Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Friday, 6 October 2023

Virtual Hearing

Name of Registrant:	**Susan-Jane Dunford**
NMC PIN	00I0359W
Part(s) of the register:	Registered Nurse – Adult (RNA) 7 September 2003
Relevant Location:	Cardiff
Type of case:	Misconduct
Panel members:	Anthony Mole (Chair, Lay member) Susan Jones (Registrant member) Jane McLeod (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Sharmilla Nanan
Nursing and Midwifery Council:	Represented by David Claydon, Case Presenter
Ms Dunford:	Not present but represented at the hearing by Marc Walker, (What Rights)
Consensual Panel Determination:	Amended
Facts proved:	Charges 1a, 1b, 1c, 2, 5a, 5b, 5c, 6, 7ai, 7aii, 7aiii, 7aiv, 7bi, 7bii
No evidence offered:	Charges 3 and 4
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to amend the charge

The panel invited submissions from Mr Claydon, on behalf of the Nursing and Midwifery Council (NMC), and Mr Walker, on Ms Dunford's behalf to amend the wording of charge 1c.

It noted that the current wording of the stem of charge 1 did not accurately reflect the date of the alleged misconduct as outlined by the information contained in the CPD and that a further amendment should be made to charge 1c to reflect the correct name of the medication.

Mr Claydon submitted that these issues could be addressed by the panel including the words 'on or after' in the stem of the charge so the date of the misconduct is more accurately reflected in the charge. He also submitted that correcting the medication in charge 1c would provide clarity and more accurately reflect the evidence.

<u>Original wording of the charge:</u>

> "That you, a registered nurse:
>
> 1) On 2 October 2017 in respect of Patient VR:
>
> > a) Administered incorrect medication namely Sando K, on 3 occasions
> >
> > b) Sought advice from Colleagues A and B when it was inappropriate to do so
> >
> > c) Incorrectly amended the medical records to show that Sandos Phos was required when it was not"

<u>Proposed wording of the charge:</u>

> "That you, a registered nurse:

1) On **or after** 2 October 2017 in respect of Patient VR:

a) Administered incorrect medication namely Sando K, on 3 occasions

b) Sought advice from Colleagues A and B when it was inappropriate to do so

c) Incorrectly amended the medical records to show that ~~Sandos Phos~~ **Sando K** was required when it was not"

The panel heard submissions from Mr Walker that these amendments do not make any significant changes to the charges and the proposed amendments would cover the panel's observations to more accurately reflect the evidence.

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

The panel was of the view that such amendments would more accurately reflect the information provided in the agreed consensual panel determination. The panel was satisfied that there would be no prejudice to Ms Dunford and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Details of charge (AS AMENDED)

That you, a registered nurse:

1) On or after 2 October 2017 in respect of Patient VR:

a) Administered incorrect medication namely Sando K, on 3 occasions

b) Sought advice from Colleagues A and B when it was inappropriate to do so

c) Incorrectly amended the medical records to show that Sando K was required when it was not

2) Your actions in charge 1 c) above were dishonest in that you falsified Patient VR's notes to induce others to believe the correct medication had been administered and / or to cover up that you had administered the incorrect medication

(Charges 3 and 4 are dealt with separately)

5) Did not disclose to the Cardiff & Vale Health Board:

a) That you had been employed by the Ravenscourt GP Practice

b) That your employment at Ravenscourt GP Practice has been terminated by the Practice

c) That you were the subject of an ongoing NMC referral

6) Your actions in charge 5 above were dishonest in that they were intended mislead the Cardiff & Vale Health Board

7) Whilst working at Cardiff & Vale Health Board:

a) Were unable to carry out 'collar care' in that:

i) You were unable to recognise when a collar had been fitted incorrectly

ii) You were unable to recognise the difference between 'clavicle' and 'cervical' on 2 occasions

iii) Did not accept guidance from a colleague in relation to the correct terms in 7(a)(ii) above

iv) Did not alert colleagues when you lacked clinical knowledge

b) In respect of Patient A

i) used a 4mm catheter instead of a 22mm catheter

ii) Were unable to recognise why your conduct in 7(a)(i) was incorrect

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

Consensual Panel Determination

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

Mr Claydon submitted that it is a matter for the panel to agree the CPD before it. He submitted that the panel will need to also consider the application to offer no evidence in relation to charges 3 and 4, which were not accepted by Ms Dunford. He submitted that the NMC did not seek to pursue these charges and the reasons for this are set out in the CPD. He highlighted to the panel the paragraphs which related to the alleged misconduct, impairment and sanction.

Mr Walker submitted that he, on behalf of Ms Dunford, accepts the NMC's position to offer no evidence in relation to charges 3 and 4. He reminded the panel that Ms Dunford admits the remainder of the charges and that her actions amount to misconduct. He submitted that the clinical matters are secondary to the dishonesty matters, which Ms Dunford has admitted in full. He referred the panel to Ms Dunford's reflective statement, and completion of a probity and ethics course, which indicate the steps she has taken toward remediation. He also noted her recent admissions and acceptance of impairment which also indicate steps toward her remediation. He submitted that a suspension order for a period of 12 months appropriately meets the overriding objectives to protect the public and to maintain public confidence in the profession. He informed the panel that Ms Dunford intends to work as a healthcare assistant in the meantime whilst further reflecting on her misconduct, completing further training and putting together a body of good work to be allowed to return to nursing practice in the future.

The agreement, which was put before the panel, sets out Ms Dunford's full admissions to the facts alleged in charges 1a, 1b, 1c, 2, 5a, 5b, 5c, 6, 7ai, 7aii, 7aiii, 7aiv, 7bi, 7bii and that her actions amounted to misconduct, and that her fitness to practise is currently

impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a suspension order for a period of 12 months.

The panel has considered the provisional CPD agreement reached by the parties. It invited the parties to consider whether they were satisfied to make the following amendment to the following paragraphs, to be consistent with the reasoning in later paragraphs within the CPD.

Original wording:

> *"76. The Panel may consider the aggravating features of this case are:*
>
> *• Dishonesty in relation to clinical practice compounded by further dishonesty to a new employer*
>
> *• Repeated poor clinical practice*
>
> *• Lack of insight*
>
> *77. The Panel may consider the mitigating feature of this case is as follows:*
>
> *Admissions"*

Proposed wording:

> *"76. The Panel may consider the aggravating features of this case are:*
>
> *• Dishonesty in relation to clinical practice compounded by further dishonesty to a new employer*
>
> *• ~~Repeated p~~**P**oor clinical practice **in a number of areas***

~~*• Lack of insight*~~

77. The Panel may consider the mitigating feature of this case is as follows:

•Admissions ***during the investigation***

• ***Developing insight"***

Mr Claydon indicated that he had no objections to these changes of the CPD.

Mr Walker also indicated that he had no objections to these changes.

That provisional CPD agreement, as amended by the panel and agreed by parties, reads as follows:

"Fitness to Practise Committee
Consensual panel determination ("CPD"): provisional agreement

The Nursing & Midwifery Council ("the NMC") and Ms Susan-Jane Dunford, PIN 00I0359W ("the Parties") agree as follows:

1. Ms Dunford is aware of the CPD hearing. Ms Dunford does not intend on attending the hearing and is content for it to proceed in her and her representative's absence. Ms Dunford will endeavour to be available by telephone should clarification on any point be required, or should the panel wish to make amendments to the provisional agreement.

2. Ms Dunford understands that if the panel proposes to impose a greater sanction or make amendments to the provisional agreement that she does

not agree with, the panel will reject the CPD and refer the matter to a substantive hearing.

Application to Offer No Evidence – Charges 3 and 4

3. The NMC seeks to offer no evidence in respect of the following charges:

> *3) Between 12 May 2018 and 1 June 2018 did not intervene in a safeguarding incident, namely where a Patient's daughter in law used a sewing needle in an attempt to draw a blood sample*
> *4) Between 12 May 2018 and 12 June 2018 did not report / escalate in the incident described in charge 3 above*

4. Charges 3 and 4 articulate the following regulatory concern, which the Case Examiners found Ms Dunford had a case to answer in respect of: Concerns about [your] practice whilst employed at Vale Group Practice specifically that [you] failed to intervene or report a safeguarding incident.

*5. The background to this regulatory concern/these charges is that, on 1 May 2018, Ms Dunford began working at the Vale Group Practice ('the Vale') as a Primary Care (**Frailty**) Nurse. As part of the NMC's investigation into the referral from Aneurin Bevan University Hospital Board ('the Board'), the NMC sought a reference from the Vale. The Vale informed the NMC that Ms Dunford had been involved in an incident.*

6. During a home visit, Ms Dunford attempted to carry out a finger prick blood glucose test on a patient. However, the blood glucose machine had run out of needles. The patient's carer who was present then offered Ms Dunford a sewing needle they had sterilised in boiling water to use instead. Ms Dunford refused to use this but the patient's daughter in law took the

needle and said ‘I can get great revenge now, this woman hates me, I don't have a problem doing this’ before pricking the patient’s finger twice. No blood was drawn due to the patient having cold hands. It is alleged Ms Dunford did nothing to intervene to prevent this and failed to report the incident or escalate it to safeguarding.

7. The Panel is invited to consider the case of PSA v NMC & X [2018] EWHC 70 (Admin) and in particular to have regard to paragraphs 55 and 57:

“It is sufficient for the purposes of this case, first, to record Mr Bradly’s realistic concession that, even though this is not expressly provided for in the Rules, it must be open to the NMC, in an appropriate case, to offer no evidence. I note that the NMC has produced operational guidance about offering no evidence which makes it clear that this course is only appropriate in limited circumstances. None of those circumstances applied in this case. I accept Mr Bradly’s further submission that the cases in which it would be appropriate to offer no evidence will be rare.”

“I consider that it is especially important, if the NMC considers that it is appropriate to offer no evidence, that it fully opens the case, so that the Committee is able to make a decision, informed by a sufficient knowledge of the facts, whether it is appropriate for the NMC to offer no evidence, or whether it should require the NMC to reconsider that view, and try and obtain more evidence.”

8. The guidance published by the NMC in relation to offering no evidence is now contained within the online Fitness to Practise Library Reference: DMA-2 which states:

“We keep all cases under review while we prepare them for the Fitness to Practise Committee. Sometimes, as part of that review, it becomes clear to

us that it wouldn't be in the public interest to carry on with all or part of the case. In limited circumstances it may be appropriate for us to use our power to 'offer no evidence'. This means that we'll ask a full panel of the Fitness to Practise Committee to approve our decision not to continue with all or part of the case against a nurse, midwife or nursing associate. We will only offer no evidence in a particular case if it fits with our overarching objective.

We'll only apply to offer no evidence against a nurse, midwife or nursing associate in the following circumstances:

- *When a particular part of the charge adds nothing to the overall seriousness of the case.*
- *When there is no longer a realistic prospect of some or all of the factual allegation being proved.*
- *When there is no longer a realistic prospect of a panel finding that the nurse, midwife or nursing associate's fitness to practise is currently impaired.*

It will be up to the panel to decide whether it agrees that it's appropriate for us to offer no evidence, and not continue with all or part of the case against the nurse, midwife or nursing associate. When we ask a panel to do this and the case is at a hearing, we will open our case and fully explain the background, and our reasons for offering no evidence. If the case is being considered at a meeting we will set this out clearly in our statement of case."

9. The NMC invites the Panel to consider its published guidance on offering no evidence. The Panel is invited to consider that this is a case where it is appropriate to offer no evidence in accordance with this guidance and PSA v NMC & X [2018] EWHC 20 (Admin) because having considered the case in the round charges 3 and 4 do not add to the overall seriousness of the case.

10. The NMC has considered the Case Examiner's ("CE's") decision which gave rise to charges 3 and 4. This reads:

> *You began working at the Vale on 1 May 2018. As part of the NMC's investigation into the referral from the Board the NMC sought a reference from the Vale. Ms 1, Practice Manager at the Vale, told the NMC you had been involved in three incidents; a drug error, a data protection failure, and a failure to ensure a patient's safety during an intervention by a third party. As a result of these three incidents you were dismissed by the Vale on 12 June 2018. It is the third issue that is the basis for Regulatory concern 5.*
>
> *The Vale were informed by a patient's relative that on a home visit an ordinary sewing needle was used to carry out a finger prick blood glucose test. When asked about this allegation you said that despite repeated attempts you could not get a blood sample due to the patient having cold hands. You then found the blood glucose machine had run out of needles. The patient's carer who was present then offered you a sewing needle they had sterilised in boiling water to use instead. You refused to use this but the patient's daughter in law took the needle and said "I can get great revenge now, this woman hates me, I don't have a problem doing this". The daughter in law then pricked the patient's finger twice but did not draw any blood. You did nothing to intervene to prevent this and failed to report the incident or escalate it to safeguarding…*
>
> *Your representative has told us this regulatory concern is not accepted. It appears this is on the basis that they say there is a lack of evidence to establish that the allegation is capable of proof, rather than a denial than the event occurred at all.*

When first asked about the incident of the sewing needle and the blood sample you prepared a brief account, which you signed, and a chronology giving further details of what had occurred. While you did not sign the chronology, Ms 1 confirms that it is a document you prepared and presented as part of your explanation.

We concluded this evidence is sufficient to establish a realistic possibility that the Fitness to Practise Committee would decide the factual allegations in respect of regulatory concern 5 are proved...

In respect of regulatory concern 5, your failure to intervene when a relative was pricking a patient's finger with a sewing needle placed that patient at risk of harm, and indeed could be said to have caused them actual harm. Further, not reporting or escalating the incident, and the seemingly threatening language used by the daughter in law towards the patient, may have placed that patient at risk of further harm...

You reflections make no mention of the incident with the Vale patient set out in regulatory concern 5…

While there is some evidence of current good practice, given our concerns about your insight into the events in question, we cannot be satisfied that you have adequately addressed all the issues raised by the regulatory concerns, which in turns means we cannot be satisfied that the risk of repetition of some or all of the alleged misconduct has been fully addressed either. Therefore, we must conclude that you remain a current risk to a risk to the health, safety or wellbeing of the public.

11. Ms Dunford (through her representative) does not accept this concern.

12. The sole evidence against Ms Dunford comes from her local statement (signed) and a chronology (unsigned), which it is understood she prepared.

13. It is noted that there is no evidence that the event described was a safeguarding incident or that it required the Registrant to make a report or escalate what had occurred. Given the nature and age of the case it is considered disproportionate to pursue further investigations into this element of the case.

14. In the light of complete admissions to the other charges the events in charges 3 and 4 do not add to the seriousness of the global misconduct in this case.

15. NMC guidance provides that:

> *If we're satisfied that one or more of the alleged facts against the nurse, midwife or nursing associate doesn't add anything to how serious the case against them is, we may decide to offer no evidence on those parts of the charge. We won't do this unless we're satisfied that the remaining parts of the charge properly reflect the extent of our concerns about the nurse, midwife or nursing associate's fitness to practise, and the evidence about them. We'll need to consider the risk of harm to patients, or the public's trust in nurses, midwives and nursing associates that could arise from what the nurse, midwife or nursing associate is alleged to have done*

16. The NMC considered Charges 3 & 4 and apply to offer no evidence as these charges do not add to the seriousness of the case. As such the NMC is satisfied that the remaining charges properly reflect the extent of our concerns about Ms Dunford's fitness to practise.

The Charges

17. Ms Dunford admits the following charges:

That you, a registered nurse:

1) On or after 2 October 2017 in respect of Patient VR:

a) Administered incorrect medication namely Sando K, on 3 occasions

b) Sought advice from Colleagues A and B when it was inappropriate to do so

c) Incorrectly amended the medical records to show that Sando K was required when it was not

2) Your actions in charge 1 c) above were dishonest in that you falsified Patient VR's notes to induce others to believe the correct medication had been administered and / or to cover up that you had administered the incorrect medication

(charges 3 and 4 are dealt with separately)

5) Did not disclose to the Cardiff & Vale Health Board:

a) That you had been employed by the Ravenscourt GP Practice

b) That your employment at Ravenscourt GP Practice has been terminated by the Practice

c) That you were the subject of an ongoing NMC referral

6) Your actions in charge 5 above were dishonest in that they were intended mislead the Cardiff & Vale Health Board

7) Whilst working at Cardiff & Vale Health Board:

a) Were unable to carry out 'collar care' in that:

i) You were unable to recognise when a collar had been fitted incorrectly

ii) You were unable to recognise the difference between 'clavicle' and 'cervical' on 2 occasions
iii) Did not accept guidance from a colleague in relation to the correct terms in 7(a)(ii) above
iv) Did not alert colleagues when you lacked clinical knowledge
b) In respect of Patient A
i) used a 4mm catheter instead of a 22mm catheter
ii) Were unable to recognise why your conduct in 7(a)(i) was incorrect

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

The Statement of Agreed Facts

18. Ms Dunford appears on the register of nurses, midwives and nursing associates maintained by the NMC as a Registered Nurse specialising in adult care and has been on the NMC register since 7 September 2003.

19. On 30 May 2018, the NMC received a referral from Aneurin Bevan University Hospital Board ('Referrer 1'). At the time of the concerns Ms Dunford was employed as a band 7 Staff Nurse at Royal Gwent Hospital ('RGH') and later at Nevill Hall Hospital ('NHH').

Charge 1a

20. Patient VR was prescribed Sando Phos, a phosphate supplement for patients with a phosphate deficiency. The prescription was for two tablets to be taken three times over the course of the day. Some of the symptoms caused by Phosphate deficiency include anaemia, muscle weakness and bone pain.

21. During a day shift on 2 October 2017, Ms Dunford administered 2 tablets of Sando K to patient VR rather than the Sando Phos prescribed on 3 occasions. Sando K is a potassium supplement for patients with potassium deficiency.

22. Colleague A worked the night of 2 October 2017 and looked at patient VR's drug chart and noted Ms Dunford had signed for administering Sando Phos three times during that day. Colleague A went to patient VR's locker and found a tube of Sando K, not the Sando Pho prescribed. Colleague A checked the drug chart again and noted Sando K was not mentioned at all. With the help of a care assistant, Colleague A counted out the Sando K tablets in patient VR's locker and found there were 6 tablets missing. This corresponded with the number of tablets Ms Dunford had signed as having administered, but for the wrong medication. Patient VR was not prescribed Sando K and as a result was put at a risk of developing the above symptoms due to Ms Dunford's drug error.

Charge 1b

23. In relation to the drug error Ms Dunford asked Colleagues A and B what to do as the word 'phos' on patient VR's drug chart was crossed through. Colleagues A and B advised her to administer the Sando K. Ms Dunford inappropriately sought advice

from Colleagues A and B as she was aware the patient was not prescribed Sando K and she was responsible for crossing out the word 'phos'.

Charge 1c

24. During a night shift on 2 October 2017 both Colleagues A and B checked patient VR's drug chart which was perfectly legible in stating that Sando

Phos was the drug prescribed. Contrary to what Ms Dunford had told them during the day, there was no line crossed through the word 'phos'. The issue was raised with the Deputy Ward Sister who also reviewed patient VR's drug chart and noted the word 'phos' was not crossed out and no mention of Sando K.

25. On 3 October 2017 the Deputy Ward Sister spoke with Ms Dunford about patient VR's drug chart where she explained that the word 'phos' had been crossed out but it had not been. Ms Dunford also spoke with the doctor on the ward to discuss the patient's prescription and reviewed their drug chart which stated Sando Phos. Ms Dunford explained to the doctor that 'phos' had been crossed out but it had not been.

26.

Charge 2

27. As discussed in paragraphs 16-18 Ms Dunford altered patient VR's drug chart by crossing out the word 'phos' to induce her colleagues, the Deputy Ward Sister and the doctor on the ward to believe that Sando K was the correct prescription to be administered. This act of dishonesty was in an attempt to cover up her drug error.

Charges 5 a, b and c

28. On 10 August 2020 the NMC received a second referral from Cardiff and Vale University Health Board ('the Board'). At the time of the concerns Ms Dunford was working at Rookwood Hospital as a Band 5 nurse on the Spinal Injuries Rehabilitation Ward ('the Ward').

29. It came to light that Ms Dunford failed to disclose information on her application form and during the interview/appointment process. Specifically, Ms Dunford failed to declare on her application that she had been employed by the Ravenscourt GP Practice and that her employment at that Practice had been terminated within 4 weeks due to significant concerns about her clinical practice. She did not declare that there was an NMC referral and an investigation pending.

Charge 6

30. On 17 July 2020 the Board questioned Ms Dunford about her failure to disclose her previous employment, the NMC referral and NMC investigation as part of a fact finding/initial assessment meeting. Ms Dunford admitted that she deliberately withheld this information as she was afraid she would not obtain the role if she disclosed this.

Charges 7a (i-iv)

31. Ms Dunford began working at the Board on 3 May 2020. Within the first 4 weeks of her employment concerns were raised about her clinical practice. The concerns included Ms Dunford's inability to carry out 'collar care' to a patient with an unstable spinal injury. Collar care is a treatment prescribed to a patient in an attempt to alleviate symptoms of spinal injuries by stretching the spinal vertebrae to relieve pressure and pain on the nerves that transverse the cervical vertebrae. Ms Dunford had to be stopped and it was explained to her how dangerous the care she was about to carry out was to the patient. She later admitted it was over 20 years since she had provided any care of this type.

32. Ms Dunford mistook the C in relation to C2 level spinal injury for 'clavicle' instead of 'cervical' on two occasions despite education from her colleague

who was the Spinal Injuries Clinical Nurse and became defensive when this was recognised.

33. It was recognised that many of the skills which Ms Dunford had problems with were specialised to the Ward, however Ms Dunford did not inform anyone that she did not have the required skills.

Charges 7b (i-ii)

34. Ms Dunford failed to catheterise a male patient properly, inserting only 4mm instead of the required 22cm. Ms Dunford had to ask a colleague why it was not draining urine properly as she was unable to recognise that she had inserted the incorrect catheter.

Misconduct

35. Ms Dunford admits her conduct as particularised by the charges amounts to misconduct.

*36. In the case of **Roylance v. GMC (No.2) [2001] AC 311** the following assistance was given with what could amount to misconduct:*

'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances'

*37. The same case also reinforced that the misconduct must be **'serious professional misconduct'.***

38. The Parties have assessed that Ms Dunford's conduct fell below the standards ordinarily required of a registered nurse by having regard to the

fundamental importance of honesty and integrity and to the local expectations of a nurse in a similar role.

39. The Parties have also considered the document published by the NMC namely ***The Code: Professional standards of practice and behaviour for nurses and midwives (effective 31 March 2015),*** *which sets out the standards expected of a member of the profession. This will be referred to as 'the Code' hereafter in this document.*

40. Consideration of such standards was endorsed in the case of ***Roylance*** *which stated;*

> *'The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in particular circumstances'.*

41. The Parties have identified the following standards of the Code, which it is agreed that Ms Dunford has breached by way of her conduct as set out above;

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

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

8.2 *maintain effective communication with colleagues*

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

8.5 *work with colleagues to preserve the safety of those receiving care*

8.6 *share information to identify and reduce risk*

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*

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

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 […]*

42. The Parties agree that the conduct in the Charges individually and cumulatively fall far below the standard expected of a registered nurse for the reasons set out below:

- *These were failures to provide basic nursing care that a competent registered nurse should be able to provide. When Ms Dunford's error came to light she then dishonestly tried to conceal it.*

- *The clinical failures are multiple, relating to failures to administer medication correctly, provide correct 'collar care' and an inability to inform colleagues of gaps in practice.*

- *The dishonest failures are two-fold. There is the dishonesty that is clinically related, namely in relation to medication administration – the falsification of medical records to cover up medication errors is serious and something that should not have occurred. Further there is dishonesty relating to failing to advise an employer of the previous referral.*

Impairment

43. The Parties agree that Ms Dunford's fitness to practise is currently impaired on public protection and public interest grounds by reason of her misconduct.

44. The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. The question that will help decide whether a professional's fitness to practise is impaired is:

"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"

45. If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.

46. Answering this question involves a consideration of both the nature of the concern and the public interest. In addition to the following submissions the panel is invited to consider carefully the NMC's guidance on impairment.

47. When determining whether the Registrant's fitness to practise is impaired, the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions were:

1. has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or

2. has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or

3. has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or

4. has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.

48. The Parties agree that all the questions above can be answered in the affirmative in this case.

49. The Parties agree that Ms Dunford's actions placed Patient VR at an unwarranted risk of harm. As discussed in paragraph 12, Sandos Phos is a drug prescribed to patients with phosphate deficiency to help prevent or alleviate symptoms of anaemia, muscle weakness and bone pain. By administering Sando K, the drug prescribed for potassium deficiency which the patient did not have, Patient VR missed 6 tablets of Sando Phos which placed him at risk of developing the above named symptoms.

50. Ms Dunford inappropriately sought advice from colleagues in relation to which of the drugs she should administer due to the confusion she caused by altering Patient VR's drug chart. The public rightly expect nurses to practice in a way that protects and safeguards them. At a basic level this means administering the correct drugs, keeping accurate records without falsification and reporting incidents to management.

51. The Parties agree that Ms Dunford's dishonesty following her failure to administer the correct drugs to Patient VR at this basic level breached fundamental tenets of the profession and brought the profession into

disrepute. Significantly, Ms Dunford has acted dishonestly by crossing out 'phos' on Patient VR's drug chart indicating the medication had been administered and inducing colleagues to believe she had administered the correct medication to cover up her drug error.

52. The Parties also agree that Ms Dunford's actions placed Patient A at unwarranted risk of harm by her; failure to carry out collar care by not being able to recognise when a collar had been fitted correctly, inability to recognise the difference between 'clavicle' and 'clerical' on 2 occasions and became defensive when her colleague tried to correct her and using a 4mm catheter instead of a 22mm catheter blocking the urine drainage. 'Collar care' is a treatment prescribed for patients with spinal injuries and should be dealt with carefully which Ms Dunford failed to do. Ms Dunford also failed to inform her colleagues she had not worked in this area of nursing in 20 years which is a significant amount of time.

53. She acted dishonestly by misleading the Board by failing to disclose her previous employment, dismissal from the GP Practice and the NMC referral and investigation in order to secure a role with them.

54. Again, the public rightly expect nurses to practice in a way that protects and safeguards them. The public also expect nurses to be competent in handling high risk patients. The Parties agree Ms Dunford's actions in relation to Patient VR, and Patient A put the profession into disrepute and breached fundamental tenets of nursing. Further, Ms Dunford acted improperly by not informing her colleagues she lacked clinical knowledge of this area of nursing.

55. The failure to disclose the previous employment, NMC referral and investigation is a breach for gain as accepted by Ms Dunford. Nurses should

be open, honest and truthful. Dishonesty in this instance is serious as it attacks the integrity of the employment and regulation system.

56. The Parties have also considered the comments of Cox J in Grant at paragraph 101:

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

57. The public expect nurses to act professionally and honestly. Ms Dunford's dishonest conduct, has brought the profession into disrepute and has the potential to undermine trust and confidence in the profession. Ms Dunford's actions went against the very foundations of trust which the profession is built upon.

Remorse, reflection, insight, training and strengthening practice

43. Impairment is a forward thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

58. The first question to consider is whether the concerns can be addressed. On one reading, some of the concerns are essentially clinical and could be addressed through training and supervision. However, the Parties agree that

the length of time over which the failings set out in the charges occurred, the repetition of the conduct and the risk, when coupled with an attitudinal issue pertaining to dishonesty mean they cannot be considered easily remediable.

59. The NMC guidance (FTP-3a – available here Serious concerns which are more difficult to put right - The Nursing and Midwifery Council (nmc.org.uk)) provides that a small number of concerns such as these in this case relating to dishonesty may be less easy to remediate due to aspect of Ms Dunford's attitude which led to the incidents happening. The concerns particularized in charges amount to a breach of the professional duty of candour to be open and honest when things go wrong, including covering up and falsifying records.

60. The second question to ask is whether the concern has been addressed. Ms Dunford has provided reflective statements addressing the regulatory concerns in the case and some evidence of training from her development reviews. In one statement, Ms Dunford did not initially explain the reason for her departure or indeed her previous employment. It is to Ms Dunford's credit that she has abandoned her initial denials of being dishonest. Ms Dunford now admits she deliberately did not disclose this to the Board as she did not want to risk not getting the role.

61. Ms Dunford had taken measures to conceal previous concerns with her clinical practice from her employer. In addition, her new employer had identified further clinical concerns. As a result of this, it is difficult to say that the concern has been remedied simply by her admission and also calls her integrity into question.

62. In another reflective statement Ms Dunford shows remorse by apologising for her mistakes and provides evidence of training she had undertaken. However, the training does not evidence strengthened practice

as they were mandatory courses to complete and does not demonstrate full insight into the concerns. In her reflective statement Ms Dunford explained she worked in a stressful work environment and was not provided with proper training. Ms Dunford has not demonstrated sufficient insight into the impact of her actions on patients, her colleagues, and the nursing profession by not taking full responsibility for her own failings and dishonesty by mentioning her stressful work environment.

63. In light of the above concerns regarding Ms Dunford's attitude, reflection and training, the Parties agree there remains a risk of repetition if permitted to practise unrestricted.

Public interest impairment

64. A finding of impairment is necessary on public interest grounds.

65. In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:

> *"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."*

66. Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to

uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.

67. In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which hasn't been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.

68. However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.

69. The Parties agree that Ms Dunford's fitness to practise is impaired on public interest and public protection grounds by reason of her dishonesty and not being open and honest when things go wrong. Preventing the Board from understanding what/if any risk she might pose by failing to disclose her dismissal and NMC referral engages the public interest. Covering up drug errors and trying to convince colleagues into believing false records is serious as her actions put patients at a risk of harm which is a serious departure from our standards. Standards such as the NMC Code which are intended to ensure that registrant's practise safely and effectively.

70. The Parties agree that Ms Dunford's behaviour falls far below the behaviour expected of a registered nurse. A restriction on Ms Dunford's nursing practise is necessary; firstly to address the risk that she would repeat similar behaviour with another patient and; secondly to maintain public confidence in the profession by declaring such behaviour as unacceptable for a registered nurse.

71. The medication errors and deficiencies in practice have yet to be remediated. All the clinical errors had the potential to cause significant harm to patients. The parties agree that there is a public protection issue and further training and reflection will be required to remediate these concerns.

72. The two instances of dishonesty bring the profession into disrepute. The public would rightly be appalled if action were not taken, especially as there was a repeat of dishonest actions when moving to a new employer. It is agreed that in order to preserve public trust and confidence and to uphold the NMC as regulator a finding of impairment is required.

Sanction

73. The NMC sanctions guidance on dishonesty is relevant here. The NMC invites the Panel to consider our guidance on how we determine seriousness (FTP-3). It notes that concerns will be particularly serious if there is a direct risk to patients and to the public's trust and confidence in Registrants in some cases such as this one. It also goes on to say the nature of concerns such as these, if they aren't put right are likely to lead to restrictive regulatory action. The Parties agree that the concerns in this case are difficult to put right due to Ms Dunford's dishonesty.

74. The Panel are also invite to consider the NMC guidance on dishonesty SAN-2, that can be found here: Considering sanctions for serious cases - The Nursing and Midwifery Council (nmc.org.uk)

75. Our guidance continues to say that the level of risk to patients will be an important factor. Ms Dunford breached the professional duty of candour to be open and honest when things go wrong by covering up her drug error in relation to Patient VR., putting them at risk of unwarranted harm. Second, by not being honest with her new employer. A Panel should also consider that

generally, dishonesty will always be serious because of the importance of honesty to a nurse. The Parties agree that the appropriate sanction in this case is a 12 month suspension order with review.

Aggravating and Mitigating features

76. The Panel may consider the aggravating features of this case are:

- *Dishonesty in relation to clinical practice compounded by further dishonesty to a new employer*

- *Poor clinical practice in a number of areas*

77. The Panel may consider the mitigating feature of this case is as follows:

- *Admissions during the investigation*

- *Developing insight*

78. With regard to the NMC's sanctions guidance the following aspects have led us to this conclusion and looking at each of the sanctions in turn:

No action or a caution order

79. Taking into account our sanction guidance SAN-3a and SAN-3, the case is too serious for taking no action or a caution order. Ms Dunford's conduct clearly presents a continuing risk to patients and undermined the public's trust in nurses. Ms Dunford breached one of the fundamental tenets of the professions. A caution order is only appropriate if there is no risk to the public or to patients requiring a nurse, midwife or nursing associate.

Therefore, the Parties agree that these sanctions are not sufficient to ensure public protection.

Conditions of practice

80. The NMC's sanctions guidance states that a conditions of practice order may be appropriate when there are identifiable areas of the registered professionals practice in need of assessment and/or retraining; and conditions can be created that can be monitored and assessed. Although Ms Dunford has completed some mandatory training courses since the incidents, it is difficult to address the concerns in this case, in particular dishonesty, through re-training or assessment. The Parties agree that it would be difficult to formulate workable conditions of practice which would address the concerns relating to her dishonesty protect the public given the multifaceted nature of the misconduct.

81. In any event the combination of clinical issues and dishonesty that occurred on 2 occasions mean that a conditions of practice order does not adequately reflect the seriousness of this case.

A suspension order for 12 months with review

82. The parties agree that the most appropriate sanction in this matter is a suspension order for a period of 12 months with a review. The appropriate NMC guidance can be found here at SAN-3d Suspension order - The Nursing and Midwifery Council (nmc.org.uk)

83. The matters are both clinical and attitudinal. This requires at least temporary removal from the nursing register. This will protect patients and public confidence in both the profession and the NMC as regulator. The

admissions made by Ms Dunford show that the panel can be satisfied that she has sufficient insight so as to reduce the level of risk she poses.

84. The clinical matters are wide ranging across the spectrum of nursing practice. They occurred over a significant period of time and relate to medication administration, catheters and collar care. They are coupled with either dishonesty as outlined below or an inability by Ms Dunford to advise colleagues when she was unable to work in certain areas eg: neck injuries.

85. The dishonesty matters are attitudinal and therefor harder to remediate. They are serious. The initial dishonesty related directly to patient care. It had the potential to cover up a mistake that could have exacerbated patient harm. This is compounded by a failure to advise a new employer of the previous employment where issues occurred, the NMC referral and investigation. Especially relevant as this was the second instance of dishonesty. Nurses hold a privileged position in society, that position requires honesty and openness that was absent here. As such it is important the matter is properly marked.

A striking off order

86. Sanction is a matter for the Panel to decide. This case has the potential to result in a striking off order. However, having considered the guidance and Ms Dunford's reflection the Panel are invited to conclude that a striking off order is not required when taking into account the matters set out below;

87. The sanctions guidance relating to making a striking off order can be found here at SAN 3E Striking-off order - The Nursing and Midwifery Council (nmc.org.uk)

88. Whilst these regulatory concerns raise fundamental questions about Ms Dunford's professionalism, her admissions demonstrate a level of insight that although it requires developing and fortifying is sufficient to mean that a striking off order is not required.

89. Public confidence can be maintained through a lengthy suspension as outlined above and as such a striking off order is not the only sanction that will protect the public and maintain professional standards.

Interim order

90. An interim order is required in this case. The interim order is necessary for the protection of the public and is otherwise in the public interest for the reasons given above. The interim order should be for a period of 18 months in the event that Ms Dunford seeks to appeal the panel's decision. The interim order should take the form of an interim suspension order.

91. The Parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The Parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so."

Here ends the provisional CPD agreement between the NMC and Ms Dunford. The provisional CPD agreement was signed by Ms Dunford and the NMC on 5 October 2023.

Decision and reasons on the CPD

The panel decided to amend the CPD, as outlined above.

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

The panel had regard to paragraphs 8-16 of the CPD which referred to the NMC's application to offer no evidence to charges 3 and 4. The panel determined to endorse these paragraphs. It bore in mind that there was limited evidence available in relation to these charges and that it would be difficult to obtain further evidence given the lapse of time since the alleged conduct. The panel was of the view that these charges did not increase the seriousness of the alleged conduct identified in this case. The panel bore in mind that Ms Dunford has since made admissions to the other charges in this case. The panel took into consideration that the concerns regarding public protection and public interest remain even in the event that charges 3 and 4 are no longer pursued. The panel therefore accepted the NMC's application to offer no evidence in relation to charges 3 and 4.

The panel noted that Ms Dunford admitted the facts of charges 1a, 1b, 1c, 2, 5a, 5b, 5c, 6, 7ai, 7aii, 7aiii, 7aiv, 7bi and 7bii. Accordingly, the panel was satisfied that the charges are found proved by way of Ms Dunford's admissions, as set out in the signed provisional CPD agreement.

Decision and reasons on impairment

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

In respect of misconduct, the panel considered whether Ms Dunford's conduct, underlying in the charges admitted, are serious enough to amount to misconduct. It noted that she had made the same error, in relation to the incorrect administration of Sando K, on three occasions and that she sought to cover up her mistake and apportion blame to her colleagues. It noted that Ms Dunford had not been candid about her employment history with her employer in that she was subject to an NMC referral. It noted that Ms Dunford attempted to complete tasks that she did not have the correct clinical knowledge for. The panel determined that Ms Dunford's conduct was serious enough to amount to misconduct. In this respect, the panel endorsed paragraphs 35 to 42 of the provisional CPD agreement in respect of misconduct.

The panel then considered whether Ms Dunford's fitness to practise is currently impaired by reason of her misconduct. The panel determined that Ms Dunford's fitness to practise is currently impaired in relation to both public protection and public interest. In this respect the panel endorsed paragraphs 43 to 72 of the provisional CPD agreement.

Decision and reasons on sanction

Having found Ms Dunford'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:

- Dishonesty in relation to clinical practice compounded by further dishonesty to a new employer
- Poor clinical practice in a number of areas

The panel also took into account the following mitigating features:

- Admissions during the investigation
- Developing insight

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Dunford'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 Ms Dunford'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 Ms Dunford's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. However, the panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the dishonesty charges admitted in this case. Further, the panel concluded that the placing of conditions on Ms Dunford'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 panel took into consideration that the admitted misconduct in this case relate to clinical and attitudinal concerns. It noted that the clinical concerns are wide ranging. It noted that Ms Dunford's conduct demonstrated a failure to advise colleagues when she was unable to undertake work in certain clinical areas. It took into consideration that the dishonesty misconduct admitted in this case is attitudinal in nature and more difficult to remediate. The panel was of the view that this misconduct is serious and should properly be marked.

The panel bore in mind Ms Dunford's admissions, developing insight and initial steps to strengthen her professional practice. 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.

Balancing all of these factors the panel agreed with the CPD that a suspension order for a period of 12 months with a review would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Ms Dunford. 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.

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:

- An updated reflective statement that addresses Ms Dunford's professional nursing practice and dishonesty misconduct;
- Evidence of training and any experience which addresses the clinical concerns identified in this case; and
- Testimonials and references from your workplace colleagues and managers regarding your clinical practice and integrity.

This will be confirmed to Ms Dunford in writing.

Decision and reasons on 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 Ms Dunford's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

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

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

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

That concludes this determination.