Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday, 7 March 2024 - Monday, 11 March 2024

Virtual Meeting

Name of Registrant:	**Christine Helen Duncan Watson**
NMC PIN:	89B0352S
Part(s) of the register:	Registered Nurse- Sub Part 1 RN3: Mental Health Nurse, Level 1 (28 March 1992)
Relevant Location:	Aberdeen
Type of case:	Misconduct
Panel members:	Lucy Watson (Chair, Registrant member) Sandra Lamb (Registrant member) Jayanti Durai (Lay member)
Legal Assessor:	John Bromley-Davenport KC
Hearings Coordinator:	Samantha Aguilar
Facts proved by way of admission:	Charges 1a, 2a, 2b, 2c, 2d, 2e, 2g, 3, 4a, 4b, 4c, 4d, 4e, 5a, 5c, 6a, 6b, 6c, 6d.
Facts found proved	Charges 2f, 2h
Facts not proved:	Charges 1b, 1c,1d, 2i, 2j, 5b
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Miss Watson's up-to-date email address by secure email on 30 January 2024. The panel has also seen the Royal Mail '*Track and trace'* printout which showed the Notice of Meeting was delivered to Miss Watson's registered address on 31 January 2024. It was signed for against the printed name of *'C Watson'*.

The panel also had regard to the exchange between Miss Watson and the Nursing and Midwifery Council (NMC) on 31 January 2024, in which she confirmed that she had received the bundle and informed the NMC that her email address has since changed.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date and the fact that this meeting was heard virtually.

In light of all of the information available, the panel was satisfied that Miss Watson has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Panel's decision to amend charge 5b

During the course of the panel's discussion regarding the charges alleged, the panel considered changing the date contained within charge 5b due to a typographical error. It heard and accepted the advice of the legal assessor and was reminded that any amendment to the charges must be in the interest of justice and no prejudice or injustice caused to Miss Watson. The proposed amendment is as follows:

"5) Your actions at charge 4(a), 4(b), 4(c), 4(d) and 4(e) were dishonest as you knew;
   a) […]
   b) That you had not spoken to NHS24 on 29 ~~July~~ **June** 2018;

c) […]”

The panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Watson and no injustice would be caused by the proposed amendment being allowed. It was therefore appropriate to make the amendment to correct the typographical error contained in charge 5b.

Details of charges (as amended)

That you, a registered mental health nurse:

1) Between 13 November 2017 and 29 June 2018:
    a) On an unknown date provided Ms 1 and/or Patient A with your personal mobile telephone number without clinical justification. ***[PROVED BY WAY OF ADMISSION]***
    b) On dates unknown on one or more occasions contacted Patient A by telephone and/or text message without clinical justification. ***[NOT PROVED]***
    c) On dates unknown on one or more occasions contacted Patient A out with your working hours without clinical justification. ***[NOT PROVED]***
    d) On dates unknown on one or more occasions visited Patient A at her home address without clinical justification. ***[NOT PROVED]***

2) Between 29 June 2018 and 30 June 2018 in respect of Patient A:
    a) Remained with them from around 3pm on 29 June 2018 until around 12 noon on 30 June 2018 when there was no clinical need. ***[PROVED BY WAY OF ADMISSION]***
    b) Did not inform your team and/or anyone from [PRIVATE] that you were with them out with your working hours and/or of the circumstances. ***[PROVED BY WAY OF ADMISSION]***
    c) Delayed seeking support from NHS 24. ***[PROVED BY WAY OF ADMISSION]***
    d) Failed to escalate concerns by contacting the police and/or Cornhill Hospital. ***[PROVED BY WAY OF ADMISSION]***
    e) Failed to contact a manager. ***[PROVED BY WAY OF ADMISSION]***

f) Failed to complete an incident record and/or DATIX form. ***[FOUND PROVED]***

g) Failed to complete an up-to-date risk and wellness plan. ***[PROVED BY WAY OF ADMISSION]***

h) Allowed them to lay their head on your lap. ***[FOUND PROVED]***

i) Consumed alcohol. ***[NOT PROVED]***

j) Failed to complete detailed patient notes. ***[NOT PROVED]***

3) Between 29 June 2018 and 2 July 2018 did not to notify Colleague A, your team leader/manager, of the incident at charge 2(a). ***[PROVED BY WAY OF ADMISSION]***

4) On 25 July 2018 stated that;

a) NHS24 had been telephoned by Ms1 around 10pm on 29 June 2018. ***[PROVED BY WAY OF ADMISSION]***

b) "[Ms1] phoned NHS24, it took ages for her to get through" or words to that effect. ***[PROVED BY WAY OF ADMISSION]***

c) "[Ms 1] said they wanted to speak with me, I was on the phone and they said they can't get anyone out to her for 2 hours so I said that's fine" or words to that effect. ***[PROVED BY WAY OF ADMISSION]***

d) "They phoned back two hours later and I said the patient was sleeping, I told them she was sleeping and hopefully everything was okay.." or words to that effect. ***[PROVED BY WAY OF ADMISSION]***

e) "I said to [Ms 1] this is not settling so [Ms1] phoned NHS24 again and they said they would send someone out" or words to that effect. ***[PROVED BY WAY OF ADMISSION]***

5) Your actions at charge 4(a), 4(b), 4(c), 4(d) and 4(e) were dishonest as you knew;

a) That NHS 24 had not been contacted at around 10pm; ***[PROVED BY WAY OF ADMISSION]***

b) That you had not spoken to NHS24 on 29 June 2018; ***[NOT PROVED]***

c) That you had not spoken to NHS 24 on more than one occasion. ***[PROVED BY WAY OF ADMISSION]***

6) On 25 April 2021 when Patient A contacted you by telephone [PRIVATE];
    a) Failed to contact emergency services to carry out an urgent welfare check. ***[PROVED BY WAY OF ADMISSION]***
    b) Failed to contact any of the professional's involved in their care*.* ***[PROVED BY WAY OF ADMISSION]***
    c) Failed to contact out-of-hours. ***[PROVED BY WAY OF ADMISSION]***
    d) Attended at and entered the home address of Patient A when you had no clinical justification to do so. ***[PROVED BY WAY OF ADMISSION]***

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

Background

Miss Watson has been a Registered Nurse since 28 March 1992, specialising in Mental Health Nursing. On 15 October 2021, the NMC received a referral from NHS Grampian raising concerns about Miss Watson's practice.

At the time of the concerns, Miss Watson was working for NHS Grampian as a Mental Health Nurse. She began working for NHS Grampian in April 1992 as a Community Mental Health Nurse and continued in that role until July 2018 when she was re-deployed to work as a Band 5 Mental Health Nurse on the inpatient ward at Royal Cornhill Hospital (the Hospital).

Between 13 November 2017 and 29 June 2018, it was alleged that Miss Watson provided Patient A and/or [PRIVATE] (Ms 1) with her personal mobile phone number. During this period, it was alleged that Miss Watson contacted Patient A by telephone and or text message. It was also alleged that Miss Watson contacted Patient A outside of her working hours and visited Patient A at their home address without clinical justification.

On 29 June 2018, Miss Watson received a telephone call from [PRIVATE]. Miss Watson allegedly visited Patient A at their home address before accompanying them to [PRIVATE]. Miss Watson allegedly stayed with Patient A from 29 June 2018 to 30 June 2018, leaving around midday on 30 June 2018. During this time, Miss Watson allegedly

did not inform her team or anyone from [PRIVATE]. During this time, Miss Watson also allegedly allowed Patient A to lay their head on Miss Watson's lap and consumed alcohol which had been offered to her [PRIVATE]. About 00:44 hours on 30 June 2018 [PRIVATE] contacted NHS24 and Miss Watson spoke to the call handler. Following the call to NHS24 a General Practitioner (GP) attended around 03:00 hours to assess Patient A.

Following the incident, it was alleged that Miss Watson did not complete an incident report, [PRIVATE], and did not complete detailed patients notes.

On 3 July 2018, Miss Watson informed her Team Leader (Colleague A) regarding the incident involving Patient A that took place between 29 and 30 June 2018.
NHS Grampian commenced a local investigation into the incident and Miss Watson attended a meeting on 25 July 2018. During this meeting Miss Watson alleged that [PRIVATE] had contacted NHS24 on two occasions. Miss Watson alleged the first call was on 29 June 2018 around 21:30 to 22:00 hours and that she had spoken to the NHS24 call handler at that time.

On 8 January 2019, during a subsequent meeting during NHS Grampian's local investigation, Miss Watson confirmed that a call had been made to NHS24 around 21:30 to 22:00 hours on 29 June 2018. When Miss Watson was confronted with evidence that there was no record of an earlier call to NHS24, she attempted an explanation that there was confusion [PRIVATE] before stating that she *'assumed'* [Ms 1] had called. Miss Watson then conceded that '*it was possible it didn't happen'*.

Miss Watson was interviewed a third time as part of NHS Grampian's local investigation on 23 April 2019. During this interview, Miss Watson was asked about the call around 21:30 to 22:00 hours on 29 June 2018 to NHS24, specifically whether she had instructed [MS 1] to end the call. [PRIVATE].

On 29 October 2019, NHS Grampian issued a first and final warning to Miss Watson regarding the incident with conditions on her practice, which was to be held on file for two years.

On 25 April 2021, Patient A contacted Miss Watson on her personal mobile phone [PRIVATE]. Miss Watson had not been responsible for Patient A's care since July 2018 so was unaware of their current care needs. Miss Watson allegedly did not contact emergency services, [PRIVATE] or any professionals involved in Patient A's care. Miss Watson attended Patient A's home address without any clinical justification to do so.

On 27 September 2021, Miss Watson retired from nursing.

Decision and reasons on facts

At the outset of the meeting, the panel noted the written representations from Miss Watson, which stated that Miss Watson has made full admissions to charges 1a, 2a, 2b, 2c, 2d, 2e, 2g, 3, 4a, 4b, 4c, 4d, 4e, 5a, 5c, 6a, 6b, 6c and 6d.

The panel therefore finds charges 1a, 2a, 2b, 2c, 2d, 2e, 2g, 3, 4a, 4b, 4c, 4d, 4e, 5a, 5c, 6a, 6b, 6c and 6d proved by way of Miss Watson's admissions.

The panel acknowledged that Miss Watson, in her Case Management form dated 17 February 2024, has made admissions to charge 1c. She specified on her Case Management form that she made this admission only in relation to the date of 25 April 2021 and only in response to answering Patient A's call. As this fall outside the dates in the charge, the panel considered charge 1c as a disputed fact.

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and from Miss Watson.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Ms 1: [PRIVATE];
- Colleague A: Miss Watson's Team leader/manager at the time of the incidents;
- Colleague B: [PRIVATE];
- Colleague C: [PRIVATE].

The panel also had regard to the On Table Documents provided by Miss Watson.

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

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

Charge 1b)

1) Between 13 November 2017 and 29 June 2018:
   b) On dates unknown on one or more occasions contacted Patient A by telephone and/or text message without clinical justification.

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 1's witness statement dated 17 June 2022:

> *'After Nurse Watson became involved with Patient A, they provided Patient A with their personal mobile number, although I cannot remember when, and they would be calling and texting each other all the time in a friendly way rather than in relation to [PRIVATE]. Patient A told me about this, they said*

that Nurse Watson had given them their mobile number to contact her out of hours and that they would be messaging in the evenings. […]*'*

The panel also had regard to the Investigation Notes from the interview on 8 January 2019 in which Colleague A stated that there were, *'12 contacts between 25-29/6/18'.* [PRIVATE].

The panel determined that based on the evidence before it, it had seen no evidence to confirm the content of those phone and text messages to determine whether or not those were made with clinical justification. With the panel only having sight of the investigative meeting notes by NHS Grampian and one account from Ms 1 and no copy of the said text messages, log of telephone conversations or evidence that such communication was from Miss Watson's personal telephone number or a work telephone number, on the balance of probabilities, the panel does not find this charge proved.

Charge 1c)

1) Between 13 November 2017 and 29 June 2018:
   c) On dates unknown on one or more occasions contacted Patient A out with your working hours without clinical justification.

This charge is found NOT proved.

The panel considered Ms 1's witness statement dated 17 June 2022, in which she stated:

'[…] *Nurse Watson was very helpful and would go and collect* [PRIVATE] *I am not sure if they were supposed to do this, but it appeared that over time Nurse Watson was in Patient A's flat a lot of the time during the week. Every time I was at the flat, Nurse Watson was there and would be laughing and joking with Patient A. Nurse Watson used to spend quite a long time at Patient A's flat, sometimes a morning or afternoon, sometimes what seemed like a whole day, but it seemed like much more than I would have expected.* [...]*'*

The panel noted that Miss Watson disputed this in her written submission on 19 February 2024:

> ‘ […] *Prior to the incident on the 29th of June 2018,* [PRIVATE] *would regularly ask me to be present at* [PRIVATE] *I never attended any of these events, I always declined the invitation and I advised my manager, Consultant Psychiatrist and clinical supervisor.*
>
> […]
>
> *It is untrue that I spent whole days at the patients home, i had a caseload of at least 40 patients, i* [sic] *completed data sheet’s every week recording my visits and my manager had a copy of my diary so as* [Community Psychiatric Nurse] *CPNs we were monitored on progress and service.’*

The panel found no evidence of contact or care records indicating that Miss Watson contacted Patient A outside of working hours, or evidence of any text messages or calls. The panel determined that there is insufficient evidence to find this charge proved.

Charge 1d)

1) Between 13 November 2017 and 29 June 2018:
   d) On dates unknown on one or more occasions visited Patient A at her home address without clinical justification.

This charge is found NOT proved.

The panel took the view that the evidence considered for this charge is similar to that for charge 1c. It considered the above evidence from Ms 1 and Miss Watson’s written submission dated 19 February 2024:

> ‘[…] [Ms 1] *mentioned on occasions I visited this patient on a daily basis, the reason for this was* [Ms 1] *would regularly telephone my Consultant*

Psychiatrist, GP or myself and make demands [Patient A] was visited as she had concerns [PRIVATE]*.'*

The panel determined that this charge is not proved, as there is insufficient evidence to suggest that Miss Watson visited Patient A's home without clinical justification between 13 November 2017 and 29 June 2018.

Charge 2f)

2) Between 29 June 2018 and 30 June 2018 in respect of Patient A:
   f) Failed to complete an incident record and/or DATIX form.

This charge is found proved.

The panel had regard to Colleague A's witness statement dated 27 June 2022:

'There was an obvious lack of up to date [PRIVATE] plans for this patient. *Nurse Watson also did not complete an incident record or complete a DATIX form about this incident.*

[…]

Nurse Watson also should have followed the incident process and completed a DATIX form about what had happened. If Nurse Watson had done this, we could have look at retrospectively managing the incident to see what better practice could be put in place but Nurse Watson did not do this.'

The panel also had regard to Miss Watson's undated written response (sent alongside her Case Management Form dated 17 February 2024) in relation to this charge in which she stated, *'I am certain I completed a Datix form'.*

In light of the documentary evidence before the panel, it determined that Colleague A's account and investigatory notes are credible evidence that Miss Watson failed to complete an incident record and or DATIX form in line with NHS Grampian's practice. The

determined that if a DATIX had been completed Colleague A would have found a record of it with a reference number and included it in their review of the incident/investigation findings. Accordingly, the panel found this charge proved.

Charge 2h)

2) Between 29 June 2018 and 30 June 2018 in respect of Patient A:
h) Allowed them to lay their head on your lap

This charge is found proved.

The panel considered the account put forward by Miss Watson during the Investigation meeting on 8 January 2019.

> *'[…] [*Patient A*] sat beside me on the sofa, head on my shoulder and sitting, Patient A got up for a pillow and returned and put it on my knee and I suggested [they were] tall so suggested [they] sat on other sofa [PRIVATE] but no, [they] wanted to lay here. Patient A lay with [their] head on pillow on my lap'*

The panel determined that the evidence before it, and Miss Watson's admission, indicated that this incident did take place. Miss Watson recalled Patient A being sat next to her. Miss Watson stated in her undated response (sent alongside her Case Management Form dated 17 February 2024), *'The patient spontaneously hugged me, I have no recollection of them placing [their] head on my lap'.*

The panel noted the inconsistency between Miss Watson's response to this charge back when it was first investigated, and to her latest (albeit undated) response. Accordingly, by reference of what Miss Watson said in the initial investigation, which is the contemporaneous evidence, the panel found this charge proved.

Charge 2i)

2) Between 29 June 2018 and 30 June 2018 in respect of Patient A:

i) consumed alcohol.

This charge is found NOT proved.

The panel took into account Colleague A's statement dated 27 June 2022:

> *'*[…] *there was a question as to whether Nurse Watson had consumed some wine during this time. The initial question mark over this was when the doctor had attended the home in the morning and had seen two glasses out, with only Nurse Watson and* [PRIVATE] *sitting. This information was volunteered by* [PRIVATE] *during their call when they mentioned that Nurse Watson had stayed for a meal with the* [PRIVATE]*. It was not clarified how much wine was consumed as* [PRIVATE] *did not want to say anymore through fear of getting Nurse Watson into trouble. Nurse Watson denied consuming any wine but did not deny having a meal.'*

The panel also had sight of the local investigation meeting notes, in which the GP from GMed Out of Hours Service was interviewed on 3 October 2018 and said:

> '*The first thing I noticed when I went In* [sic] *was the alcohol on the side stool, obviously I cannot be 100% sure. It could have been the patient and her mum. I did not know. I cannot be sure of this. So* [sic] *I cannot state this fact.'*

The panel also considered Miss Watson's written response dated 10 February 2024:

> *'I never consumed alcohol in the patients* [sic] *home or* [PRIVATE]*, the 2 glasses* […] *were that of* [PRIVATE]*'*

The panel was also mindful of Miss Watson's response on 19 February 2024:

> *'I categorically deny drinking alcohol at the* [PRIVATE] [sic] *home on the 29th of June.'*

The panel determined that there is insufficient evidence to establish who had been using the glass of alcohol. Miss Watson strongly denied that she drank the alcohol offered to her by Ms 1. Miss Watson was consistent throughout her written evidence in denying this charge. The only objective account came from the GP, who was unable to state with certainty who had been drinking alcohol and whether it was consumed by Miss Watson. Accordingly, this charge is found not proved.

Charge 2j)

2) Between 29 June 2018 and 30 June 2018 in respect of Patient A:
   j) failed to complete patient notes.

This charge is found NOT proved.

The panel noted that during the local investigation on 25 July 2018, Colleague A questioned Miss Watson in relation to her notes:

> *'*[Colleague A] *I've looked at the patient notes and your notes are quite good, your initial management plan and making reference to risk and safety and assessment; however one thing that was missing was the [PRIVATE] plan.* […]*'*

The panel also considered Colleague A's statement dated 22 June 2022, in which he stated:

> *'Nurse Watson had then come in to write notes on Saturday afternoon about the visit to Patient A. This was a concern as they had been up all night, gone home and then come back to work with no break* […]*'*

Miss Watson stated in her response during the local investigation held 23 April 2019 that she had returned to work on 30 June 2018 to document her notes after resting, and *'when it was still fresh'* in her mind. She also said, *'I always write notes, especially after a crisis. My notes are not shoddy in that respect'.*

The panel determined that there was evidence that Miss Watson came to the office after she left Patient A's home and after going home to rest. Miss Watson was consistent during the local investigation interview that she had attended the office specifically to update the record, and to accurately record the history of the event. Colleague A attested that Miss Watson's notes included a detailed summary of the incident although it did not include information regarding the subsequent care plan as a result of the incident on 29 June 2018. The panel found charge 2j, on the balance of probabilities, not proved.

Charge 5b)

5) Your actions at charge 4(a), 4(b), 4(c), 4(d) and 4(e) were dishonest as you knew;
j) That you had not spoken to NHS24 on 29 July 2018.

This charge is found NOT proved.

The panel had regard to Colleague A's witness statement dated 27 June 2022:

'[…] *regarding Nurse Watson saying that they had contacted NHS 24 on two occasions when in fact this had only been once, put into question the validity of their recall of events. Nurse Watson could not explain/ did not know why there were not two phone calls as they had originally said that they contacted NHS 24 twice. However later, Nurse Watson did say that they had asked* [Ms 1] *to contact NHS 24. Nurse Watson did not know why there had only been one call and why it was recorded significantly later than they had originally intimated. This is why we had to interview Nurse Watson on multiple occasions as their recall was not clear. This confirmed the risk for both her and Patient A at the time because if their recall was not clear it called in to question what else could have been missed or was not in the right order.*

[…]

In terms of calling NHS 24, I would have expected there to be reasons why Nurse Watson did not call NHS 24 as this was at the detriment to the patient.

However the amount of time that Nurse Watson had spent with the patient up until 17:00 would have suggested that a second opinion was needed. NHS 24 were not officially contacted until around midnight, when Nurse Watson had already been with the patient for a considerable amount of time. Nurse Watson also did not directly call NHS 24 and instead did this via [Ms 1] who handed Nurse Watson the phone.

I would have expected Nurse Watson to be honest about their interactions with NHS 24 but instead they could not give a reason why this was not done earlier. Only Nurse Watson knows the reason why this happened. There were times when Nurse Watson said they thought [Ms 1] *had called NHS 24 and had not called at times when they could have and done it themselves.'*

The panel also noted the Clinical Lead from [PRIVATE] response during the local investigation interview on 11 September 2018, in which she stated:

'[…] I *then asked to speak to CPN, I thought she's there so I'll use her professional opinion and again I just wasn't very comfortable with what I was being told. CPN said* [PRIVATE] *she was handling the situation and [PRIVATE] I heard* [Miss Watson] *hold the phone away saying to [Ms 1] "but I can stay, I can help, I can handle this" and then she came back and her story didn't correlate with [Ms 1].*

[…] *I thought for a few moments then called back and got [Ms 1] on the phone*[…]

I actually said "Maybe you can't speak freely at the moment", [Ms 1] said yes, […] [Clinical Lead from GMed Out of Hours Service] *said", I'm not comfortable with what is going on in the house & what the CPN has said", [Ms 1] saying yes*. […] *proposed was to send a doctor* [PRIVATE] *& take it from there* […]'

The panel noted that there were some ambiguities in Miss Watson's recollection of the events about not being clear as to when she contacted NHS24. The NHS24 log

showed that a call was made around midnight when Miss Watson was already with Patient A. In Miss Watson's account, she stated that she spoke to a doctor, which was supported by the information provided by the Clinical Lead [PRIVATE] during the local investigation. It is clear from the documentary evidence before the panel that Miss Watson did in fact speak to NHS 24, although she did not initiate the contact. Accordingly, the panel found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Watson's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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 NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Miss Watson's actions amounted to misconduct.

> *'20. The NMC considers the conduct in this case serious and that it amounts to serious misconduct. Miss Watson's actions, as set out in the charges, involve breaching professional boundaries with a [PRIVATE] patient over a significant period of time, which put the patient at serious risk of harm. Her actions continued even after receiving a final warning from her employer for the same behaviours towards the same patient. In failing to adhere to the standards of the Code, Miss Watson's actions amount to serious misconduct.*
>
> *21. By failing to inform members of her team and/or anyone from* [PRIVATE] *that she was with Patient A between 29 and 30 June 2018 and the circumstances which led to this Miss Watson breached her duty under paragraphs 8.1, 8.2, 8.3, 8.4, 8.5 and 8.6 of the Code by failing to work co-operatively with her colleagues. She also breached these paragraphs of the Code when, as detailed in charge 3, she delayed informing her team leader of the incident involving Patient A. Miss Watson failed to share information with her colleagues which would have assisted in identifying and reducing risk in relation to Patient A* [PRIVATE] *when receiving care. She did not escalate concerns regarding Patient A's health to colleagues in out of hours or emergency services, as detailed in charges 2 and 6, which would have been appropriate under the circumstances ensuring reduced risk and improved care for the patient. In both charges 2 and 6, Miss Watson's actions demonstrate that she failed to keep her colleagues informed in a timely manner that she had been involved in Patient A's care which could have led to a delay in Patient A not receiving the most appropriate care. Also, the length of time which Miss Watson was with Patient A for could have posed a risk to the patient's care and both their and Miss Watson safety due to her being the only health professional present and providing care for the patient*

for an extended period without a break or support, which could have led to Miss Watson making errors due to fatigue.

22. Miss Watson breached her duty under paragraphs 10.1 and 10.2 of the Code in relation to charges 2f, 2g […] *as she failed to ensure that Patient A's records were complete, accurate and up to date following the incident with Patient A between 29 and 30 June 2018. By failing to ensure that Patient A's records were updated appropriately Miss Watson put the patient at risk as other professionals involved in Patient A's care would not have all available information when making decisions about their care and treatment.*

23. In delaying in seeking support from NHS 24 and failing to escalate concerns to out of hours or emergency services, in relation to charges 2c, 2d, 2e and 6, Miss Watson failed under her duties specified in paragraphs 13.1 to 13.4 of the Code. She failed to take account of her own personal safety as well as Patient A's safety by not promptly seeking support from other professionals and did not make a timely referral to another practitioner as she delayed seeking support from NHS 24. […] *In relation to the most recent incident, detailed in charge 6, Miss Watson failed to escalate to colleagues who had knowledge of Patient A's current care which placed Patient A as risk of harm as Miss Watson's colleagues who were at that time directly involved in Patient's A care and treatment would be best placed to provide the most appropriate and beneficial care. Despite being under a final warning for a similar situation, Miss Watson failed to identify worsening signs* [PRIVATE] *and make a timely referral to other professionals to care for Patient A.*

24. Miss Watson has breached paragraph 15 of the Code in her actions, in relation to charges 2b, 2c, 2d, 2e and 6, by failing to notify other colleagues involved in Patient A's care, delaying seeking support from NHS 24 and failing to escalate concerns relating to Patient A's condition to out of hours or emergency services. She delayed in seeking emergency support and failed to escalate concerns which could have arranged emergency care for Patient A. In failing to notify other colleagues or management that she was with Patient A, as detailed in the same charges, she failed to take account of her

own safety and the safety of others and did not consider other options for providing care to Patient A.

25. In relation to charge 6, as Miss Watson had not been involved in Patient A's care since July 2018, she would not have had up to date information regarding the patient's health and care and therefore breached paragraph 15.1 of the Code as she acted out with the limits of her knowledge potentially putting Patient A at risk of harm.

[…]

27. Miss Watson has breached paragraph 20.1 of the Code in that her actions, as detailed in all the charges, demonstrate that she failed to uphold and keep the standards and values set out in the Code.

28. In relation to charges 4 and 5, Miss Watson has breached her duty under paragraph 20.2 of the Code by failing to act with honesty and integrity when being interviewed during NHS Grampian's local investigation. In stating that NHS 24 had been contacted around 2200 hours on 29 June 2018, that she had spoken to the call handler at this time and that she had spoken to staff from NHS 24 on more than one occasion, Miss Watson was dishonest as she knew that no call had been made around that time, that she had not spoken to NHS 24 on that date or on more than one occasion during the incident with Patient A.

29. Miss Watson breached her duty under paragraph 20.6 of the Code as she repeatedly failed to maintain appropriate professional boundaries with Patient A [PRIVATE]. *In relation to charge 1, Miss Watson failed to maintain professional boundaries by providing Patient A* [PRIVATE] *with her personal mobile phone number when there was no clinical justification for doing so. Also, in contacting Patient A out with working hours and without clinical justification Miss Watson demonstrated over a significant period of time that she failed to stay objective and have clear professional boundaries with Patient A as required by the Code. In relation to charge 2a Miss Watson*

again failed in her duty under paragraph 20.6 of the Code as she remained with Patient A for a prolonged period of time when there was no clinical need to do so. During the time she remained with Patient A, Miss Watson continued to fail in her duty under paragraph 20.6 of the Code as demonstrated by charge 2h when she allowed Patient A to lay their head on her lap […]*. In relation to charge 6d Miss Watson has demonstrated again that she failed to maintain her duty under the Code in maintain professional boundaries as she visited Patient A in their home when she had no clinical justification to do so, despite no longer being responsible for the patient's care and still being under a final warning by her employer for similar behaviour towards the same patient.*

30. Miss Watson's actions have breached fundamental tenets of the profession, namely: practise effectively, preserve safety and promote professionalism and trust.

31. The concerns raised are serious and fall far below the standards of a registered professional. Miss Watson's actions have breached the above provisions of the Code and have fallen far short of the standards expected of a Registered Nurse and as such they amount to serious misconduct.'

On 19 February 2024, Miss Watson responded:

'I take full responsibility for my actions on June 29th 2018, April 25th 2021 and any other possible dates whereby I contacted [PRIVATE] *patient outwith* [sic] *working times to discuss clinical issues. I am fully aware that my actions broke the nursing code of conduct, professional guidelines and boundaries and I am fully aware of the consequences of my actions and I can only apologise for my behaviour.'*

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

The NMC invited the panel to find Miss Watson's fitness to practise impaired.

*'**Impairment***

[…]

38. Miss Watson's actions placed patients at unwarranted risk of harm when she failed to maintain clear professional boundaries with Patient A [PRIVATE] *and stay objective in the way in which she interacted with Patient A. By providing Patient A with her personal mobile phone number, contacting and visiting Patient A without clinical justification, including out with her working hours, Miss Watson placed Patient A at risk as it created an unrealistic expectation of what support services could be provided for their care. It also could have led to Patient A becoming dependent on Miss Watson to the exclusion of other professionals and support which could have negatively impacted their* [PRIVATE] *care and treatment. An indication of Patient A becoming dependent on Miss Watson is illustrated that on 12 May 2023, a member of staff who was checking and updating an electronic patient data system discovered that Miss Watson was entered as* [PRIVATE]. *This could indicate that Patient A was dependent on Miss Watson and viewed her as a personal friend or family member rather than a medical professional. The member of staff who noticed this entry asked Patient A about the entry and Patient A requested that* [PRIVATE] *be updated to a friend. The reason Patient A provided for this change to the staff member is that they knew Miss Watson "would get in trouble"* [PRIVATE]*.*

39. Ms Watson's actions between 29 and 30 June 2018 in relation to the incident involving Patient A placed the patient at unwarranted risk of harm. In remaining with Patient A, during this time when there was no clinical need, Miss Watson again failed to maintain clear professional boundaries and stay objective which could have negatively impacted on Patient A's willingness to accept care from other professionals. She placed Patient A at risk of harm when she failed to contact any colleagues from [PRIVATE]*, any staff from out*

of hours or emergency services or management to inform them of the situation as this meant that she did not have any support and Patient A may have not received the most appropriate care. When Miss Watson delayed seeking support from NHS 24, she placed Patient A at risk by them not receiving timely and appropriate care, which could have impacted their [PRIVATE] *and treatment.*

40. In failing to complete a record of the incident, an up-to-date risk and wellness plan and detailed patient notes, Miss Watson placed Patient A at risk of harm as without access to current and accurate records other professionals involved in Patient A's care might not have the required information to make appropriate decisions in relation to their treatment [PRIVATE]*. In failing to maintain clear professional boundaries when Miss Watson allowed Patient A to place their head in her lap, she placed the patient at risk as this was likely to lead to the blurring of differences between the roles of professionals* [PRIVATE]*. Miss Watson put Patient A at risk when she consumed alcohol while she was in their presence as this could have affected her ability to provide appropriate and adequate care.*

41. In failing to inform her team leader regarding the incident on 29 and 30 July 2018 until 2 July 2018 Miss Watson placed Patient A at unwarranted risk of harm in that management within NHS Grampian were not aware of a situation which may have required change in the oversight and management of the patient's care as a result of the incident and any ongoing impact on the patient's mental health.

42. On 25 April 2021, when Miss Watson attended Patient A and failed to contact any other professional or service, she placed the patient at unwarranted risk of harm. If Miss Watson had contacted emergency services as soon as Patient A contacted her [PRIVATE]*, instead she chose to attend the patient's home herself. This delayed care being provided to Patient A and placed them at risk as during this delay* [PRIVATE]*. Miss Watson had not been actively involved in Patient A's care since July 2018 and therefore would not be aware of their current care needs or any changes in their health*

and associated treatment. Patient A was put at unwarranted risk when Miss Watson did not contact any professional who was involved in the patient's care or any appropriate out of hours service. There was a potential for harm to be caused to Patient A under these circumstances as Miss Watson may not have been aware of any changes to their health and treatment, resulting in her making inappropriate choices regarding the patient's care based on her outdated information. In attending Patient A's home address without clinical justification Miss Watson placed the patient at unwarranted risk of harm as again this was failing to maintain appropriate professional boundaries which could have the impact of Patient A becoming dependent on her and failing to seek support from other professionals who were currently involved in their care.

43. Miss Watson has brought the profession into disrepute as her conduct includes multiple instances of failing to maintain professional boundaries with a vulnerable patient. The public expect nurses to behave in a professional manner and by failing to remain objective when caring for a patient and involve other professionals, who may be better suited to care for and act in the patient's best interests, Miss Watson's actions clearly breached the expected standards of a registered professional. This therefore has a negative impact on the reputation of the profession and, accordingly has brought the profession into disrepute.

44. The failures resulting from Miss Watson's actions have breached fundamental tenets of the nursing profession, namely practise effectively, preserve safety, and promote professionalism and trust. She failed to maintain professional boundaries with a vulnerable patient and repeated this behaviour following a first and final warning from her employer. Miss Watson's actions impacted on Patient A's care as she failed to inform other professionals, including her team leader, regarding incidents involving the patient in a timely manner and failed to update the patient's records appropriately which could have affected care provided by other healthcare professionals.

45. Miss Watson acted dishonestly when she stated to NHS Grampian's local investigation that NHS 24 had been contacted about 2200 hours on 29 June 2018, that she had spoken to a NHS 24 call handler at that time and that she had spoken to NHS 24 on more than one occasion when she knew that she had only spoken to NHS 24 on one occasion about 0044 hours on 30 June 2018. Miss Watson maintained that NHS 24 had been contacted earlier and that she had spoken to them on more than one occasion until presented with evidence during the local investigation that this was not the case.

[…]

47. The concerns in the charges 1, 2 and 6 which involve breach of professional boundaries are considered to relate to behaviour and attitudinal issues, as do the those in charges 4 and 5 which involve dishonesty. As per guidance SAN-2, cases involving dishonesty can be considered serious and that dishonesty a concern which can be more difficult to put right. The NMC's sanction guidance SAN 3a-e identifies that behaviour and attitudinal issues are more difficult to remediate. Breaching professional boundaries and dishonesty are behavioural and attitudinal concerns as they are not clinical issues that can be remediated by training. Also, Miss Watson had repeated these behaviours following receiving a final warning from her employer which indicates that these issues are deep-seated.

48. We consider Miss Watson has displayed limited insight, whilst she accepted during the internal investigation that she had breached professional boundaries and the majority of the other allegations, she did not appreciate the impact her actions could have had on Patient A. Miss Watson submitted an agreed removal application to the NMC in September 2023 in which she accepted all of the allegations except consuming alcohol. There was no reflection or insight demonstrated in this application and she disputed the account provided to the NMC by [Ms 1]*.*

49. We consider Miss Watson has not undertaken relevant training in respect of the issues of concern.

50. We note Miss Watson has not worked as a Registered Nurse since 28 April 2021, following the incident detailed in charge 6. [PRIVATE]*.*

51. We consider there is a continuing risk to the public due to the registrant's lack of full insight. Whilst she accepts the majority of the charges, these mostly relate to attitudinal issues. Behavioral and attitudinal issues, as per guidance SAN3a-e, are more difficult to put right and remediate. Miss Watson was dishonesty during the internal investigation and repeated the dishonesty in two interviews until presented with evidence detailing the record of her call to NHS24. She also repeated the same behaviour in breaching professional boundaries when she answered a telephone call from Patient A and attended at their home address on 25 April 2021 despite having been issued a formal written warning from her employer for the same type of conduct with the same patient. Miss Watson in both the internal investigation and the NMC case has failed to acknowledge the impact her behaviour in breaching professional boundaries and failing to notify and escalate concerns to other medical professionals and support services could have had on Patient A [PRIVATE]*. Miss Watson has not undertaken any training or demonstrated that she has reflected on the incidents that resulted in the charges. Whilst Miss Watson has stated to the NMC that she considers herself retired, there is a continuing risk to the public if she remains free to return to practise with no restrictions and no evidence submitted that she has sufficiently reflected and remediated the concerns.*

[…]

56. We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behavior. Miss Watson's conduct engages the public interest because it relates to breaching professional boundaries with a vulnerable patient and failing to ensure that this patient received appropriate care in a timely manner. Also, there was repetition of the behaviours which led to the concerns, in that Miss Watson's was on a first and final written warning from

her employer for similar conduct regarding the same patient when the allegations relating to charge 6 occurred. A reasonably informed member of the public would be concerned if Miss Watson was allowed to practise unrestricted given the circumstances. Therefore, a finding of impairment is necessary to maintain public confidence in the professions and the NMC as regulator.'

Miss Watson admitted her fitness to practise was impaired in her Case Management Form dated 17 February 2024.

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*, *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin)*, Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), and *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67.

Decision and reasons on misconduct

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

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

*'**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.

8 Work co-operatively.
To achieve this, you must:
8.1 Respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate.

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 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:

10.1 Complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event.

10.2 Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.

13 Recognise and work within the limits of your competence.

To achieve this, you must, as appropriate:

13.1 Accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care.

13.2 Make a timely referral to another practitioner when any action, care or treatment is required.

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

13.4 Take account of your own personal safety as well as the safety of people in your care.

15 Always offer help if an emergency arises in your practice setting or anywhere else.

To achieve this, you must:

15.1 Only act in an emergency within the limits of your knowledge and competence.

15.2 Arrange, wherever possible, for emergency care to be accessed and provided promptly.

15.3 Take account of your own safety, the safety of others and the availability of other options for providing care.

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 […].

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

20.6 Stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the individual charges and asked itself whether the charges found proved and the charges found proved by way of Miss Watson's admission amounted to misconduct.

The panel considered that in charges 1a and 2a, Miss Watson breached professional boundaries. In addressing charge 1a, Miss Watson should not have given her personal number to Patient A and/or Ms 1. Miss Watson's account from the NHS Grampian Outcome of Conduct Hearing dated 24 September 2021 was that:

> *'*[…] *you stated that you sent a text from your private mobile at that time in response to a text received on your work phone, which you could not use due to a flat battery.'*

In relation to 2a, it is clear from the documentary evidence before the panel that Miss Watson was in Patient A's home for more than 12 hours, including overnight. This was an extraordinary length of time and Colleague A identified during the course of his investigation that there were six opportunities when Miss Watson could have left Patient A's home. Miss Watson would have had full knowledge of the role expected of her at the

time of the incident, and stated at interview that emergency services or the Hospital could have been contacted [PRIVATE]. However, she chose to stay there for over 12 hours, including when Ms 1 left the property but [PRIVATE] had remained in the accommodation and Patient A was asleep at this stage.

The panel considered that Miss Watson's actions in charge 2b, 2c, 2d, and 2e, were serious in that she failed to take into account her safety, as well as the safety of Patient A. She remained inside Patient A's home for a significantly long period of time during an incident in which at times Patient A was in a [PRIVATE] situation. Miss Watson failed to seek help from other professionals which could have benefitted Patient A and enabled Miss Watson to leave. Miss Watson failed to assess and plan care to properly respond to the situation. This delayed the emergency care response to Patient A.

The panel bore in mind that there was not a designated [PRIVATE] team for that specific area, however Miss Watson could have contacted emergency services, such as the police [PRIVATE]. The panel was of the view that a reasonable nurse would have been expected to contact emergency services or have accessed the On Call Manager at the Hospital and seek proper professional assistance during such an incident.

The panel noted that because the incident took place during the weekend, Miss Watson thought it was difficult to contact her manager. However, the panel was of the view that an experienced nurse should have recognised the seriousness of the situation and escalated the incident via the emergency services as described above. Miss Watson's conduct could have harmed Patient A. It seemed as if she believed that she was the only person that could provide care for Patient A. The panel therefore found that Miss Watson's actions in charge 2b, 2c, 2d, and 2e amounted to serious misconduct.

The panel noted Miss Watson's failings in charges 2f and 2g and that the incident in June 2018, were serious and outside the scope of normal practice. With the experience that Miss Watson has had in her nursing career, a DATIX form should have been completed for an incident of this nature, as well as an up-to-date risk and wellness plan, to inform other healthcare professionals of the appropriate care and interventions to be provided to Patient A.

The panel found that in relation to charge 2h, given Patient A's [PRIVATE], it acknowledged that Miss Watson could have had difficulties in stopping Patient A from laying their head on Miss Watson's lap. However, within the context of a registered nurse working with a patient with [PRIVATE], the misconduct in this charge is that she had allowed herself to get into a situation where boundaries became blurred. As a mental health nurse, Miss Watson should have had the strategies to be able to deal with that type of situation, which may include easing herself up, moving away from Patient A and sitting elsewhere.

The panel considered that Miss Watson's actions in charge 3 did amount to misconduct. She failed to raise the incident on 29 and 30 June 2018 with her manager until 3 July 2018. Miss Watson had a professional responsibility to report the incident, either in writing or orally to her line manager. However, the panel did note that Miss Watson indicated that she made some efforts to try and contact Colleague A by going to his office on 2 July 2018, but there was no evidence of calls or messages left on his phone. The panel also acknowledged that Miss Watson spoke to Patient A's consultant on 2 July 2018, nonetheless, Miss Watson's actions still fell short of the standard expected of her.

In looking at charges 4a, 4b, 4c, 4d and 4e and the dishonesty charges 5a and 5c, the panel bore in mind that it must carefully consider Miss Watson's actions, what was her state of mind at the time the dishonesty took place, and whether her actions would constitute dishonesty in the minds of a reasonable person. The panel accepted that despite Miss Watson's own admissions to the dishonesty elements of the charges, her actions constituted misconduct which in itself is serious. The panel noted that part of the context of such admission is that Miss Watson thought that she could manage the situation on her own, which in her hindsight, now realises that it was not right to do so. The panel found that during the interviews, Miss Watson sought to conceal her lack of escalation to NHS24.

The panel then addressed charge 6 and whether Miss Watson's behaviour constituted misconduct. The panel considered the facts, in that Miss Watson was removed as Patient A's nurse following an extensive investigation of the incident on 29 and 30 June 2018. Despite no longer being in charge of Patient A's care at the time (April 2021) and having been placed to work on a ward setting, Miss Watson still allowed herself to become

involved. At this time, she was still subject to a written warning including conditions by NHS Grampian that she could not be the sole trained nurse. During the investigation, Miss Watson defended her actions by saying that

> *'* […] *prior to attending the patient's flat she had actively encouraged* [Patient A] *to contact the out of hour's services or supportive networks.*
> - *CW reported that she made contact with* [PRIVATE] *as soon she was in receipt of a telephone number.*
> - *CW argued that, as a registered nurse, she had a duty of care to respond to former patient* [PRIVATE]
> - *CW suggested that had she not responded, [PRIVATE], she may have found herself subject to an investigatory process, as a result of her failure to act.'*

The panel determined that Miss Watson should have contacted the police [PRIVATE] or the Hospital, so that the correct healthcare professional assigned to Patient A's care could have taken the appropriate approach. Given that Miss Watson had not been involved in Patient A's care for 18 months, Miss Watson would not have had access to Patient A's updated care plan and had again placed herself in an unprofessional relationship without boundaries with Patient A.

The panel found that Miss Watson's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, 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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

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 determined that all four limbs of Dame Janet Smith's test were engaged in light of the charges found proved. The panel found that Patient A was placed at unwarranted risk of harm. The panel noted Miss Watson's actions and omissions placed Patient A at potential risk of harm. Further, the lack of professional boundaries and objectivity could have made Patient A overly reliant on Miss Watson which could have impacted Patient A's access to care and treatments. The panel noted that in all of Miss Watson's local investigation interviews and responses, she talked a lot about Patient A [PRIVATE] at the time the incident in June 2018 occurred. [PRIVATE]. However, it would have been important for Miss Watson to have worked with other professionals in the multidisciplinary team to ensure Patient A received the appropriate care and intervention.. Miss Watson indicated that her plan was to deescalate and then leave. However, she failed to recognise that she should have sought support from the Emergency Services and then left as soon as an opportunity had presented itself.

The panel determined that Miss Watson's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel acknowledged that there was an element of compassion and kindness to her behaviour, her lack of objectivity and professional boundaries could have brought the profession into disrepute. She failed to communicate with the appropriate team and acted outside the scope of her practice. The panel saw evidence from Ms 1 that she felt unsafe with Miss Watson being there without any other multiprofessional support on 29 June 2018, [PRIVATE]. A well-informed member of the public, appraised of the facts of this case, would have been concerned if a finding of impairment was not found given the nature of the charges found proved.

Furthermore, the panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. Miss Watson had been dishonest in more than one interview in relation to contacting NHS24. It was only when the evidence was put to her when she gave a more honest account. The panel accepted that her recollection may have varied, or she struggled to remember what happened, nonetheless, she admitted that her initial accounts were not necessarily correct.

Regarding insight, the panel noted that Miss Watson made admissions and demonstrated some understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession. However, Miss Watson has not provided the panel with a comprehensive account as to why her actions were wrong, the impact it would have had on Patient A and Ms 1, and a full account of what Miss Watson would have done differently in the future. The panel acknowledged in Miss Watson's written response:

> *'I have no intentions of defending my actions as I am happy to be removed from the nursing register. I would like the panel to know I will never engage in nursing or any caregiving role in the future.'*

The panel therefore acknowledged that the reason Miss Watson had not provided the panel with a full written insight, is due to her intentions of not to return to nursing. The panel took the view that Miss Watson's behaviour would be difficult to remediate since the misconduct found proven related to behaviour and attitudinal issues. There was no real recognition of Miss Watson's failings, particularly around her attitude and behaviour around the breach of professional boundaries. Whilst the panel accepted that behavioural issues would be difficult to put right, it determined that an in-depth and meaningful reflection from Miss Watson would have benefitted her to demonstrate her full insight into her behaviour and mitigation of any future risk of repetition.

The panel is of the view that there is a risk of repetition. Miss Watson was subject to a final written warning, and conditions placed on her employment by her employers at NHS Grampian when she responded to a call from Patient A on 25 April 2021. Miss Watson again failed to show objectivity or act within the scope of her role at the time and attended Patient A's address instead of contacting the relevant emergency services [PRIVATE].

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Watson's fitness to practise impaired on the grounds of public interest. A well-informed member of the public, knowing the full facts of this case, would be concerned that Miss Watson was not able to maintain boundaries and ensure proper processes were followed.

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

Miss Watson's application for an agreed removal on 10 September 2023

The panel sought clarification having seen reference in Miss Watson's bundle that she had applied for Agreed Removal from the Register. The panel found that Miss Watson's second application was not sent to the Assistant Registrar, as she had not provided the necessary information to indicate a change in her circumstances or provided new information for the Assistant Registrar to consider. An earlier application was rejected by the Assistant Registrar on the following grounds:

> *'I've taken into account the seriousness of the allegations and that if found proved, could be viewed as fundamentally incompatible with being a registered professional. Accordingly, I refuse Miss Watson's application for voluntary removal.'*

Having seen Miss Watson's application, the panel considered whether to make a referral to the Assistant Registrar for reconsideration of Miss Watson's application. The panel was of the view that it is in the interest of fairness to Miss Watson, that such a matter ought to be considered.

The panel was informed of the powers available to it by the NMC in these particular circumstances. The panel heard and accepted the advice from the legal assessor.

The panel received further information from Miss Watson on 8 March 2024 after she was contacted by the NMC to clarify her email dated 19 February 2024 in which she stated, *'I am happy to be removed from the nursing register'.* The NMC provided the following summary of the conversation:

> *'Call back from Christine Watson.*
>
> *I explained the reasons for my call and asked her to about the part of her written statement (in the email she sent) where she says that she 'is happy to be removed from the register'.*
>
> *She just said that she meant she was very happy to not be on the register any more however that happens. She said she is OK to be struck off, she just doesn't want to be on the register and has no intention of working as a nurse in the future.*
>
> *I asked if it was a possible would she like the panel to consider the application she made for Agreed Removal in September. She said they can do this and she has no problem with this but she is 'not fussed either way'.*
>
> *I thanked her for calling me back so quickly and explained how she would receive the outcome.'*

The panel considered the NMC guidance on *'Applying the agreed removal criteria to particular cases'* (Reference: CMT-5d):

'Where allegations of misconduct are the main concern, a decision to agree removal will need to take into account the overall seriousness of the misconduct.

Where the misconduct is so serious that it's fundamentally incompatible with being a registered professional, the Assistant Registrar is unlikely to agree removal. The Assistant Registrar will take into account our guidance on seriousness, (particularly our guidance on concerns that are more difficult to put right) as well as our guidance on sanctions, when making their decision.

Agreed removal is unlikely to be appropriate where the concerns involve:

[…]

- *Deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care;*
- *Dishonest conduct involving misuse of power, vulnerable victims, personal financial gain from a breach of trust, direct risk to people receiving care, premeditated, systematic or longstanding deception;*
- *Abusing their position as a registered nurse, midwife or nursing associate or other position of power to exploit, coerce or obtain a benefit;*
- *Where the misconduct is less serious, or could be addressed if the nurse, midwife, or nursing associate did not wish to stop practising, then the Assistant Registrar is more likely to agree to the removal.'*

The panel determined that the dishonesty in Miss Watson's case is at the lower end of the spectrum, and when given the evidence, she admitted she had been dishonest or gave a more accurate account. Moreover, Miss Watson was open about what had happened. However, Miss Watson repeated her misconduct when she took the call from Patient A on 25 April 2021 and attended Patient A's address. As such, given that there has been no material change to the circumstances of Miss Watson's application for an Agreed Removal, the panel decided that it could not make the referral to the Assistant Registrar. The panel next moved onto the sanction stage.

Sanction

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

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 30 January 2024, the NMC had advised Miss Watson that it would seek the imposition of a striking off order if it found Miss Watson's fitness to practise currently impaired.

The NMC identified the following:

' 58. The aggravating factors in this case include:

- *[PRIVATE]*
- *There was a risk of serious harm to Patient A.*
- *Repeated behaviour over a long period of time.*
- *Charge 6 occurred while Miss Watson was on a final written warning from her employer for similar concerns relating to the same patient.*
- *Miss Watson has failed to demonstrate sufficient insight, remorse, or appropriate reflection regarding the concerns.*

59. The mitigating factors in this case include:

- *Miss Watson admitted the majority of the concerns during the local investigation and subsequently to the NMC.*

[…]

64. As per guidance SAN-3d, a suspension order would not be an appropriate or proportionate sanction in this case as there is evidence of repetition since the initial incident, evidence of deep-seated attitudinal issues and due to lack of insight there remains a significant risk of Miss Watson repeating the behaviour in the charges. Miss Watson's actions relating to breach of professional boundaries and dishonesty are attitudinal and more difficult to put right, there is a particular risk of repetition as this case involves more than one instance of breaching professional boundaries [PRIVATE]. During the meeting on 25 July 2018, Miss Watson was dishonesty when she made the statements detailed in charge 4 which were attempts to mislead the internal investigation that she had contacted NHS24 earlier than she had and on more than one occasion. Miss Watson repeated this dishonesty by maintaining the position that she had contacted NHS24 earlier than she in fact did and that she had spoken to a call handler on two occasions throughout the first interview until presented with evidence that contradicted her account. As per guidance SAN-2, conduct involving dishonesty will be considered the most serious and call into questions whether a nurse should be allowed to remain on the register includes if the dishonesty involves deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients and premediated, systematic or longstanding deception. Miss Watson knew her statements during the first interview were dishonest, they were not statements made due to misremembering, she provided detailed statements regarding the call to NHS24 which did not take place. As her statements were made to the effect to attempt to convince the internal investigation that she contacted NHS24 earlier than she did, her conduct breached her professional duty of candour and was premediated. in Parkinson v Nursing and Midwifery Council [2010] EWHC 1898 (Admin) made it clear that a nurse who had acted dishonestly will be at risk of being struck off from the register, particularly if they do not demonstrate sufficient remorse for the dishonest conduct. A suspension order, under the circumstances of this case, is neither an appropriate nor proportionate sanction.

65. A striking-off order is the appropriate sanction in this case based on the guidance SAN-3e. In warranting its submission to impose a striking-off order, the NMC highlight the fundamental concerns regarding the Registrant's trustworthiness as a registered professional and that the Registrant's conduct was fundamentally incompatible with continued registration. The charges including more than one instance of breaching professional boundaries [PRIVATE], putting them at serious risk of harm and dishonesty. She repeated her behaviour towards the patient even after a final written warning from her employer. The public confidence in the professions would not be maintained if Miss Watson remained on the register despite her actions and a striking-off order is the only sanction which will sufficiently protect patients and maintain professional standards. Therefore, under the circumstances of this case, a striking-off order is appropriate and proportionate.'

Decision and reasons on sanction

Having found Miss Watson'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:

- Breach of professional boundaries [PRIVATE] on two occasions.
- Charge 6 occurred whilst Miss Watson was subject to a final written warning from her employer for similar concerns relating to the same patient.
- Failure to escalate to emergency services which placed Patient A at risk of suffering harm.
- Lack of insight into professional boundaries and damage to the reputation of the profession.

The panel also took into account the following mitigating features:

- Miss Watson engaged with the local investigation and subsequently with the NMC.
- Miss Watson had an unblemished nursing career prior to her involvement with Patient A.
- Miss Watson's early admission to most of the facts.
- Miss Watson's engagement in group supervision with the Nurse Psychotherapist and discussion about [PRIVATE] approaches to be taken.

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 Miss Watson'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 Miss Watson's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Watson's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. In addition, Miss Watson has ended her career as a nurse and is not open to retraining or addressing the failings found. Furthermore, the panel concluded that the placing of conditions on Miss Watson's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

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

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

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Miss Watson's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. Miss Watson's case included a serious misjudgement on her part of the situation with Patient A, and lack of objectivity in her professional relationship with Patient A. The panel acknowledged that Miss Watson has had a long-standing career of good practice and was regarded as experienced and well respected by her peers. It took into account Miss Watson's previous 30-year unblemished nursing career as stated in the Investigation Report in 2018:

'Ms Watson has worked as a Community Mental Health Nurse for many years and during that time has contributed positively to all aspects of clinical work, most recently within the Aspen Team. During the course of Ms Watson's career incidents of concern have never been raised or recorded whereas positive feedback from patients and staff have been noted.

Ms Watson is currently employed as a Band 6 Community Mental Health Nurse (protected Band 7 following an organisational redesign of the Community Mental Health Services in October 2016). Over the course of her community nursing career Ms Watson has gained significant experience of lone working and contributing to the work of the Community Mental Health Team as an autonomous practitioner as well as a senior nurse within the multidisciplinary team. She is a respected practitioner within the nursing team, the wider multidisciplinary team and by patients and family members that she is in contact with.'

The panel also noted Colleague B's description of Miss Watson:

'[…] *she has been an effective practitioner, she works incredibly well. She is a very caring, kind and compassionate person* […]*'*

However, the panel was of the view that the findings in this particular case demonstrate that Miss Watson's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Miss Watson's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Miss Watson in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Watson's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC:

> *'If a finding is made that the Miss Watson's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed, we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest. This is because any sanction imposed by the panel will not come into immediate effect but only after the expiry of 28 days beginning with the date on which the notice of the order is sent to the registrant or after any appeal is resolved. An interim order of 18 months is necessary to cover any possible appeal period.*
>
> *If a finding is made that the Miss Watson's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registration, we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest. This is because any sanction imposed by the panel will not come*

into immediate effect but only after the expiry of 28 days beginning with the date on which the notice of the order is sent to the registrant or after any appeal is resolved. An interim order of 18 months is necessary to cover any possible appeal period.'

The panel also had regard to Miss Watson's conversation with the NMC on 8 March 2024 in which she stated that she *'has no intention of working as a nurse in the future'.*

Decision and reasons on interim order

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

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

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

That concludes this determination.