge 7 above, the Probationary Meeting dated 12 November 2019 and the signed the bowel irrigation chart.

Within the Investigation Meeting dated 7 November 2019 between Mr 4 and Ms Jones, the panel noted the following:

> *"[Mr 4]: Why did you lie to me?*
> *[Ms Jones]: I asked [Ms 6] before she left and she told me to tell you that we had done the bowel irrigation, she told me sign that it had been done. [Ms 6] is my superior, so I followed her instructions.*
> *[Mr 4]: So you think that is a plausible excuse that you followed these instructions?*
> *[Ms Jones]: No*
> *[Ms 4]: You had 5 hours from [Ms 6] leaving to carry out this task. You had opportunity to inform me, if [Ms 6] is your superior what am i? you have a duty of care to inform me and follow the NMC guidelines.*
> *[Ms Jones]: I don't know what to say…"*

The panel bore in mind that Ms Jones accepted that she had not carried out the bowel irrigation on Resident C and had falsified entries on the bowel irrigation chart. The panel noted that Mr 4 in his evidence was supportive of Ms Jones and that he did not think she intended to be dishonest. However, the panel considered the level of clinical detail of the entries Ms Jones falsified within the chart and was of the view that it displayed a clear intention of deceit because it was written with more detail than just a signature to indicate the process was carried out.

The panel was therefore satisfied that Ms Jones conduct at charge 7b was dishonest in that she intended anyone reading the bowel irrigation chart to be believe that she had carried out the bowel irrigation when she had not. It found that Ms Jones' actions would be considered dishonest by the standards of ordinary reasonable people.

The panel therefore found charge 8 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 Ms Jones' 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, Ms Jones' fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Mr Kennedy invited the panel to take the view that the facts found proved amount to misconduct.

He referred to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code). Mr Kennedy identified the specific, relevant standards where Ms Jones' actions amounted to misconduct. He submitted that the charges relate to poor record keeping and poor communication with colleagues including dishonesty, which are particularly serious. He submitted that Ms Jones' actions did fall short of the standards expected of a registered nurse and was sufficiently serious to amount to misconduct.

Mr Kennedy moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Kennedy invited the panel to find that Ms Jones' fitness to practise is impaired both on the grounds of public protection, and also in the public interest. He submitted that although Ms Jones' misconduct did not cause direct harm to any patients, she did expose residents to risk of harm through her failure of completing their documents and associated dishonesty. He submitted that Ms Jones has not provided the panel with any substantive information to any of the charges nor has she provided any information of insight or remediation. He submitted there is no information to indicate whether Ms Jones understands how her actions impacted on patients, colleagues, her employers or the nursing profession.

Mr Kennedy referred to the case of *Cohen*, and stated that whilst Ms Jones' conduct in relation to the record keeping is capable of remediation, it has not yet been remediated. He submitted that dishonesty on the other hand is difficult to remediate. He reminded the panel that Ms Jones had resorted to two attempts of dishonesty. He further told the panel, given that there is no information of any insight or remediation, there is a risk of repetition, and a risk of harm to the public should Ms Jones be permitted to practise unrestricted.

He therefore invited the panel to find Ms Jones' practice impaired on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000]

1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Grant* and *Cohen.*

Decision and reasons 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.'*

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 Ms Jones' 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:

> *"**1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***8.2** maintain effective communication with colleagues*
>
> ***8.6** share information to identify and reduce risk*
>
> ***10.1** complete 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

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*

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…*

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered them individually and collectively. It took account of all the evidence before it and the circumstances of the case as a whole. However, the panel was of the view that Ms Jones' failings fell into a number significant categories: not completing observations charts and care plans, failing to disclose that she was subject to NMC investigation to future employers, falsifying records and associated dishonesty. The panel determined that although these failures did not result in actual harm to any residents, they placed residents at an unwarranted risk of harm.

In its consideration of the charges, the panel grouped the charges found proved into two categories. Firstly, clinical charges which comprised of charges 1b, 6d, 6e and 6f and secondly, charges that resulted in concerns of dishonesty, which comprised of charges 4, 5, 7 and 8.

In relation to the clinical charges, the panel was of the view that the charges individually do not amount to misconduct. However, it noted that these concerns involved poor record keeping or a failure to accurately record a number of documents following residents' falls.

It further bore in mind that these failures occurred over two days in two separate care homes, and that the residents in question had similar vulnerabilities. The panel also noted that these two events occurred 13 months apart. The panel was of the view that that these failures put the residents at an unwarranted risk of harm, and collectively fell below the standards of a registered nurse.

In respect of the charges of non-disclosure of the NMC investigation and the failure to do a bowel irrigation and the associated dishonesty, the panel determined that these failures put patients at an unwarranted risk of harm. Her actions in concealing the investigation from her employers put them at risk of employing staff who may pose a risk to the residents. The panel was of the view that the dishonesty in relation to the disclosure of the NMC investigation and its associated charges are serious. It bore in mind the number of NMC documents including letters and email correspondence sent to Ms Jones at each stage of its pre-investigation and investigation stage. It noted that these correspondences clearly informed and updated Ms Jones of progression of the investigation. The panel also reminded itself of the evidence of repeated requests from the NMC for completed paperwork, some of which included responses from Ms Jones. The panel was therefore satisfied that it had ample information before it to conclude that Ms Jones knew she was under investigations and therefore had deliberately indicated ‘no’ in answer to the question of whether she was under any NMC investigation. The panel was of the view that there was a personal opportunity for her in doing so, to increase the chances of securing employment.

The panel then considered charge 7 and 8 and bore in mind the fact that a failure to carry out a bowel irrigation on its own, would not amount to misconduct. It noted that the bowel irrigation was to be conducted three times a week and the resident had good mental capacity to inform the staff whether he wanted one/ did not want one/ had one done or not. However, the panel considered the deliberate act of falsifying records in a detailed manner, to give the view that she had completed the bowel irrigation was serious. The panel was of the view that this action was more than a signature in a record to say that an action had been completed and then the task had possibly been forgotten. Ms Jones

included a detailed description that she had completed the bowel irrigation on 6 November 2019 with additional information such as *"Excessive wind, 1000 ml in- good result".* The panel determined that Ms Jones was intending to mislead others that she had done the bowel irrigation when she had not. The panel appreciated that the resident was of good mental capacity and therefore had brought the fact that there had not been a bowel irrigation to light. However, it considered that this could have had serious ramifications on the health and wellbeing of a different resident with different vulnerabilities had Ms Jones acted in a similar manner. Ms Jones did not concede that she had falsified Resident C's care records until called to account by her manager the following day as part of an investigation meeting to consider what had happened. In addition she sought to place blame on her team leader for this act.

> *"[Mr 4]:… I asked you what time you said you and [Ms 6] did the bowel irrigation and you told me you had done it at 15:30 hours…*
> *Why did you lie to me?*
> *[Ms Jones]: I asked [Ms 6] before she left and she told me to tell you that we had done the bowel irrigation, she told me sign that it had been done. [Ms 6] is my superior, so I followed her instructions.*
> *[Mr 4]: So you think that is a plausible excuse that you followed these instructions?*
> *[Ms Jones]: No…"*

Taking account of Ms Jones' departures from the Code, the panel decided that her actions in each of the charges found proved fell significantly short of the conduct and standards expected of a registered nurse, and breached fundamental tenets of the nursing profession and as such it was serious enough to amount to misconduct. The panel concluded that these actions followed a theme of documentation failures and dishonesty over a period of 22 months and in a number of different settings. The panel therefore found that Ms Jones's actions amounted to misconduct. To characterise her actions as other than misconduct would fail to declare and uphold proper standards of conduct and behaviour on the part of a nurse and fail to maintain public confidence in the NMC as a regulator.

Decision and reasons on impairment

The panel next went on to decide, if as a result of the misconduct, Ms Jones' 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 *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 *(Admin)* in reaching its decision. In paragraph 74, she said:

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

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's in the Fifth Shipman Report 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 found that all four limbs of the Shipman test to be engaged in this case, both as to the past and the future.

The panel found that some residents were put at risk of harm as a result of Ms Jones' misconduct. Her misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Further, the panel noted that it has found proved that Ms Jones acted dishonestly both in an attempt to secure employment and through the falsification of records regarding Resident C's bowel irrigation.

Regarding insight, the panel acknowledged that Ms Jones is entitled to not admit the charges. However, the panel considered that she has not provided any evidence or information of any insight into the charges, how her actions impacted on patients, colleagues or the nursing profession. The panel noted that Ms Jones had acknowledged her wrong doing and expressed some remorse during her internal investigation and acknowledged that she had lost the trust of her manager, Mr 4, however, no further information has been provided to this panel today. Further, the panel noted Ms Jones' email to the NMC dated 9 May 2022 in which she provided a brief explanation for the concerns, however, the panel noted that she sought to blame a senior colleague for her actions.

The panel was satisfied that the misconduct in relation to the clinical concerns in this case are capable of being addressed. However, it determined that dishonesty is harder to remediate due to the nature of the concerns. Therefore, the panel carefully considered the evidence before it in determining whether or not Ms Jones has taken steps to strengthen her practice. The panel bore in mind that no further information had been presented by Ms Jones. She has not provided the panel with any attempts at strengthening her practice, any training courses she has undertaken or any evidence of reflection. The panel therefore determined that Ms Jones has not demonstrated any insight or addressed the concerns identified.

In this regard, the panel is of the view that there is a risk of repetition should Ms Jones be in a similar environment again. The panel considered that the charges relate to multiple failures and multiple dishonest acts, which occurred on separate days, in two different care homes, a number of months apart. The panel considered that Ms Jones has not provided sufficient evidence to indicate that she has insight or that she has strengthened her practice. 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 nursing profession and the NMC as its regulator would be undermined if a finding of current impairment were not made in this case and therefore also finds Ms Jones' fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Jones' 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 Ms Jones off the register. The effect of this order is that the NMC register will show that Ms Jones 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. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Kennedy informed the panel that in the Notice of Hearing, dated 5 April 2022, the NMC had advised Ms Jones that it would seek the imposition of a striking-off order if the panel found her fitness to practise currently impaired. Mr Kennedy submitted that the position has not changed. He outlined the aggravating and the mitigating factors in this case.

Mr Kennedy, whilst recognising that the decision and sanction was for the panel alone, submitted that the NMC considered a striking-off order, to be the appropriate sanction in this case.

He took the panel through each of the sanctions available and set out the view of the NMC. He submitted that these were serious breaches, which involved record keeping issues and deliberate repeated dishonest conduct. He submitted that Ms Jones' misconduct had the potential to cause harm to the residents. He submitted that given the seriousness of the concerns identified and the public interest involved, taking no action or imposing a caution order would not be appropriate. Mr Kennedy submitted that although the record keeping concerns can be addressed through a conditions of practice order, the

dishonesty in this case cannot, and therefore a conditions of practice order would not be appropriate in this case.

Mr Kennedy submitted that the dishonesty in this case is placed at the higher end due to the repeated and premeditated nature of the dishonesty. Therefore Mr Kennedy submitted that striking-off order would be the only appropriate sanction in Ms Jones' case.

Decision and reasons on sanction

Having found Ms Jones' 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:

- Multiple record keeping errors of a similar nature over a prolonged period of time which put patients at risk of suffering harm;
- Repeated and deliberate dishonesty;
- Tendency to pass blame onto others;
- Very limited insight into failings;
- No evidence of how Ms Jones is intending to strengthen her practice; and
- Lack of any evidence of recent and relevant training.

The panel also took into account the following mitigating features:

- Evidence of some apologies within the Investigation interview to her Manager; and
- In relation to charge 1b, it was Ms Jones' first day at the Home, in a new work environment.

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

The panel 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 Ms Jones' 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 Ms Jones' misconduct and the dishonesty attached was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 Jones' registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel noted that Ms Jones' failings related to misconduct in record keeping and dishonesty. It was of the view that although the record keeping issues can be addressed through a conditions of practice order, the dishonesty elements are much more difficult remedy. Further it was mindful that there are attitudinal concerns of passing blame onto others, which could not be addressed through a conditions of practice order. It further bore in mind that there has been limited engagement and the panel formed the view that Ms Jones is unlikely to comply with any conditions. The panel decided that in light of all of the concerns above, Ms Jones' very limited insight demonstrated within the internal investigation related to charge 7 and the absence of any evidence of strengthening her

practice to date, sufficient conditions could not be formulated which would 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 has insight and does not pose a significant risk of repeating behaviour.*

The panel noted that Ms Jones' actions were not a single instance and took place on multiple occasions, over a prolonged period of time and involved multiple residents. The panel was of the view that Ms Jones has demonstrated by her answers at the internal interview held with Mr 4 on 7 November 2019 and her single email to the NMC dated 9 May 2022, evidence of harmful deep-seated personality or attitudinal problems in her attempting to pass blame to her senior colleague.

It also took the view that because of her lack of insight into the impact her actions had on colleagues, her employers and the potential risk to patients under her care, Ms Jones poses a continuing risk of repeating her 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 fundamental tenets of the profession evidenced by Ms Jones' actions is incompatible with Ms Jones 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 raise fundamental questions about their professionalism?*
- *Can public confidence in nurses be maintained if the nurse 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 was of the view that Ms Jones' actions raise fundamental questions about her duty of candour. Ms Jones used her position of trust that employers had in her to secure employment and similarly, she abused her position of trust that patients had in her to falsify records to the extent that she created false and detailed entries in a patient record to indicate she had conducted a clinical procedure when she had not. Ms Jones has demonstrated no evidence to this panel of any insight or steps taken to strengthen her practice and has sought to place blame on others for her actions. The panel was of the view that the repetition of Ms Jones' actions both in record keeping and dishonesty demonstrated a continuing absence of insight. It is the view of the panel that Ms Jones will continue to pose a serious risk of similar conduct in the future.

Ms Jones' actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Jones' actions were serious and 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 Ms Jones'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.

Not withstanding the undoubted effect this sanction will have on Ms Jones, the panel considered that this order was necessary to mark the importance of protecting the safety of patients, 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 Jones 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 Ms Jones' own interests 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 Kennedy. He invited the panel to impose an interim suspension order for a period of 18 months for the same reasons identified by the panel for imposing a striking off order.

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.

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

That concludes this determination.