Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 12 June 2023 – Tuesday 13 June 2023

Virtual Hearing

Name of registrant:	**Margo Murray**
NMC PIN:	06I0317S
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – September 2009
Relevant Location:	Glasgow
Type of case:	Misconduct
Panel members:	Scott Handley (Chair, lay member) Richard Lyne (Registrant member) Mary Golden (Lay member)
Legal Assessor:	John Caudle
Hearings Coordinator:	Rene Aktar
Nursing and Midwifery Council:	Represented by Rebecca Paterson, Case Presenter
Mrs Murray:	Not present and unrepresented at the hearing
Facts proved:	Charges 1, 2
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
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 Murray was not in attendance and that the Notice of Hearing letter had been sent to Mrs Murray's registered email address on 9 May 2023.

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

Ms Paterson, 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 of the information available, the panel was satisfied that Mrs Murray 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 Murray

Ms Paterson referred the panel to the documentation from Mrs Murray's case officer which included a telephone note which stated Mrs Murray is content for hearing to proceed in their absence. It stated:

> *'Received my email re CMF/next steps but was not able to open the form (Egress) and can't remember the contents of the emial. [sic]*
>
> *I explained what it was about and that I wanted to speak with her about the case to see if she wanted to engage going forward and if she had any questions.*

She informed me she would not want to attend a hearing.
I suggested she could provide written submissions about the concerns.

She is not sure if she wants to practice as a nurse in the future and she hasn't worked for a couple of years. She has tried to get a job as a carer [PRIVATE].

[PRIVATE] On an specific occasion she was offered some red wine for someone's birthday and this led to her being dismissed.
We discussed providing a response for the panel if she doesn't attend.

I will resend the form password protected with the cover letter and contact her in two weeks to follow up on this. I asked her to let me know if she has any questions about the form.'

Additionally, Ms Paterson referred the panel to an email dated 5 June 2023. Mrs Murray responded in response to the case officer's query. It stated:

'I'm happy for the hearing to go ahead in my absence.'

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

- No application for an adjournment has been made by Mrs Murray;
- Mrs Murray has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Witness 1 has attended today to give live evidence;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019 and 2020;
- 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 Mrs Murray in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to her by email, 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 Murray's decision to absent herself from the hearing, waive her right 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 Murray. The panel will draw no adverse inference from Mrs Murray's absence in its findings of fact.

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

At the outset of the hearing, Ms Paterson made a request that parts of this case be held in private on the basis that proper exploration of Mrs Murray's case may involve reference to personal matters. The application was made pursuant to Rule 19.

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.

The panel decided to hold parts of the hearing in private because it concluded that this was justified by the need to protect Mrs Murray's privacy concerning personal matters and that this outweighed any prejudice to the public interest in holding the hearing in public.

No application was in fact made during the hearing.

Decision and reasons on application to admit documents relating to Charge 2 as hearsay

Ms Paterson requested that the documents, as set out below, which related to Charge 2, be read into evidence under Rule 31:

- Referral form dated 9 May 2019
- Email dated 27 March 2019 from Ms 1, the nurse on duty at the time of the incident.
- Police Scotland, Liberation from Custody document, dated 22 March 2019
- Extract Conviction Report, dated 15 July 2019
- Police Scotland Letter & case summary, dated 14 October 2019
- Email dated 24 May 2019 from Mrs Murray,
- Regulatory Response Form from Mrs Murray, dated 12 September 2019

The panel considered whether Mrs Murray would be disadvantaged by admitting the hearsay documents. It considered that as Mrs Murray had been provided with a copy of the documents and had raised no objection to their admission, no unfairness will be caused to Mrs Murray if the documents were admitted into evidence.

In these circumstances, the panel came to the view that the information in the documents was relevant, and their inclusion would not cause any unfairness to Mrs Murray. The panel therefore decided to allow the application to include all of the

documents and acknowledged that it would need to consider what weight to give to each document.

Details of charge

That you, a registered nurse:

1. On 7 September 2020 were in attendance at work and unfit for duty.
2. On 21 March 2019 were in attendance at work and unfit for duty.

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

Background

Charge 1 - (7 September 2020)

Mrs Murray was referred to the NMC for a second time (see Charge 1 below) on 18 September 2020, by Witness 1, Care Home Manager, Parkhouse Manor Care Home (the Home). At the time of the alleged concerns in the referral, Mrs Murray was working as a registered nurse at the Home.

On 7 September 2020, Mrs Murray undertook a medication administration round at the Home whilst intoxicated. A senior carer was concerned about her behaviour and contacted Witness 1. Witness 1 attended the Home and found a cup of red wine on the top of the medication trolley. Witness 1 found Mrs Murray to be *"slurring"* her words, [PRIVATE] and *"clearly very intoxicated".* Witness 1 also found that the medication trolley was in disarray and that she had a number of resident's medications in her pockets. Mrs Murray was sent home from her shift and her contract was terminated with the Home the following day.

Charge 2 – (21 March 2019)

Mrs Murray was referred to the NMC on 9 May 2019 by Ms 1, the Care Manager at Buckreddan Care Centre (the Care Centre), where Mrs Murray was employed as a registered nurse.

On 21 March 2019, Mrs Murray arrived at work at the Care Centre and *"appeared to be out of sorts and slurring her words a bit",* the staff were concerned and raised their concerns with the duty manager. At this time, the Police arrived at the Home and Mrs Murray was arrested and subsequently received a driving conviction.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the evidence in this case, as well as submissions made by Ms Paterson on behalf of the NMC.

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

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 witness, called on behalf of the NMC in relation to Charge 1:

- Witness 1: Care Home Manager at Parkhouse Care Home

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1

That you, a registered nurse:

On 7 September 2020 was in attendance at work and unfit for duty.

This charge is found proved.

In reaching this decision, the panel took into account the live evidence of Witness 1 and her statement.

On her way home, Witness 1 received a call from one of the senior car staff advising her to return to the Home. In the call she was advised by the caller that *'she thought Margo was intoxicated whilst doing the drug round'*. On returning to the Home Witness 1 saw that Mrs Murray had been removed from the drug trolley and taken into the nursing station.

Witness 1 states that on top of the drug trolley was a mug, *'a few of us sniffed the contents of the mug and it was definitely red wine'*. Witness 1 observed the drugs trolley, pills were lying everywhere. Witness 1 with a colleague then approached Mrs Murray, she notes *'she was clearly intoxicated, she was slurring her words,* [PRIVATE] *it was just very obvious she was very intoxicated'.* Witness 1 took Mrs Murray into a room to speak to her about the incident. She recalled, in her statement, pulling pills from her pockets which she concluded would have been for residents. She noted that the pill count *'had been all over the place'.*

In the private room Witness 1 states in her statement that Mrs Murray broke down in tears, she was begging to keep her job, she was told by Witness 1 that *'she was clearly intoxicated – she just looked and shook her head'.* In her statement Witness 1 sets out that she had concluded from what she had seen that Mrs Murray had been drinking the wine from the cup on the drugs trolley while dispensing the medication. She noted that there were little pots of pills everywhere on the trolley, it was not possible for her to determine which medication belonged to each resident. Witness 1 stated that this meant that residents could have had the wrong medication. In live evidence, Witness 1 stated that Mrs Murray did not admit to having drunk alcohol on shift but that she was apologetic [PRIVATE].

The panel found Witness 1 to be a credible witness and concluded that the referral was genuine. It was clear that Witness 1 had a good deal of compassion for Mrs Murray.

The panel noted that there has been little engagement from Mrs Murray since the first incident occurred in 2019. The panel took into account that this is an ongoing incident, and that Mrs Murray has not disputed any of the charges. In the light of the evidence and the reasons stated above, the panel finds this charge proved on the balance of probabilities.

Charge 2

That you, a registered nurse:

On 21 March 2019 was in attendance at work and unfit for duty.

This charge is found proved.

In reaching its decision the panel had sight of, and took into account, the documents already listed above.

The panel assessed the appropriate level of weight it should give to each of the documents. It concluded that the referral, the Police Scotland documents, the Court extract and the regulatory response and email from Mrs Murray were consistent and could be fully relied upon. It therefore gave considerable weight to these sources of evidence. The panel had some concerns with regard to the email from the staff nurse, it noted that, whilst this document did provide corroboration for a number of points set out in other evidence, there were also potential inconsistencies, and it was not fully clear how this document had been produced. This being the case, it gave limited weight to this document.

The panel noted that Mrs Murray accepted the regulatory concerns as set out in the referral document of '*attending work unfit – alcohol*' and '*criminal conviction*' (the panel

noted that no charge in relation to the conviction has been put to Mrs Murray). In her response in relation to the concern of attending work unfit, she states *'this is correct, however, it was a one-off incident [PRIVATE]. I can assure the NMC this will never happen again and has never happened before'*.

The panel notes that the referral states that when Mrs Murray attended for work, she appeared to be out of sorts. The statements from the staff nurse expanded on this and stated that *'she was slurring her words a bit'.* Staff on duty had concerns about Mrs Murray's presentation, these were escalated by the staff nurse to management. The referral notes, as does the statement from the staff nurse, that the police arrived at the Care Centre and that Mrs Murray was arrested and taken into custody. The Police Liberation from Custody Document corroborates this. The Police case summary and the Extract conviction Report confirms that Mrs Murray was convicted of driving a motor vehicle on 21 March 2019, with the proportion of alcohol in her breath being over the prescribed limit (94 micrograms of alcohol in 100 millilitres of breath, the prescribed limit is 22 micrograms of alcohol in 100 millilitres of breath).

Given the evidence of the staff observations, the Police action, the subsequent conviction and Mrs Murray's own admissions, the panel concluded that Mrs Murray was in attendance at work while unfit for duty and therefore found the 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 Murray'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 Murray'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.'*

Ms Paterson 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.

Ms Paterson identified the specific, relevant standards where Mrs Murray's actions amounted to misconduct. She submitted that in this case, there have been facts found proved on two separate occasions where Mrs Murray attended work whilst not being fit to do so.

Ms Paterson referred the panel to paragraph 1.2 of the code which sets out that nurses and midwives must make sure that they deliver the fundamentals of care effectively, and paragraph 19.1 which sets out that they must take measures to reduce as far as possible the likelihood of mistakes near misuse, harm and the effect of harm.

Ms Paterson submitted that Mrs Murray had been found to have been under the influence of alcohol while at work and that during the incident that led to Charge 1, there were pills lying everywhere on the drug trolley. She submitted that Witness 1 sets out that Mrs Murray started pulling pills from her pocket, which were said to belong to the patients, as well as the pill count being all over the place.

Ms Paterson invited the panel to take this evidence into account and to consider that in attending work whilst under the influence of alcohol, Mrs Murray was not ensuring that she delivered the fundamentals of care effectively or taking measures to reduce the risks.

Submissions on impairment

Ms Paterson 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).

Ms Paterson invited the panel to have regard to the NMC guidance. She submitted that Mrs Murray's fitness to practice is currently impaired on both public protection and public interest grounds.

Ms Paterson submitted that Mrs Murray's actions, being under the influence of alcohol at work, did have the potential to expose patients to an unwarranted risk of harm as well having an impact on a registrant to work effectively.

Ms Paterson made reference to Witness 1's evidence. She submitted that Mrs Murray's actions have brought the profession in disrepute and that an informed member of the public would be very concerned to learn that a nurse attended work whilst under the influence of alcohol.

Ms Paterson submitted that the conduct, seen in Charge 2 (21 March 2019) was repeated in Charge 1 (7 September 2020) and therefore this is not a case that can be considered as an isolated event. She submitted that Mrs Murray, in relation to Charge 1, was very apologetic and appeared to be remorseful. However, regarding Witness 1's evidence, she submitted that Mrs Murray's insight was focused on her

concern for losing her job. Ms Paterson submitted that there has been no evidence of real insight into the wider potential impact on public confidence and safety.

Ms Paterson submitted that there is no evidence of steps taken to remediate the misconduct and that there is a real risk of Mrs Murray acting in a similar way in the future. She invited the panel to find that Mrs Murray's fitness to practice is impaired by reason of her misconduct 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), and *General Medical Council v Meadow* [2007] QB 462 (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 Murray's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Murray's actions amounted to a breach of the Code. Specifically:

> *'**1.2 make sure you deliver the fundamentals of care effectively***
>
> ***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'***

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

Charge 1

The panel considered all the evidence and concluded that Mrs Murray was unfit to attend work and had put patients at risk of harm through her consumption of alcohol whilst attempting to undertake a drugs round. The trolley itself was covered in drugs and there were more found in Mrs Murray's pockets. It was impossible to tell what patients had received what medication.

The panel took into account Witness 1's evidence who stated that Mrs Murray was [PRIVATE] and apologetic. The panel took into account Witness 1's and Ms 1's evidence, as well as the documents put before it that there were medications found in Mrs Murray's pockets.

Charge 2

The panel considered all of the evidence and concluded that Mrs Murray was unfit to attend work and had the potential to put patients at risk through her consumption of alcohol when attending her shift.

The panel found that Mrs Murray's actions on both occasions fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Murray'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.'*

Whilst there is no evidence to suggest that Mrs Murray's actions caused actual harm to patients, her misconduct and failure to act professionally at work put patients at risk of significant harm. Furthermore, having breached some provisions of the Code,

the panel determined that Mrs Murray's misconduct had breached 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 Mrs Murray's fitness to practise to be impaired and the charges relating to misconduct as extremely serious. The panel concluded that the first three limbs have been engaged.

The panel referred to the NMC's guidance on insight (FTP-13b):

'A nurse, midwife or nursing associate who shows insight will usually be able to:

- *step back from the situation and look at it objectively recognise what went wrong*
- *accept their role and responsibilities and how they are relevant to what happened*
- *appreciate what could and should have been done differently*
- *understand how to act differently in the future to avoid similar problems happening.'*
- *'If they had the opportunity to do so, did the nurse, midwife or nursing associate cooperate with their employer's or any other local investigation into the concerns?*
- *Did the nurse, midwife or nursing associate accept the concerns against them when first raised by their employer?*
- *Did the nurse, midwife or nursing associate, voluntarily or without prompting, draw any failings or inappropriate conduct to the attention of their employer?*
- *Did the nurse, midwife or nursing associate 'self-report' to the NMC, when a referral might otherwise not have been made by someone else?*
- *Does the nurse, midwife or nursing associate accept the substance of our regulatory concern, and accept responsibility for any failings or inappropriate conduct?*
- *Has the nurse, midwife or nursing associate done so since the early stages of our investigation?*

- *Does the nurse, midwife or nursing associate acknowledge:*
  - *any harm or risk of harm, to patients?*
  - *any damage to public confidence in the professions?*
  - *how far their conduct or practice fell short of professional standards?*
  - *their own responsibility for the problem, without seeking to blame others or excuse their actions?'*

In considering insight, it took into account that Mrs Murray has not shown any insight into her failings, neither has she made any attempts to remediate. It therefore considered there to be a risk of repetition of her conduct and an unwarranted risk of harm to patients in her care.

The panel took into account that there is a risk of repetition as the second incident had occurred 18 months after the first. It also noted that, in relation to the first incident (2019), Mrs Murray had stated that it was *"a one-off…this will never happen again".* Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered there to be a public interest in the circumstances of this case. The panel found that the charges found proved are serious. It was of the view that a fully informed member of the public would be concerned by its findings on facts and misconduct. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mrs Murray's fitness to practise as a registered nurse is currently impaired on the grounds of public protection and public interest.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mrs Murray's registration has been suspended.

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

Ms Paterson informed the panel that the NMC would be seeking a suspension order and referred the panel to specific areas of the SG. She submitted that there is a clear risk of repetition of the behaviour found proved.

Ms Paterson submitted that there is some evidence of mitigation provided by Mrs Murray in her email to the Fitness to Practise team on 24 May 2019. [PRIVATE] She submitted that taking no action and imposing a caution order would not be appropriate in this case.

Ms Paterson submitted that a conditions of practice order would not be workable or measurable to address the risks. She submitted there is nothing to suggest that Mrs Murray would be willing to comply or engage with any conditions.

Ms Paterson explained that a suspension order is the most appropriate and proportionate sanction in this case. She submitted that the panel could consider imposing a strike off order if it considers that it is the only appropriate order to address the risks. She submitted that the NMC are seeking a 6-month suspension order.

Decision and reasons on sanction

Having found Mrs Murray'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:

- Putting patients at risk of harm by carrying out medication administration whilst being under the influence of alcohol
- Mrs Murray has not shown any evidence of having taken any steps to remediate her behaviour
- The proportion of alcohol in Mrs Murray's breath, at the time she attended for work on 21 March 2019 (Charge 2) as noted in the Police case summary is considered by the panel to be high
- No evidence of insight into the potential impact of her actions whilst attending work when not fit to do so

The panel also took into account the following mitigating features:

- There were early admissions to the original regulatory concerns in relation to Charge 2 in 2019
- [PRIVATE]

The panel first considered whether to take no action but concluded this would be neither proportionate nor in the public interest given the seriousness of the case.

It then considered the imposition of a caution order but again determined that, due to the public protection issues identified, an order that does not restrict Mrs Murray'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 Murray's misconduct 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 Mrs Murray's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that, given the nature of the charges found proved, there are no practical or workable conditions that could be formulated. The panel concluded that the misconduct identified in this case was not something that could be addressed through retraining.

Furthermore, the panel concluded that the placing of conditions on Mrs Murray's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG 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;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Murray's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Mrs Murray. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A reflective statement which demonstrates Mrs Murray's full insight on the incidents and their impact herself, the patients, the profession and the general public
- Testimonials or references from employers during the period
- Mrs Murray's full engagement and attendance at the next hearing

This will be confirmed to Mrs Murray in writing.

Interim order

As the suspension 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 Murray's own interest until the suspension 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 Ms Paterson. She submitted that in relation to patient safety and public protection, an interim suspension order would seek to address those risks whilst the appeal period is ongoing. Ms Paterson submitted should any appeal be made, an interim suspension order should cover the relevant period.

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 suspension order 28 days after Mrs Murray is sent the decision of this hearing in writing.

That concludes this determination.