Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 4 December 2023 – Thursday, 21 December 2023
Wednesday, 1 – Wednesday, 8 May 2024

Virtual Hearing

Name of Registrant:	**Sarah Elizabeth Bartle**
NMC PIN	01E0171E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 03 May 2004 V300, Nurse Independent/ Supplementary Prescriber – 31 January 2022
Relevant Location:	Leicestershire
Type of case:	Misconduct
Panel members:	Nicholas Rosenfeld (Chair, Lay member) Patience McNay (Registrant member) Anne Phillimore (Lay member)
Legal Assessor:	Nigel Pascoe (12, 14 – 21 December 2023, 1 – 8 May 2024) Charles Parsley (4 – 11 December 2023) Michael Levy (13 December 2023)
Hearings Coordinator:	Franchessca Nyame (1 – 8 May 2024) Tyrena Agyemang (4 – 11, 18 - 21 December 2023) Amanda Ansah (12 December 2023) Jessie Miller (13 – 15 December 2023)
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Miss Bartle:	Present and represented by Chris Pataky
Facts proved by admission:	Charges 1c and 4a

Facts proved:	Charges 1a, 1b, 1d, 1g i, 1g ii, 1g iii, 5a, 5b, 6a and 6b
Facts not proved:	Charges 1e, 1f, 1g iv, 1g v, 2, 3 and 4b
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (1 month)**
Interim order:	**No order**

Details of charge (as amended)

That you, a registered nurse:

1) On 19 January 2019 in respect of Client A:

   a) Failed to ensure a nurse prescriber personally carried out clinical assessments and/or medical record checks. – **Found proved**

   b) Administered prescription-only medication, Botulinum toxin A, without a prescription. – **Found proved**

   c) Administered prescription-only medication, Botulinum toxin A, which was prescribed for someone else. – **Found proved by admission**

   d) Administered prescription-only medication, Botulinum toxin A without a patient specific direction as to the dose and range. – **Found proved**

   e) Stocked prescription-only medication Botulinum toxin A when you were not authorised to do so. – **Found not proved**

   f) Stored prescription only medication, Botulinum toxin A, in your handbag. – **Found not proved**

   g) Failed to document and/or record adequately or at all:

      i) Details of the consultation. – **Found proved**

      ii) Details of any purported prescriber/prescription. – **Found proved**

      iii) Client A's expectations. – **Found proved**

      iv) Treatment plan. – **Found not proved**

v) Direction to administer. – **Found not proved**

2) Your actions at charge 1(c) were dishonest as you knowingly administered prescription-only medication, Botulinum toxin A, that was not prescribed for Client A. – **Found not proved**

3) Between 19 January 2019 and 19 February 2019; – **Found not proved in its entirety**

   a) Did not arrange follow-up care in respect of Client A.

   b) Did not undertake follow-up care in respect of Client A

   c) Refused to review treatment.

4) Between 19 January 2019 and 2 March 2019 in respect of Client A failed to take;

   a) Pre-treatment photographs. – **Found proved by admission**

   b) Post-treatment photographs. – **Found not proved**

5) In relation to a consultation with Client A on 19 January 2019, incorrectly informed the Nursing and Midwifery Council ("NMC") that in relation to a consultation on 19 January 2019 you stated: – **Found proved in its entirety**

   a) On 15 May 2019 that:

      i) "we consulted my prescriber [Colleague Y] who saw [Client A]".

      ii) "[Colleague Y] explained the risks of treatment and what the aims of treatment were, what longevity to expect from treatment, and how long treatment takes to start showing effects"

b) On 24 May 2019 that “**my prescriber saw the referrer with me in the salon on 19/1/19**”.

6) Your actions at charge 5 above were dishonest in that you: – **Found proved in its entirety**

a) Knew Colleague Y had not consulted with Client A.

b) Sought to mislead the NMC in relation to an investigation into your fitness to practise.

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

The first decision and reasons on application to amend the charge

The panel heard an application made by Mr Edwards on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charge 2.

The proposed amendment was to remove the words '*was not prescribed'* in the charge. He submitted that the proposed amendment corrected a simple typographical error and it would not prejudice any parties but provide more clarity.

> "That you, a registered nurse:
>
> 2) Your actions at charge 1(c) were dishonest as you knowingly administered prescription-only medication, Botulinum toxin A, that was not prescribed ~~was not prescribed~~ for Client A.
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

Neither Mr Jotangia on behalf of Colleague Y, nor Mr Pataky on your behalf objected to the application.

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 an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you or Colleague Y and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity.

Decision and reasons on application exclude parts of Witness 1's evidence

The panel heard an application made by Mr Pataky on your behalf under Rule 31 to exclude parts of Witness 1's expert report from the evidence.

Mr Pataky outlined the attempts that were made to have the bundles agreed between you and the NMC before the start of the hearing, however the redactions could not be agreed. He submitted that the panel had a wide discretion to admit evidence under Rule 31 as long as the evidence was considered both relevant and fair.

Mr Pataky referred the panel to Witness 1's expert report.

In relation to the first redaction, he submitted that the word *'routinely'* should be removed from paragraph 48 of the report. Regarding the second redaction, he referred the panel to Witness 1's conclusions on page 51, specifically the fifth bullet point and he submitted that this should also be removed.

Mr Pataky submitted to the panel that Witness 1 appears to be reaching conclusions in the case, which he submitted is a matter for the panel. He further submitted that this evidence is therefore prejudicial and that the conclusion that is included goes beyond the case the NMC have brought against you. He submitted that to include the evidence as highlighted is therefore unfair and not relevant to the proceedings.

Mr Pataky therefore invited the panel to redact both from Witness 1's report if the panel should grant the application.

Mr Jotangia on behalf of Colleague Y remained neutral to the application and submitted that it is a matter for the panel's judgement.

Mr Edwards submitted the NMC agree with the first application to remove the word '*routinely'*, but he told the panel the NMC do not agree with the second application.

Mr Edwards submitted that it is alleged you saw and treated Client A on the same day without her being seen and consulted by Colleague Y, so it is relevant to the panel's considerations.

Mr Edwards submitted that the NMC would not object to removing the letter '*s'* so it refers to a singular *'patient'* rather than *'patients'*. However, he submitted that there is no prejudice or otherwise, to you with this remaining in the bundle.

Mr Edwards submitted that the panel have already noted the evidence before it, however as an experienced panel, if having heard the evidence from Witness 1, the panel do not agree with her conclusions, then it can disregard that evidence when it is considering the facts in this case. He further submitted that the evidence can also be put to Witness 1, when she gives her evidence before the panel.

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

The panel gave the first application in regard to the removal of the word *'routinely',* serious consideration. The panel noted that the application was unopposed by both Mr Jotangia or Mr Edwards and that was not unjust nor would there be prejudice as a result of its removal. The panel was therefore content to grant the application.

The panel went on to consider the second application.

The panel considered the submissions of both Mr Pataky and Mr Edwards and the NMC's guidance entitled *'Evidence'* (referenced at DMA-6, last updated on 1 July 2022). The panel was of the view that the conclusion which had been highlighted, constituted an opinion. The panel would need to reach its own views and conclusions having regard to all the relevant evidence. The panel would approach with care the findings of this witness when reaching its own decision on the issues before it.

The panel was therefore of the view that it would be unjust for this section not to be redacted. The panel concluded that it would exercise its own expertise and experience as an independent panel to evaluate the experts remaining evidence.

In these circumstances, the panel came to the view that it would be fair to accede to Mr Pataky's application.

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

During the course of the hearing, Mr Pataky made a request that parts of this case be held in private [PRIVATE. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Edwards and Mr Jotangia did not object to the application.

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.

[PRIVATE, the panel determined that those parts of the hearing which related to such issues should be held in private session.

Background

You were referred to the NMC on 3 April 2019 by Client A in relation to your practice at Eden Skincare and Beauty Salon (the Salon), where you provided aesthetic treatments on a self-employed basis. On 19 January 2019, Client A attended the Salon for a Botox treatment whereupon you consulted and treated Client A within the same consultation.

It is alleged that Client A was not happy with the results of her treatment and contacted the Salon. It is alleged that during a telephone call with Client A, you stated that you had explained things correctly to her, and informed Client A that you did not provide two-

week top ups as you did not deem these necessary. Client A went on to request a refund, but you refused.

It is further alleged that Client A asked you to provide evidence of your nursing training and insurance certificates and you provided a photograph of your nursing diploma, a certificate of attendance for a fillers course and a letter relating to insurance at a later stage.

During the course of the NMC's investigation, Colleague Y, another registered nurse, informed the NMC that she had consulted with Client A on 19 January 2019. Colleague Y provided a copy of the prescription she issued, dated 28 March 2019. The NMC subsequently closed the investigation and informed Client A of this outcome.

Client A, on receipt of the NMC's notification about the closure of the case, provided further information. She stated that she had never been seen by Colleague Y and alleged that Colleague Y was not involved in her consultation. It is alleged you were dishonest when providing information about Ms 1's involvement to the NMC during the course of the investigation and the NMC reopened the case.

Second application on decision and reasons on application to amend the charge

The panel heard an application made by Mr Edwards, on behalf of the NMC, to amend the wording of charge 5b.

The proposed amendment was to accurately reflect the concerns raised. It was submitted by Mr Edwards that charge 5b was a repeat of Charge 5a (ii) and that the proposed amendment would provide clarity and more accurately reflect the evidence. He further submitted that this was an administrative error that was not picked up earlier.

That you, a registered nurse:

5) In relation to a consultation with Client A on 19 January 2019, incorrectly informed the Nursing and Midwifery Council ("NMC") that in relation to a consultation on 19 January 2019 you stated:

b) On 24 May 2019 that "**my prescriber saw the referrer with me in the salon on 19/1/19** ~~[Colleague Y] explained the risks of treatment and what the aims of treatment were, what longevity to expect from treatment, and how long treatment takes to start showing effects~~".

The panel heard submissions from Mr Pataky who stated that he objected to the requested changes. He submitted that this was not a typographical error, but rather amended the allegations and widened the case against you. He went on to note that this was a late application and for all of the reasons stated, is not fair to you.

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 an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It rejected the notion that this amendment would widen the case against you, and therefore determined it was appropriate to allow this application, as applied for, to ensure clarify around the charges being brought forward.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Pataky, who informed the panel that you made admissions to charges 1c and 4a.

The panel therefore finds charges 1c and 4a proved, by way of your admissions.

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

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

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

- Client A: The referrer and patient in this case;

- Witness 1: NMC Expert Witness

The written evidence of Witness 2 and Witness 3 had been agreed between the parties with no requirement for them to be called to provide oral evidence before the panel.

The panel recognised that Witness 1 is an expert in a developing field. Witness 1 may not be experienced in drafting expert reports for proceedings nor giving expert evidence, however, it was clear to the panel that she was an expert witness in the field of aesthetics. Indeed, Mr Pataky on your behalf, during his closing submissions, stated *'her aesthetic experience is clear'.* The panel agreed with this submission, found her to be credible, reliable and therefore both her written and oral evidence carried significant weight.

The panel also bore fully in mind your good character when making its determination on the facts.

The panel additionally heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Mr Pataky, which included a document entitled *'Responsible Prescribing*

for Cosmetic Procedures' by the Joint Committee for Cosmetic Practitioners dated 18 July 2019 which was presented to the panel by Mr Jotangia on behalf of Colleague Y.

Central to the panel's determination of these charges is a fundamental finding of the panel on the balance of probabilities, that registrant Colleague Y was not present at the time of the treatment of Client A by you on 19 January 2019.

The panel find Client A on the available evidence to have been consistent, reliable and truthful in her repeated assertions throughout all these proceedings that the two registrants were never there together at the time of her treatment.

It follows from that fundamental finding that, in so far that the registrants assert otherwise, the panel reject those assertions as untrue.

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

Charge 1a)

1) On 19 January 2019 in respect of Client A:

    a) Failed to ensure a nurse prescriber personally carried out clinical assessments and/or medical record checks.

This charge is found proved.

The panel had regard to the Witness 1's expert witness report. In the report dated 22 June 2022, she stated:

> *'The patient should have been assessed and consented by a professional registrant qualified to prescribe…'*
>
> *'The prescribing nurse should introduce herself to the patient. Take a medical, social and psychological history to identify any medical*

contraindications, potential interactions with other medicines and social circumstances or activities that might act as barriers to following aftercare advice, or impact on expectations…'

…

'The prescribing nurse needs to assess and consult with the patient. The prescriber should not be prescribing for a patient they have not assessed and consulted…'

The panel also had regard to the *'Guidelines for prescribing in medical aesthetics'* from the British Association of Cosmetic Nurses dated 15 August 2012, which states:

- ***'The prescriber should undertake this medical history personally, rather than merely review a medical history already taken. [Emphasis added]***

- ***It is expected that this would include a comprehensive medical history and physical assessment. [Emphasis added]***

- *The assessment will include the patient/client expectations and reasons for wanting treatment in the decision to prescribe.'*

During the course of her oral evidence, Witness 1 stated:

'The initial consultation needs to be with a prescriber'

And:

'Sarah Bartle's records and the experience from the patient don't show that there was an assessment by the prescriber. There are no records that this patient was seen by the prescriber.'

Given the evidence provided by the expert witness, the panel was satisfied that there was an obligation upon the prescriber to personally undertake and document a consultation. The panel inferred, given your experience that you would have known of this obligation and that it was incumbent on you, as the registered nurse, to ensure that the prescriber carried out the consultation.

Having found in charge 5b relating to Colleague Y that she did not undertake a consultation for Client A on 19 January 2019, the panel determined that there was an obligation on you to ensure a nurse prescriber personally carried out a clinical assessment and/or medical records check, you failed to do so and therefore the panel finds this charge proved.

Charge 1b)

1) On 19 January 2019 in respect of Client A:

    b) Administered prescription-only medication, Botulinum toxin A, without a prescription.

This charge is found proved.

In reaching this decision, the panel took into account that you treated Client A without a signed patient specific prescription from Colleague Y. You stated in your reflection:

> *'At this point this is where my judgement was impaired and my normal thinking compromised, I had a vial of botulinum toxin unused in my bag, that was from someone that had not attended, in my mind it was the same product, unused and unopened and had not label on the bottle from the pharmacy. I offered to treat [Client A] there and then with this vial.'…*
>
> *'Ive [sic] laid awake so many nights wishing I could go back, I wouldn't have gone to the salon that day, I wouldn't have offered her the treatment, and I*

certainly would not have used a vial of botulinum toxin that was initially intended for someone else.'

The panel note from your reflective statement, that there is no mention of Colleague Y generating a written prescription on 19 January 2019. Furthermore, in your email to the NMC dated 15 May 2019, you do not mention the generation of a prescription by Colleague Y nor is it mentioned in the regulatory concerns response form signed by you dated 4 May 2021.

It would appear that the first time you mention that Colleague Y generated a paper prescription, was during the course of your oral evidence. The panel noted that the handwritten prescription was not available, with the explanation from Colleague Y that [PRIVATE] had shredded all her certificates and records.

In the absence of any documentary evidence to substantiate a prescription being generated on 19 January 2019, the panel was not persuaded by your evidence or the corroborating evidence of Colleague Y and rejected your account. The panel accepted the evidence of the NMC and finds that Botulinum toxin A was prescribed without a prescription.

Furthermore, having found that Colleague Y was not present at the consultation on 19 January 2019, the panel determined on the balance of probabilities that a prescription was not generated.

Charge 1d)

1) On 19 January 2019 in respect of Client A:

   d) Administered prescription-only medication, Botulinum toxin A without a patient specific direction as to the dose and range.

This charge is found proved.

The panel, on an independent consideration of your case, having found in charges 1d, 6 and 7 in relation to Colleague Y proved and charge 5b in relation to you proved, is satisfied that in respect of Client A you administered prescription-only medication, Botulinum toxin A without a patient specific direction as to the dose and range.
The panel inferred that there was an obligation on Colleague Y to undertake this with reference to the *'Guidelines for prescribing in medical aesthetics'* from the British Association of Cosmetic Nurses dated 15 August 2012. In the document it states:

- *'It is anticipated that a patient-specific direction is the appropriate method of prescribing for patients in private aesthetic practice.*
- *The PSD shall be recorded in the patient notes in line with section 3 above.'*

Furthermore, in Witness 1's expert witness report, it was stated that:

> *'In not consulting with or assessing patients, the prescriber is not writing any patient specific direction to administer in the patient record, this leaves the non-prescribing nurse to administer without a direction and in so doing, she is in breach of regulations with every treatment.'*

Additionally, during the course Witness 1's oral evidence, when referring to the manufacturer's Patient Injection Record, she stated:

> *'If the prescriber uses this as a direction, it could have served quite well. That would have been a good direction if written by 'Colleague Y' [sic], this could have been a direction to administer…'*
>
> and
>
> *'If someone else is going to administer it, there needs to be a direction – what, when, how. The nurse needs the direction.'*

and

'The prescriber is directing the nurse to administer. The nurse must be directed to administer it. The direction does not appear to be written by the prescriber.'

and

'…like a nurse taking medicine out of a cupboard without a direction from a doctor…you just can't do that.'

and

'There needs to be a direction, otherwise the nurse is just making up the dosage.'

Witness 1 stated that the patient injection record would suffice as a direction to administer, however this was not signed by Colleague Y. Therefore, having found Colleague Y not to be present at the consultation on 19 January 2019, the manufacturer's Patient Injection Record which would have sufficed as the patient specific direction, was not signed by Colleague Y. The panel finds that you administered prescription-only medication, Botulinum toxin A without a patient specific direction as to the dose and range.

Charge 1e)

1) On 19 January 2019 in respect of Client A:

   e) Stocked prescription-only medication Botulinum toxin A when you were not authorised to do so.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence from Witness 1, who stated the following in her report dated 20 June 2022:

> *"Medicines that have been dispensed for a named patient are not stock medicines."*

The panel also considered Witness 1's oral evidence, in which she stated:

> '*That would not be considered as stock medication…*
>
> *She would not be storing medication…*
>
> *I do not believe she was storing medication.'*

The panel also took into account your evidence that the medication administered had been prescribed for a client, but not for Client A.

Having regards to the evidence before it, the panel determined that your actions did not amount to stocking prescription-only medication Botulinum toxin A when you were not authorised to do so. Therefore, this charge is found not proved.

Charge 1f)

1) On 19 January 2019 in respect of Client A:

f) Stored prescription only medication, Botulinum toxin A, in your handbag.

This charge is found NOT proved.

The panel took into account your description of the '*bag'* you kept the medication in. It noted the following from your reflection:

'At this point this is where my judgement was impaired and my normal thinking compromised, I had a vial of botulinum toxin un used in my bag'

The panel referred itself to Client A's Witness statement in which she states:

'I noticed Sarah went into a silver case that she had on the floor…'

The panel also noted Client A's oral evidence in which she confirms the type of '*bag'* you stored the medication in. She told the panel that:

'it was a silver box'

The panel referred to the Witness 1's report which states:

'In this case the patient report suggests Sarah Bartle took a vial from a sliver case. The manufacturer is a medicine that should be stored securely, not shaken, and a cold chain maintained. Such a bag is unlikely to be refrigerated'

Witness 1 stated in her oral evidence:

'If it is in a lockable case with an ice pack, that is fine'

Having heard your evidence, where you stated:

'*The Botox is kept in a locked metal box with ice packs in it.'*

The panel was satisfied that you stored the medication in a locked case with an ice pack and not a handbag. The panel in preferring your evidence on this particular charge, therefore finds this charge not proved.

Charge 1g) i

1) On 19 January 2019 in respect of Client A:

g) Failed to document and/or record adequately or at all:

i. Details of the consultation.

This charge is found proved in the alternative (record adequately)

In reaching this decision, the panel took into account Witness 1's evidence, the NMC Code, the manufacturer's Consent Record, the manufacturer's Patient Injection Record and the General Consultation & Cosmetic Procedure Questionnaire.

The panel referred to Witness 1's report which states:

> *'The medical records do not adequately document the consultation, there are discrepancies in both the patient report of the experience and Ms Bartle's. The records do not provide sufficient clarity.'*
> *…*
>
> *'The nurse has failed here to properly document the patient expectations of outcome and to document properly the pre treatment state to illustrate why the frontalis could not be treated and to use to educate the patient.'*

The panel noted the NMC Code which states:

> ***'10 Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope*
> *of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
>
> ***10.3** complete records accurately…'*

The panel was satisfied that there was an obligation on you to document and accurately reflect the consultation process that took place on 19 January 2019.

The panel took into account Witness 1's oral evidence, when she stated in relation to the manufacturer's Consent Record and the manufacturer's Patient Injection Record that:

> *'The manufacturers forms are not well thought through or well informed its not designed to be a full record… this is just designed to be a record of treatment administered.'*
>
> *And*
>
> *'Sometimes they trip practitioners up into missing things'*
>
> And
>
> *'I don't think those records are good enough for this treatment episode.'*

The panel acknowledged that you did document some details of the consultation on the manufacturer's Consent Record and Patient Injection Record and the General Consultation & Cosmetic Procedure Questionnaire, however based on the evidence of Witness 1, the panel was of the view that the information documented was not sufficiently detailed, particularly in light of the circumstances, when an issue arose with the treatment you provided.

The panel therefore finds this charge proved.

Charge 1g) ii

1) On 19 January 2019 in respect of Client A:

    g) Failed to document and/or record adequately or at all:

        ii. Details of any purported prescriber/prescription.

This charge is found proved.

The panel referred to the *'Guidelines for prescribing in medical aesthetics'* from the British Association of Cosmetic Nurses dated 15 August 2012, states:

- *'A record of the PSD and prescription details should be made in the patient/client notes.*
  In addition the prescriber should retain a copy of these for their records.
- *Both nurses will sign the consultation/history sheet, together, upon completion.'*

The panel was of the view that you had an obligation to ensure that Colleague Y's details were recorded. None of the documents which were produced during the consultation with Client A on 19 January 2019, had the details of the purported prescriber, Colleague Y documented on them.

The panel was of the view that a lack of signed documentation from Colleague Y substantiates that she was not present at the consultation, and it therefore finds this charge proved.

Charge 1g) iii

1) On 19 January 2019 in respect of Client A:

    g) Failed to document and/or record adequately or at all:

        iii. Client A's expectations.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's expert report which states:

'The nurse has failed here to properly document the patient expectations of

outcome and to document properly the pre treatment [sic] *state to illustrate why the frontalis could not be treated and to use to educate the patient.'*

And

'[Client A] *wanted her 'elevenses treated (patient report), but the patient expectations were not adequately identified or clearly documented in the record, and it appears from the complaint that the patient expectations were not managed.'*

During the course of Witness 1's oral evidence she stated:

'From those treatment sites I can see where the patient wanted treating. It does not tell me what the patient expectations are.'

And

'That treatment plan would not have met her expectations. It is not ideal to scribble notes on that sheet'

And

'This is a good record of the treatment administered, … but it's not a good record, it is missing parts the patient assessment, the patient's expectations…the notes that are here do not explain what the patient is expecting or whether this is an appropriate treatment there is a chunk of information missing.'

Having reviewed the expert witness report and noted the oral evidence given, the panel is satisfied that there was an obligation for you to document and/or record adequately Client A's expectations of the treatment. The panel was not satisfied that Client A's expectations were documented on the records, you therefore failed in this obligation, and it finds this charge proved.

Charge 1g) iv

1) On 19 January 2019 in respect of Client A:

g) Failed to document and/or record adequately or at all:

iv. Treatment plan.

This charge is found NOT proved.

The panel referred to the oral evidence of Witness 1, who stated:

*'This is a good treatment plan' (*When referring to the manufacturer's Patient Injection Record)

The panel referred to the NMC Code which outlines a nurse's obligation to keep clear records. The Code states:

'10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.'

The panel acknowledged Witness 1's references to the need for and importance of a treatment plan. During the course of her oral evidence, she stated:

'This is a good record of treatment administered.'

And

'The dose is there, the treatment is there, it could be a treatment plan, yes'

The expert confirmed the manufacturer's Patient Injection Record could constitute a treatment plan and in light of this, the panel finds this charge proved.

Charge 1g) v

1) On 19 January 2019 in respect of Client A:

    g) Failed to document and/or record adequately or at all:

        v. Direction to administer.

This charge is found NOT proved.

The panel having appraised all the evidence, was not satisfied based on the information before that there was an obligation on you to document and/or record the direction to administer.

The panel was of the view that it was the responsibility of Colleague Y to record the direction to administer.

The panel referred to the *'Guidelines for prescribing in medical aesthetics'* from the British Association of Cosmetic Nurses dated 15 August 2012, which states:

> *'A patient-specific direction (PSD) is a written instruction from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient.'*

The panel was therefore satisfied that this obligation was not your responsibility but that of Colleague Y and finds this charge not proved.

Charge 2

2) Your actions at charge 1(c) were dishonest as you knowingly administered prescription-only medication, Botulinum toxin A, that was not prescribed for Client A.

This charge is found NOT proved.

The panel took account of your early admission and responses to charge 1c which was documented on the regulatory concerns response form signed by you on 4 May 2021, which states:

> *'I did administer botox treatment to the complainent that was not prescribed for her. It was prescribed for someone who didnt attend on the day the complainant came for her consultation. The product is the same product, with the same indication and the complainant was keen to have the treatment that day, so after discussion with* [Colleague Y] *we agreed that it was suitable for use on the complainant.*
>
> *On reflection i should not have used it, i should have sent it back to the pharmacy, but i felt pressured by the complainant to provide her treatment, and as it was the same product i stupidly thought it would be ok.' [sic]*
>
> *'i accept full responsibility for this allegation…'*

The panel referred to the witness statement and oral evidence of Client A, who at no point throughout her evidence made the suggestion that you had stated that the Botulinum toxin A was specifically prescribed to her on 19 January 2019.

The panel considered the evidence on this point to be consistent with your account, that the Botulinum toxin A was meant for another client, who did not attend their appointment.

The panel referred to Witness 1's oral evidence, where she stated:

> *'the treatment was administered safely…'*
>
> and

'the nurse was competent nurse to administer it…'

and

'even if the prescription process was not followed, no serious harm would have come to client …There was no specific risk of harm to the patient.'

The panel was of the view that it is bad practice to administer medication that was prescribed for another client to Client A. However, in the absence of any evidence that your represented to Client A that the medication was specifically prescribed for her, this '*bad practice'* did not translate in the judgement of the panel into a finding of dishonesty.

Therefore, the panel finds this charge not proved.

Charge 3

3) Between 19 January 2019 and 19 February 2019;

   a) Did not arrange follow-up care in respect of Client A.

   b) Did not undertake follow-up care in respect of Client A

   c) Refused to review treatment.

This charge is found NOT proved.

The panel referred to Witness 1's expert report, in which she states:

*'Common practice is to follow-up at 2-3 weeks **(Appendix 7**) when the optimum outcome is achieved. It is common practice because response to the treatment can vary, there can be some compensatory movement or persisting muscle action that can be addressed with additional doses at this point in time.'*

The panel acknowledged Witness 1's oral evidence when she states:

'it is not a requirement, its common practice especially for the first time…'

and

'If the patient is paying for a specific outcome, it not fair…'

and

'You need to review to make sure it works for the patient.'

and

'Its common practice for good reason.'

and

'Its not an offence to, but not fair to patients in my opinion.'

The panel noted that this is '*common practice'*, however, this does not constitute a requirement. The panel distinguished common practice from requirement and determined that there was no requirement on you to undertake the matters referred to in the charge. Your actions may not have been '*best practice'*, but in the absence of a more specific documented requirement, the panel finds the charge not proved.

Charge 4b

4) Between 19 January 2019 and 2 March 2019 in respect of Client A failed to take;

b) Post-treatment photographs.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's expert report which states:

'Pre and post treatment photographs in good lighting with the patient in controlled positions at rest and in animation directed by the professional are an essential part of the medical record.

…

Without good photographic records per and post treatment it is challenging to address unrealistic expectations or evidence the improvement gained, and it is unlikely an insurer would be able to defend a claim.'

The panel infer that there was an obligation on you to take post treatment photographs after treating Client A.

The panel then referred to your insurance documentation, which states:

'1.16 The Insured shall use best endeavours to ensure that photographs of patients are taken both before and after treatment. The Insured shall retain these photographs for a minimum period of six (6) months from the date of the treatment.
…

1.18 The Insured shall use best endeavours to obtain photographs of patients in all cases and refusal for pre and post treatment photographs should be an exception rather than the rule.'

The panel acknowledged your evidence that Client A was too upset and agitated for you to take the post-treatment photographs. It referred to your email sent to the NMC on 15 May 2023 which states:

'Client A [sic] refused to sit on the treatment couch and was getting close to me shouting that she wasn't happy that she wasn't "frozen" and I explained as I had at her consultation that this was not the treatment we had planned and that only having her frown and around her eyes treated would not stop the movement in

her upper face. She continued to shout at me and became very angry and demanded I give her her [sic] money, she then proceeded to start to look through my documentation in the room, and to look for money. I explained that from my professional point of view the treatment she had was successful and that I would like her to leave as her behaviour was not acceptable. … she appeared erratic and angry, and my opinion is that any further treatment would not change the aesthetic result, but may add to her unrealistic expectations of treatment and cause her further upset. Client A [sic] then left the salon and slammed the door behind her.'

The panel also referred to Client A's witness statement, in which she stated:

'I said that I had the treatment and wasn't happy with the outcome and given her response I didn't want her to come near me and demanded some kind of recompense.'

The panel also took into account Client A's oral evidence, when she told the panel:

'I was not angry in the meeting at all…'

And

'I was not angry…'

And

'I spoke to her calmly'

The panel considered the evidence in relation to the meeting with Client A on 2 March 2019, which occurred after a heated telephone call between yourself and Client A, for which Client A confirmed in her oral evidence that she subsequently apologised to you. The panel thought it more likely than not that Client A would have been frustrated and agitated at the meeting on 2 March 2019.

The panel was of the view that it preferred your evidence in relation to this charge. Given the nature of that meeting on 2 March 2019 and Client A's behaviour, the circumstances were not conducive to you taking of post treatment photographs. In view of that, although there was an obligation for you take post treatment photographs, given the context of the meeting, the panel finds this charge not proved.

Charge 5

5) In relation to a consultation with Client A on 19 January 2019, incorrectly informed the Nursing and Midwifery Council ("NMC") that in relation to a consultation on 19 January 2019 you stated:

   a) On 15 May 2019 that:

      i) "we consulted my prescriber [Colleague Y] who saw [Client A]".

      ii) "[Colleague Y] explained the risks of treatment and what the aims of treatment were, what longevity to expect from treatment, and how long treatment takes to start showing effects"

   b) On 24 May 2019 that "my prescriber saw the referrer with me in the salon on 19/1/19".

This charge is found proved.

In relation to charge 5a, the panel referred to your email to the NMC, dated 15 May 2019 in which you stated:

> *'we consulted my prescriber* [Colleague Y] *who saw* [Client A]*.* [Colleague Y] *explained the risks of treatment and what the aims of treatment were, what longevity to expect from treatment, and how long treatment takes to start showing effects.'*

The panel also referred to a further email from you to the NMC dated 24 May 2019, which stated:

'My prescriber saw the referrer with me in the salon on 19/1/19'

The panel then referred itself to a letter from Client A to you dated 13 March 2019 which stated:

*'…for my Botox treatment that **I had with you** on the 19th January 2019.'* [Emphasis added]

And

*'Please can you forward to me, any paperwork relating to my treatment **with you**. This to include my medical records and my prescriptions.'* [Emphasis added]

The panel also had regard to the text message conversations, during which Client A corresponds with you, requesting copies of your insurance certificates, medical records and copies of any prescriptions. In one text message, Client A requests to see a copy of your prescribing certification.

The panel was of the view that Client A would have mentioned the prescriber (Colleague Y) during her correspondence with you if she had been present. Client A had no hesitation in mentioning all those she had come into contact with. The absence of any reference to Colleague Y was significant to the panel in its determination.

The panel took into account an email sent from Client A to the NMC, dated 12 June 2019 in which it was stated:

'Specifically there is a claim that a nurse 'Colleague Y' [sic] *saw me and wrote out the prescription. This is a false statement and I am concerned about fraudulent activity in this whole consultation.'*

and

'As a first person witness on the day I can categorically confirm that 'Colleague Y' [sic] *did not have any contact with me whatsoever. I have never heard of her until receipt of the letter.'*

and

'The treatment was done by 'Colleague X' [sic] *and 'Colleague X'* [sic] *alone.'*

In Client A 's witness statement, she stated that:

'If Colleague Y [sic] *had been present I would have mentioned it in the first place. I never saw her, I never even spoke to her on the phone and Colleague X* [sic] *never called her when I was there. Colleague Y* [sic] *wasn't there on the second occasion I attended either. I don't know why she is saying this as it is untrue.*

The panel heard oral evidence from Client A on 5 December 2023 which it found consistent and reliable on this point. During the course of this evidence, she stated:

'I can categorically swear, on my children's life, that she was not there. When the reports from the NMC came back, I was astounded. She was not there.'

and

'I have never met Colleague Y [sic] *in my life.'*

and

'I would know if there was another person there – she was not there.'

and

'I have been telling the truth.'

and

'I am not delusional, she was not there.'

During the course of the oral evidence of Witness 1, she stated that:

'There are no records that this patient was seen by the prescriber.'

In Witness 1's expert witness report, it was stated that:

'The patient should have been assessed and consented by a professional registrant qualified to prescribe. The prescriber should document the assessment and co-sign the consent and document the treatment plan and direction to administer…'

The panel noted that none of the patient consultation documents were co-signed by Colleague Y. In Colleague Y's oral evidence, she admitted that this is her normal practice, however she was unable to provide an explanation as to why, on this particular occasion, she failed to do so.

During the course of Colleague Y's evidence, she told the panel that she is hard of hearing and that during the consultation on 19 January 2019, which Colleague Y stated lasted no less than nine minutes, she would have needed to see Client A's face to enable her to lip read the conversation. Given this assertion, it would have been highly unlikely for Client A not to have acknowledged Colleague Y's presence, remember her and reference her in the complaint. The panel have inferred that it was more likely than not that Colleague Y was not present during this consultation and preferred the evidence of Client A.

The panel referred itself to the evidence you produced which outlined that on 28 January 2019, there was a transaction from you to Colleague Y for the amount of *'£40.00'*. The panel noted that this was the usual payment made for providing a consultation and prescription, however, the information contained no further detail of what the treatment was, where it was provided and on what date. The panel was of the view that there was significant detail lacking, and the evidence before it cannot be considered conclusive to demonstrate that Colleague Y was present during the consultation with Client A on the date in question.

Given the evidence before it, the panel had determined therefore that on the 15 and 24 May 2019, you incorrectly informed the NMC that Colleague Y saw Client A and prescribed for her.

In light of this decision, the panel went on to considered charges 5 a (ii) and 5b.

The panel was of the view that as it has already determined that Colleague Y was not in attendance at the consultation on 19 January 2019, she therefore would not have been able to explain the risks of treatment to Client A, neither would she have been able to explain what the aims of the treatment were, what longevity to expect from the treatment, and how long treatment takes to start showing effects as part of her consultation.

The panel referred to your email sent to the NMC on 15 May 2019, in which you stated:

> *'Colleague Y* [sic] *explained the risks of treatment and what the aims of treatment were, what longevity to expect from treatment, and how long treatment takes to start showing effects.'*

In essence, you are describing a conversation that you did not hear as you knew that Colleague Y was not present with you on 19 January 2019. Your representations in your emails to the NMC were incorrect.

The panel therefore finds charge 5 proved in its entirety.

Charge 6

6) Your actions at charge 5 above were dishonest in that you:

    a) Knew Colleague Y had not consulted with Client A.

    b) Sought to mislead the NMC in relation to an investigation into your fitness to practise.

This charge is found proved.

The panel bore in mind its decision in relation to charges relating to the non-attendance of Colleague Y at Client A's consultation on 19 January 2019.

In relation to charge 6a, the panel considered the NMC Guidance on '*Making decisions on dishonesty charges',* DMA-7, last updated 12 October 2018. By applying the *'standards of ordinary, decent people'* in that the *'law assumes that people from all walks of life can easily recognise dishonesty when they see it'* and having found charges 5a and b proved, the panel determined that you knew that Colleague Y had not consulted with Client A, despite stating that you had, in an email to the NMC dated 15 and 24 May 2019. The panel determined that this conduct was dishonest.

The panel went on to considered charge 6b.

The panel referred to the email from Colleague Y to the NMC dated 22 May 2019 in which she stated:

'Yes I saw Sarah Bartle and prescribed for her…'

It also referred to your emails dated 15 and 24 May 2019 in which you confirm, Colleague Y consulted Client A.

The panel determined that the actions of sending these emails was dishonest following its findings in relation to charge 5a and 5b. Having determined that Colleague Y did not attend the consultation, but making representations to the NMC to state that Colleague Y did, the panel was of the view, applying what it understands the *'standards of ordinary, decent people'* to be, that these actions were dishonest.

Considering the law that dishonesty must be founded on solid ground, regrettably the panel was driven to conclude that this is the position here and that your conduct was dishonest by the standards of ordinary and decent people.

The panel therefore determined, whilst applying the standard of an ordinary member of the public, that your conduct was dishonest. The consequences of your actions were that the NMC initially closed the case against you. This representation was inaccurate and the panel determined it was fundamentally dishonest.

In light of the above, the panel finds charge 6 proved in its entirety.

Dishonesty lies on a spectrum. Without prejudice to the panel's determination of potential sanctions in this case. The panel noted that the dishonesty in the context of this case does not lie at the higher end of the scale.

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 your 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 ability to practise kindly, safely and professionally.

Submissions on misconduct

Mr Edwards invited the panel to take the view that the facts found proved amount to misconduct. He identified the relevant standards where your actions breached sections

of ‘The Code: Professional standards of practice and behaviour for nurses and midwives (2015’ (the Code) and amounted to misconduct, specifically sections 1.2, 3.3, 6.1, 8.5, 8.6, 10.1, 10.2, 10.3, 18.1, 20.1, 20.2, 20.8 and 23.1.

Mr Edwards submitted that the facts found proved are so wide-ranging and serious, particularly the charges which relate to dishonesty, that a finding of misconduct must be made. He added that members of the public expect nurses to act with honesty and integrity at all times which you failed to do in addition to failing to carry out basic nursing duties in relation to Client A and knowingly misleading the NMC. He submitted that your actions fell well below the standards expected of a registered nurse and other members of the nursing profession would find your actions deplorable.

Mr Pataky stated that you acknowledged the findings made by the panel to be serious. He submitted that, given the seriousness of the findings made, you accept that those findings amounts to misconduct.

However, Mr Pataky also submitted that the facts found proved arose from a single incident and there was no evidence to suggest any patient harm. In relation to the dishonesty, he highlighted that is it limited to two emails which the panel concluded in its findings were not at the higher end of the scale in terms of seriousness.

Submissions on impairment

Mr Edwards 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Edwards submitted that all four limbs of the *Grant* test are engaged in this case. In relation to the factors set out in *Cohen*, he said that, whilst some of your conduct found

proved is easily remediable, your dishonesty is not as easy to remediate. He submitted that you have shown some level of insight and understanding into your failings, but that it is not sufficient enough for the panel to consider there to be no risk of repetition so as to not make a finding of current impairment. He added that you have not fully remedied your failings and that, despite your positive testimonials, this is a serious case as it was found that you acted dishonestly with the intention to mislead the NMC in its investigation into your fitness to practise.

Mr Edwards further submitted that the findings in your case are so serious that to not make a finding of impairment would undermine public confidence in the NMC as a regulator and the nursing profession as a whole.

As such, Mr Edwards invited the panel to find that your fitness to practise is currently impaired on public protection and wider public interest grounds.

Mr Pataky reminded the panel that the issues arose during the course of your work in the area of aesthetics which you have long since given up and have no desire to return.

Mr Pataky drew the panel's attention to a number of positive testimonials provided by your senior staff and colleagues, including your current line manager which was completed on 26 April 2024 in the full knowledge of the findings of the panel at the facts stage of the NMC proceedings in December 2023. He also referred the panel your training records and the record of your engagement with counselling services.

Mr Pataky said that you accept that the panel's findings, due to their seriousness, are likely to have an impact on public confidence in the nursing profession and its reputation. He invited the panel to conclude that such acceptance on your part is highly material to its assessment of current impairment.

Mr Pataky then set out six further points for the panel to consider when assessing whether or not your fitness to practise is currently impaired:

1. [PRIVATE]. You accept that, [PRIVATE], you probably ought not to have gone to

the appointment but you stated that you "*did not want to let anyone down*".

2. Witness 1 told the panel that the Botox was administered in an appropriate dose for the indications proposed. They also said, even if the panel were to conclude that the correct prescription process was not followed, that no serious harm could have come to Client A.

3. The case of *Amao v Nursing and Midwifery Council* [2014] EWHC 147 Admin, paragraph 156 states:

   '*The feature of impairment which, to my mind, was never properly addressed in evidence and submissions, concerned the distinction between a failure to have insight into the misconduct which had occurred and a failure to have insight into the need in future…*'

   Over the five-year period since the allegations arose, no concerns about your practice have arisen. He added that the panel only has positive testimonials as to your professionalism, integrity and probity, thus it is clear through the absence of any further concern that you have substantial insight.

4. You have engaged with these NMC proceedings throughout.

5. The facts found proved arose from a single episode with a single client as such it was a single incident in a previously unblemished career.

6. In your professional life, both before and following the incident, you have been a highly valued clinician.

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

The panel, in reaching its decision, 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 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, your fitness to practise is currently impaired as a result of that 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.'*. The panel also referred itself to the NMC guidance entitled 'Misconduct' referenced at FTP-2a, last updated on 27 February 2024.

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. The panel determined that your actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services.'

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues.

13 Recognise and work within the limits of your competence

To achieve this, you must:

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

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times…

23 Cooperate with all investigations and audits'

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

Charges 1gi, 1giii and 4a

The panel determined that, whilst your actions described in the charge constituted poor practice, your behaviour was not such so as to meet the threshold of serious professional misconduct.

Charge 1a

The panel determined that you knew you needed to have a Nurse Prescriber to assess Client A's suitability for treatment and, having failed to do so, this could have posed a risk to Client A. The panel determined that your actions breached the fundamental nursing tenets of preserving safety and promoting professionalism and trust.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

Charge 1b

The panel was mindful that Botulinum toxin A is a prescription-only medication, and you administered a spare vial you had to Client A. There was no prescription, and you were not qualified to administer prescription-only medication without a Nurse Prescriber assessing the client beforehand. The panel determined that you breached the fundamental nursing tenets of preserving safety and practising effectively.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

Charge 1c

The panel bore in mind that prescriptions are person specific. It determined that you put Client A at risk by administering medication prescribed for someone else, and a registered nurse would have known this was an unacceptable practice. The panel determined that you breached the fundamental nursing tenets of practising effectively and preserving safety.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

Charge 1d

You administered prescription-only medication when you had not been directed by a qualified Nurse Prescriber as to the specific dosage or range for Client A. The panel determined that a registered nurse would have known this was both unacceptable and unsafe practice. The panel determined that you breached the fundamental nursing tenets of practising effectively and preserving safety.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

Charge 1gii

Botulinum toxin A is a prescription-only medication which needs to be prescribed by a Nurse Prescriber who is qualified to do so, and it is basic nursing practice that this should be appropriately documented. In your failure to do this, the panel determined that you breached the fundamental nursing tenets of practising effectively and preserving safety.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

Charges 5a and 5b

You provided inaccurate and misleading information to your regulator, the NMC. The panel considered it to be not only incumbent on you but any registered nurse would know that they need to be to be transparent with their regulator. The panel determined that you breached the fundamental nursing tenet of promoting professionalism and trust.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

Charges 6a and 6b

Honesty is of central importance to a nurse's practice, and your failure to uphold this fundamental standard constituted serious professional misconduct. The panel determined that you breached the fundamental nursing tenet of promoting professionalism and trust.

As such, the panel found that your actions fell significantly short of the standards expected of a registered nurse and amounted to serious professional misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC guidance entitled 'Impairment' referenced at DMA-1, last updated on 27 February 2024, which states:

> *'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?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not 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 *Grant* in reaching its decision. In paragraph 74, she said:

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered the above test and was satisfied that all four limbs were engaged.

The panel found that Client A had become distressed as a result of your actions. Your actions have breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Further, the panel found that you had acted dishonestly.

Regarding insight, the panel considered your reflection and determined that you have demonstrated an understanding of how your actions put Client A at a risk of harm, and an understanding of why what you did was wrong and would be handled differently in the future.

The panel took into account the additional training you have undertaken and the numerous positive testimonials you provided.

The panel considered that you have been working without sanction in a different area of nursing since 2019 without further concerns being raised. [PRIVATE]. It also acknowledged that you stated that you had developed strategies to deal with such circumstances in future. On the evidence provided, the panel was satisfied that you are not liable to repeat such failures in future. The panel therefore decided that a finding of impairment is not necessary on the grounds of public protection.

However, given the nature of the panel's findings and the seriousness of the facts found proved, the panel determined that a finding of impairment on public interest grounds is required to maintain public confidence in the nursing professions and the NMC as a regulator, and to declare and uphold the proper professional standards for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel considered this case very carefully and decided to make a suspension order for a period of one month. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Submissions on sanction

Mr Edwards referenced SG SAN-2: 'Considering sanctions for serious cases', last updated on 27 February 2024.

Mr Edwards submitted that it is clear from the SG that the dishonesty in this case, is at the most serious end of the spectrum, namely deliberately breaching the professional duty of candour by covering up when things have gone wrong. Specifically, in this case, misleading or lying to the NMC when information was requested.

Mr Edwards stated that Mr Pataky will contend that your dishonesty was a one-off incident, however, he highlighted that there were two separate incidents of dishonest actions on 15 and 24 May 2019. He said that you had 9 days to correct the record and you did not, therefore, your actions can only be described as calculated and purposeful.

Mr Edwards submitted that the aggravating features in this case are as follows:

- A lack of insight into your failings
- Your attempts to cover up your failings and/or dishonest conduct to the NMC
- The potential risk of emotional harm to Client A

Mr Edwards submitted that the mitigating features in this case are as follows:

- [PRIVATE]
- The numerous testimonials supporting your good practice
- That you practised after the incident without further issue

[PRIVATE].

.

Mr Edwards submitted that the regulatory concerns in your case raise fundamental questions about your professionalism, that public confidence in nurses could not be maintained if you were not removed from the register, and that a striking-off order is the only sanction which would be sufficient to maintain professional standards given the serious nature of this case and the level of dishonesty.

Mr Edwards therefore submitted that the only proportionate and necessary sanction for the panel to impose is a striking-off order.

Mr Pataky reminded the panel of its finding that you are not liable to repeat such failures in the future. He reiterated that the charges related to an isolated incident in 2019, and that the panel must consider the extent to which public confidence would be undermined where a nurse has demonstrated good practice over a sustained period since then. He also added that these events relate to a time when you were engaging in aesthetic practice which is an area of practice you have long since put behind you, and you are now a senior practitioner with substantial clinical responsibilities within the Trust you work for.

Mr Pataky invited the panel to consider [PRIVATE] and your acceptance of the seriousness of the panel's findings. He further submitted that the dishonesty in this case was not at the higher end of seriousness. In light of this, he invited the panel to consider the imposition of a caution order.

Mr Pataky stated that, if the panel were to conclude that a lesser sanction is not appropriate in this case, then the imposition of a suspension order for a period of three months would be more than sufficient to uphold public confidence and standards within the nursing profession. He added that a striking-off order would be wholly disproportionate in this case.

Mr Pataky invited that panel to conclude that the appropriate sanction is one of a lengthy caution order representing a significant marker that would uphold the public interest whilst enabling a highly skilled and committed nurse to return to practise.

The panel accepted the advice of the legal assessor which included dishonesty lying on a spectrum. The panel also referred itself to NMC guidance SAN-2: 'Considering sanctions for serious cases', particularly the section on 'Cases involving dishonesty'. The panel took into account that '*allegations of dishonesty will always be serious…However… the Fitness to Practise Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious*.'. The examples of serious dishonesty provided in the guidance include:

> '*misuse of power*
> *vulnerable victims*
> *personal financial gain from a breach of trust*
> *direct risk to people receiving care*
> *premeditated, systematic or longstanding deception*'

The panel determined that none of the above apply in your case.

Decision and reasons on sanction

Having found your 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:

- You misled your regulator
- You colluded with Colleague Y to mislead your regulator

- Deliberately breached duty of candour by covering up when things went wrong

The panel also took into account the following mitigating features:

- Numerous testimonials of good practise
- You have practised for five years without further issue
- [PRIVATE]

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, an order that does not restrict your 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 your 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be relevant, 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;*
- *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 determined that there are no practical or workable conditions that could be formulated, given the panel's findings at the facts stage. The misconduct identified in this case was not something that can be addressed through retraining as your actions did not relate to your clinical practice.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and meet the public interest.

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

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

The panel was satisfied that in this case, the misconduct found 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 all the information before it, and of the mitigation provided, the panel concluded that it would be wholly disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

The panel considered your actions to constitute a single incident of misconduct arising out of one treatment episode. Although your dishonesty is an attitudinal issue, the panel determined that your actions were out of character and not deep-seated. The panel found that you are not liable to repeat such behaviour in future, and there is no evidence your behaviour has been repeated since 2019.

The panel particularly took into account the statement dated 26 April 2024 from your current line manager who had full knowledge of the charges found proved. They stated:

> '[She is] *a highly skilled, competent and able nurse…'* and '*the only Drug and Alcohol Specialist Nurse working within [PRIVATE] Trust…should she not be at work in her current role/capacity, this may be detrimental to the development of the service and ultimately patient care…Miss Bartle is a diligent nurse who works without direct supervision…Miss Bartle is a bright and valued nurse who has moved forward the care of some of the most marginalised groups within our society…Miss Bartle is, in my experience, an honest and trustworthy individual…her integrity is commendable, and I would employ her in any of our services. I have no concerns in relation to* [her] *skills, competence or honesty.'*.

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

The panel noted the hardship such an order will inevitably cause you. 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 nursing profession and the NMC as a regulator, 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 one month was appropriate in this case to mark the seriousness of the misconduct whilst also allowing a valuable nurse to return to practice.

Having found that your fitness to practise is currently impaired, the panel bore in mind that it determined there were no public protection concerns arising from its decision. In this respect it found your fitness to practise impaired on the grounds of public interest.

In accordance with Article 29 (8A) of the Order, the panel may exercise its discretionary power and determine that a review of the substantive order is not necessary.

The panel was mindful that it made the substantive order having found your fitness to practise currently impaired in the public interest. It was satisfied that the substantive order will satisfy the public interest in this case and will maintain public confidence in the profession(s) as well as the NMC as the regulator. Further, the substantive order will declare and uphold proper professional standards. Accordingly, the current substantive order will expire, without review.

This will be confirmed to you in writing.

Interim order

As a suspension order cannot take effect until the end of the 28-day appeal period, the panel 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 your own interests until the suspension sanction takes effect.

Submissions on interim order

The panel considered the submissions made by Mr Edwards that an interim suspension order should be made to cover the appeal period. He submitted that an interim order is necessary to protect the public and meet the public interest. He invited the panel to impose an interim suspension order for a period of 18 months to cover any appeal period.

Mr Pataky opposed Mr Edwards application for the panel to impose an interim order. He asked the panel to be mindful that, although Mr Edwards made his application on both public protection and public interest grounds, it concluded that this is not a case for which patient safety is at risk and it found current impairment on public interest grounds alone.

Mr Pataky invited the panel to conclude whether an immediate suspension is required to maintain the public interest, and be submitted that the public interest would not be undermined in the absence of an interim suspension order as a fair-minded member of the public, with an understanding of the facts in this case, would not be offended to learn that an interim order was not made in a case where the events date back to five years ago, the register has been able to practise in the meantime without restriction, and where the NMC made an application six months ago for an interim suspension order and it was rejected by the panel.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim suspension order is not necessary to protect the public and address the public interest. The panel had regard to the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It considered that to impose an interim suspension order would be inconsistent with its earlier findings.

In light of reasons given by the panel, and considering the submissions made by Mr Edwards and Mr Pataky, the panel determined it was not appropriate in the circumstances to impose an interim order.

That concludes this determination.