**Fitness to Practise Committee Hearing**
**3 – 26 June, 25-27 September, 4 October, 7 and 11-14 November 2019**
**NMC, 2 Stratford Place, Montfichet Rd, London E20 1EJ**

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| **Name of Registrant Nurse:** | Lilian Harrison |
| **NMC PIN:** | 76G0427E |
| **Part(s) of the register:** | Registered Nurse – Sub Part 1 |
| **Area of Registered Address:** | Lancashire |
| **Type of Case:** | Misconduct |
| **Panel Members:** | Robert Barnwell (Chair – Lay member)<br>Jonathan Coombes (Registrant member)<br>Alice Robertson Rickard (Lay member) |
| **Legal Assessor:** | Ben Stephenson |
| **Panel Secretary:** | Anita Abell |
| **Ms Harrison:** | Not present and not represented |
| **Registrant 1:** | Present and represented by Tom Buxton, Counsel instructed by the Royal College of Nursing |

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| **Registrant 2:** | Present and represented by Laura Bayley, Counsel instructed by the Royal College of Nursing |
| **Nursing and Midwifery Council:** | Represented by Ben Edwards, Case Presenter |
| **Facts found proved by admission:** | None |
| **Facts found proved:** | Charges 1c, 2aiii, 2biii, 3c, 4a-c, 5c, 6 and 7 |
| **Facts found not proved:** | Charges 1a |
| **(no case to answer):** | Charges 1b, 2ai, 2aii,2bi, 2bii, 3a, 3b, 5a and 5b. |
| **Fitness to practise:** | Impaired |
| **Sanction:** | Striking off order |
| **Interim order:** | Interim suspension order for 18 months |

**Decision on Service of Notice of hearing:**

Ms Harrison was not in attendance. Written notice of this hearing had been sent to her registered address by recorded delivery and by first class post on 3 May 2019. The notice contained details of the hearing including time, date and place.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Ms Harrison has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34 of The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 ("the Rules").

**Decision on proceeding in the absence of the registrant**

The panel then considered continuing in the absence of Ms Harrison.

Mr Edwards, on behalf of the NMC, produced a proceeding in absence bundle and submitted that the panel should proceed in the absence of Ms Harrison. He drew attention to a telephone note of 8 May 2019 in which details of Ms Harrison's conversation with her case officer are recorded. That note records the conversation as:

> "I told her even though she does not want to attend her hearing the panel will want to know whether she is happy for them to proceed with the hearing in her absence. She said she is ok with that. I informed her that she can send in any written representations for the hearing and she said that she didn't want to. She will wait for the outcome."

Elsewhere in the bundle there is an undated letter from Ms Harrison in which she states:

> "I have said I don't intend to come to NMC"

Further in the personal contact and employer details form Ms Harrison states that she retired in November 2017.

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

The panel concluded that Ms Harrison was aware of the hearing and had chosen not to attend. The contents of the telephone note indicate that she is happy for the hearing to proceed in her absence. The panel consider that an adjournment is unlikely to secure her attendance at a future date. Two registrants have attended the hearing with their representatives and there are a number of witnesses scheduled to attend. For these reasons the panel has decided to proceed in the absence of Ms Harrison.

**The charges**

That you, a registered nurse, while working night shifts at the Alexandra Nursing and Care Home (the Home) between 23-28 October 2015:

1. Failed to call an out of hours GP and / or other appropriate medical professional for an urgent examination of Resident A when it was clinically appropriate to do so on the night shift(s) of:

    a. 23-24 October 2015 **Not proved**

    b. 26-27 October 2015 **No case to answer**

c. 28-29 October 2015 **Found proved**

2. Failed to take or, in the alternative, failed to record Resident A's:

    a. Physiological observations on the night shift(s) of:

        i. 23-24 October 2015 **No case to answer**

        ii. 26-27 October 2015 **No case to answer**

        iii. 28-29 October 2015 **Found proved**

    b. Vital signs observations every 15 minutes on the night shift(s) of:

        i. 23-24 October 2015 **No case to answer**

        ii. 26-27 October 2015 **No case to answer**

        iii. 28-29 October 2015 **Found proved**

3. Failed to commence, or in the alternative failed to record that you had commenced, a pain monitoring chart for Resident A on the night shift(s) of:

    a. 23-24 October 2015 **No case to answer**

    b. 26-27 October 2015 **No case to answer**

    c. 28-29 October 2015 **Found proved**

4. Failed to carry out night time checks on Resident A every two hours or, in the alternative, failed to record that you had done these, on the night shift(s) of:

a. 23-24 October 2015 **Found proved**

b. 26-27 October 2015 **Found proved**

c. 28-29 October 2015 **Found proved**

5. Failed to increase, or alternatively failed to record that you had increased, the frequency of your night time checks on Resident A when it was clinically appropriate to do so on the night shift(s) of:

    a. 23-24 October 2015 **No case to answer**

    b. 26-27 October 2015 **No case to answer**

    c. 28-29 October 2015 **Found proved**

6. Administered oxygen to Resident A without a doctor's prescription and / or without medical advice on the night shift of 28-29 October 2015.
   **Found proved**
7. Your actions at one or more of 1-6 above contributed to Resident A's death, or in the alternative, contributed to a loss of chance to prevent the death of Resident A.
   **Found proved in relation to contributed to the loss of a chance of life**

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

**Background**

Resident A was a 75-year-old lady who suffered multiple medical problems. In September 2015 she collapsed whilst attending an out-patient appointment at the Royal Oldham Infirmary (the Infirmary). She was admitted as an inpatient from 19

September to 18 October 2015. Whilst in hospital, she was treated for septic arthritis of the shoulder by drainage, as antibiotics alone had proved insufficient.

Resident A was taking a significant number of medications including an anticoagulant (apixaban) and non-steroidal anti-inflammatory drugs (NSAIDs) amongst others. There was a do not resuscitate order (DNR) in her notes, dated 19 September 2015 and signed at the Infirmary. The reasons given for the DNR on the form were frailty and severe arthritis.

Resident A was discharged from the Infirmary on 18 October 2015. She was admitted to the Alexandra Nursing Home (the Home) as she was deemed medically fit for discharge but not capable of looking after herself independently. You completed her admission documentation on 19 October and completed some further assessments on 20 October 2015.

Resident A had been assessed prior to her discharge by a social worker and a nurse who concluded that she required residential but not nursing care, so she was admitted as a residential, and not nursing, resident. There was some confusion as to the purpose of the admission to the Home as Resident A and her daughter both believed that she had been admitted only for respite care prior to a return to her own home. Staff at the Home understood that Resident A was being admitted on a permanent basis with a review of her care after one month.

Resident A was initially able to mobilise by herself but on 23 October she required the help of two people to get out of bed. Her poor mobility continued on 24 and 25 October 2015. She suffered with intermittent haematuria (blood in her urine) from 24-26 October 2015 which was thought to result from a urine infection. Resident A also had persistent diarrhoea whilst she was in the Home, thought to be caused by the antibiotics she was prescribed.

Resident A's daughter, Ms B, visited her mother daily. She visited early afternoon on 28 October, with Resident A's great-grandchildren. She noticed that her mother, unusually, did not seem interested in her family and was restless. Ms B concluded that her mother was not well enough to cope with her visitors and they left.

Ms B returned alone later about 17:00. Resident A used her GTN spray which was prescribed for angina.

At 22:40 on 28 October 2015, Ms Harrison was on duty as the night nurse and she recorded that Resident A was cold and breathless. Resident A was given oxygen by Ms Harrison and she also used her GTN spray. Oxygen had not been prescribed for Resident A.

Ms Harrison recorded that at 00:10 that Resident A appeared more relaxed and settled with no further need for oxygen. At 02:20 hours Resident A was reported to have been doubly incontinent. At 04:00 Resident A remained settled.

At 05:35 hours on 29 October 2015 it was found that Resident A had passed away.

On 12 November 2015 the coroner commenced an investigation into the death of Resident A. The investigation concluded at the end of the inquest on 7 April 2016. The coroner concluded the cause of death was hypovolemic shock, massive upper gastrointestinal haemorrhage, duodenal ulcer and aortic stenosis. The coroner issued a Regulation 28 Report to Prevent Future Deaths (Regulation 28 report) to Cherry Gardens Properties, the owners of the Home, on 3 May 2016.

The Care Quality Commission (CQC) inspected the Home on 25, 26 and 28 July and 15 August 2016, the first day of the inspection being an unannounced visit. The inspection of the Home had been brought forward because of the Regulation 28 report and the CQC specifically examined how the Home had addressed the report.

**Consideration of no case to answer**

At the conclusion of the NMC case, Counsel on behalf of Registrant 1 and Registrant 2 made submissions of no case to answer in relation to a number of charges faced by them. Ms Harrison is neither present nor represented. She has made no submissions to the panel. However, the panel agreed with Mr Edwards that it should consider whether there was a case to answer in relation to the charges faced by Ms Harrison.

The panel took into account the case of R-v- Galbraith, 73 Cr. App. R 124 CA in which Lord Lane C.J. laid down a two limbed approach to the evidence:

> 'If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case. [Limb 1].
>
> The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence. [Limb 2].
>
> Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, is his duty, upon a submission being made, to stop the case.'

The panel also reminded itself that if a charge alleges a failure the NMC must prove a duty on the registrant to carry out the actions alleged as a failure.

Mr Edwards submitted that the panel must examine all of the evidence before it when reaching its decision on no case to answer.

The panel heard and accepted he advice of the legal assessor. He reminded the panel of the principles set out in Galbraith.

The panel carefully considered all of the evidence before it, oral and documentary. It has heard oral evidence from the following:

- Ms B, daughter of Resident A
- Ms C, NMC nursing expert
- Mr E, NMC medical expert.

It applied the test in Galbraith to each charge separately.

When considering the applications the panel took into account the background to Resident A's admission to the Home. That is, that Resident A was assessed by a social worker and a nurse prior to discharge from hospital. That assessment concluded that Resident A should be admitted to care home that provides both residential and nursing care and that Resident A be admitted as a residential patient, with a review in a month's time.

1. Failed to call an out of hours GP and / or other appropriate medical professional for an urgent examination of Resident A when it was clinically appropriate to do so on the night shift(s) of:

    a. 23-24 October 2015

    There is evidence that during the night shift of 23-24 October 2015 Ms Harrison noted that Resident A had "Quite a large amount of fresh blood in her urine". It is Ms C's opinion that this should have prompted an urgent referral to the GP.

    **There was therefore a case to answer in relation to charge 1a.**

    b. 26-27 October 2015

In relation to 26-27 October 2015 it is unclear upon what basis it is said that an urgent referral was warranted. Ms C does not set this out. The panel therefore concluded there was insufficient evidence to prompt a referral on this date.

**The panel concluded that there is no case to answer in relation to charge 1b.**

c. 28-29 October 2015

On the night of 28-29 October Ms Harrison found Patient A cold and breathless and was sufficiently concerned about Resident A that she administered oxygen to her. Ms Harrison returned later and concluded that Resident A had benefitted from the oxygen and had settled. Ms Harrison later recorded Resident A as doubly incontinent at 02:20. The panel considers that there is evidence of a deterioration in Resident A's condition on these dates and notes Ms C's opinion that Ms Harrison should have called the out of hours GP on this date.

**The panel concluded that there is a case to answer in relation to charge 1c.**

2. Failed to take or, in the alternative, failed to record Resident A's:

a. Physiological observations on the night shift(s) of:

i. 23-24 October 2015

ii. 26-27 October 2015

iii. 28-29 October 2015

b. Vital signs observations every 15 minutes on the night shift(s) of:

i. 23-24 October 2015

ii. 26-27 October 2015

iii. 28-29 October 2015

3. Failed to commence, or in the alternative failed to record that you had commenced, a pain monitoring chart for Resident A on the night shift(s) of:

    a. 23-24 October 2015

    b. 26-27 October 2015

    c. 28-29 October 2015

The panel considered each of these charges separately. However as the conclusion in each case is the same it has summarised them together.

Resident A had a significant number of chronic health conditions including urinary tract infections, blood in her urine, diarrhoea, diabetes and arthritis. She had, for some time, suffered pain as a result of her various health conditions and was prescribed medication prior to her entering the Home.

On the assessment of a social worker and nurse prior to her admission Resident A was admitted as a residential patient and her nursing care was provided by the community nursing team. In the NMC bundle there are copies of the notes made by the community nursing team when they attended Resident A. Community nurses would have been responsible for all of Resident A's clinical care, except if there was

an emergency situation. Ms C's evidence does not clearly set out the need to commence physiological observations, vital signs observations every 15 minutes or a pain monitoring chart on 23-24 October or on 26-27 October.

There is insufficient evidence before the panel of a deterioration in the condition of Resident A on either 23-24 October or on 26-27 October such as to make it clinically appropriate for Ms Harrison to take physiological observations, vital signs observations every 15 minutes or commence a pain monitoring chart.

**The panel therefore found no case to answer in relation to charges 2ai, 2aii, 2bi, 2bii, 3a and 3b.**

However, there is evidence of a deterioration of Resident A's health on 28-29 October 2015.

There is evidence that at 22:40 Ms Harrison recorded Resident A as being cold and breathless and Ms Harrison administered oxygen. She went to check on Resident A later and concluded that she had benefitted from the oxygen. Later that evening at 02:20 Resident A was recorded as being doubly incontinent.

There is evidence before it that Resident A's condition deteriorated on the night shift of 28-29 October when Ms Harrison was the nurse on duty caring for Resident A, and it is Ms C's opinion that in light of the deterioration that occurred on 28-29 October 2015 Ms Harrison should have commenced physiological observations, vital signs observations every 15 minutes or a pain monitoring chart

**The panel therefore concluded that there is sufficient evidence to proceed with charges 2aiii, 2biii and 3c.**

4. Failed to carry out night time checks on Resident A every two hours or, in the alternative, failed to record that you had done these, on the night shift(s) of:

    a. 23-24 October 2015

    b. 26-27 October 2015

    c. 28-29 October 2015

There is evidence of the following. The Home policy on “Night-time Checks” states “As a general rule, all service users will be checked every two hours throughout the night unless specifically requested otherwise…” The admission document records that Resident A consented to two hourly checks throughout the night. The daily records do not include entries consistent with checks every two hours in relation to any of these shifts. There is evidence from the daily care records that you were on duty on these night shifts.

**The panel therefore concluded that there is sufficient evidence to proceed with these charges.**

5. Failed to increase, or alternatively failed to record that you had increased, the frequency of your night time checks on Resident A when it was clinically appropriate to do so on the night shift(s) of:

    a. 23-24 October 2015

b. 26-27 October 2015

c. 28-29 October 2015

The Home policy on “Night-time Checks” states “As a general rule, all service users will be checked every two hours throughout the night unless specifically requested otherwise…” The policy also states “Service users who are ill will be checked more frequently if the circumstances demand”. The admission documents record that Resident A consented to two hourly checks throughout the night.

There is insufficient evidence before the panel of a deterioration in the condition of Resident A on either 23-24 October or on 26-27 October such as to make it clinically appropriate for Ms Harrison to increase the frequency of the night-time checks and Ms C does not clearly set out her opinion in relation to these dates.

**The panel therefore found no case to answer in relation to charges 5a and 5b.**

However, there is evidence of a deterioration of Resident A’s health on 28-29 October 2015.

There is evidence that at 22:40 Ms Harrison recorded Resident A as being cold and breathless and Ms Harrison administered oxygen. She went to check on Resident A later and concluded that she had benefitted from the oxygen. Later that evening at 02:20 Resident A was doubly incontinent.

The panel considers that there is evidence before it that Resident A’s condition deteriorated on the night shift 28-29 October when Ms Harrison was the nurse on

duty, caring for Resident A and that the deterioration indicated that it was clinically appropriate for Ms Harrison to increase the frequency of night-time checks.

**The panel therefore concluded that there is sufficient evidence to proceed with charge 5c.**

In relation to the other charges faced by Ms Harrison the panel considered that there was a case to answer.

**Reconvening dates**

The panel was not able to conclude the hearing within the allotted time. It will reconvene in camera on 25-27 September and 4 October 2019 to reach a determination on facts. It will hand down that decision on 7 Novembers 2019. The panel will then reconvene from 11-19 November 2019 to consider misconduct, impairment and sanction as necessary.

**Decision on interim order**

Mr Edwards informed the panel that there was no interim order in place at present. He submitted that the panel was obliged to consider whether an order is necessary, based on a risk assessment of the current situation. He reminded the panel that the information submitted by Ms Harrison indicated that she had retired in November 2017.

The panel has accepted the advice of the legal assessor. It has also had regard to the NMC's guidance to panels in considering whether to make an interim order. The

panel has taken into account the principle of proportionality, bearing in mind the interests of the public and your own interests.

In reaching its decision the panel took into account that Ms Harrison retired in November 2017 and is therefore no longer working as a nurse. The panel concluded that on the basis of the information before it an interim order is not necessary on the grounds of public protection. Further, this is not a case which meets the high bar for the imposition of an interim order on public interest grounds alone.

The panel concluded that an interim order was not required in this case.

**11 November 2019**

Ms Harrison was not present at the start of the reconvened hearing. Mr Edwards informed the panel that notice of the reconvening dates had been sent to Ms Harrison on 1 August 2019. She responded to that notice in a letter dated 4 August 2019 in which she stated:

> "I will not be attending any of the hearings…I have retired".

The panel took into account its earlier decision to proceed in the absence of Ms Harrison and noted the contents of her letter of 4 August 2019, which is consistent with earlier correspondence. The panel decided it remained appropriate to proceed in the absence of Ms Harrison.

**11 November 2019**

The panel handed down the following determination.

**Amendment to stem of charge**

After the panel had retired to consider the charges but before making any decision on them the panel observed that the stem of the charge against Ms Harrison gave the dates 23-28 October 2015.

The evidence before the panel was that Ms Harrison was working a nightshift on 28 October 2015 which would continue until 08.00 on 29 October 2015. Further, some of the alleged incidents occurred in the early hours of 29 October 2015 and this was reflected in the limbs of charges 1-6.

The panel heard and accepted the advice of the legal assessor who advised that the panel had the discretion to amend the charges provided it did not cause unfairness to any of the parties.

The panel concluded that there was a typing error and agreed that the stem be amended to read:

"That you, a registered nurse, while working night shifts at the Alexandra Nursing and Care Home (the Home) between 23-29 October 2015".

**Determination on facts**

The panel heard evidence from, and read the exhibits of the following witnesses:

- Ms B, daughter of Resident A

- Ms C, NMC nursing expert
- Ms D, CQC Inspector (relevant only to the charges faced by Registrant 1)
- Mr E, NMC medical expert
- Dr F, your medical expert.

The panel also heard evidence from Registrant 1 and Registrant 2 who attended the hearing.

Ms Harrison has not sent any written representations to the panel.

When considering the charges, the panel took into account the submissions of Mr Edwards and all of the evidence before it, both documentary and oral. There is some documentary evidence which gives Ms Harrison's account of her care of Resident A, namely her evidence to the Coroner and notes of the disciplinary meeting.

The panel found Ms B's evidence to be consistent and she had a clear recollection of events. Although she was recalling difficult and emotional circumstances the panel considered her evidence was measured and fair.

The panel considered Ms C's written and oral evidence to be muddled and lacking in attention to detail. She included information that was not relevant and, on occasions, she was not prepared to reconsider her position when challenged with new documentary evidence. The panel considered that she had a poor command of the documents for an expert witness. Further, her conclusions were sometimes generalised rather than being specific to the situation she was asked to report on.

The panel considered that she may have reported on this case with a preconception that Resident A should have been admitted as a nursing patient, something that was outside your control. The panel found it surprising that in her oral answers she frequently maintained that residential residents should have the same level of clinical assessment and input from nurses in the Home as nursing residents. The evidence before the panel indicated that most nursing care for residential patients should come from the district nurses.

The panel found Ms D's evidence to be helpful and clear. However, her evidence was limited as she attended the CQC inspection on one day only.

The panel found the evidence of Mr E to be persuasive and clear. Whilst he was a general surgeon as opposed to a gastroenterologist, he was knowledgeable about the medical matters in this case. He made appropriate concessions when he was asked about something outside his area of expertise. He stood by the conclusions in his written evidence.

The panel found the evidence of Dr F to be thoughtful, logical and clear. As a gastroenterologist, his knowledge was directly related to the clinical matters in this case. He was also prepared to make concessions when he was asked about something outside his area of expertise. He too stood by the conclusions in his written evidence.

Registrant 1 also gave evidence to the panel. The panel found her evidence to be thoughtful, concise and without embellishment. She was able to explain your role in the Home clearly.

The panel also heard evidence from Registrant 2. The panel noted that there were some inconsistencies between Registrant 2's various accounts of the care given by her to Resident A.

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

The burden of proof rests upon the NMC and Ms Harrison does not have to prove or disprove anything. The standard of proof is the civil standard, namely the balance of probabilities. This means that, for a fact to be found proved, the NMC must satisfy the panel that what is alleged to have happened is more likely than not to have occurred. In determining the facts, the panel is entitled to draw common-sense inferences but not to speculate.

The panel then considered the outstanding charges against Ms Harrison which are:

*That you, a registered nurse, while working night shifts at the Alexandra Nursing and Care Home (the Home) between 23-29 October 2015:*

1. *Failed to call an out of hours GP and / or other appropriate medical professional for an urgent examination of Resident A when it was clinically appropriate to do so on the night shift(s) of:*

    a. *23-24 October 2015*

On the night shift Ms Harrison recorded a large amount of fresh blood in resident A's urine. The documentary evidence is that on 23 October the GP had been contacted about blood in Resident A's urine and the GP did not consider that this merited a visit. Instead a urine sample was sent for analysis and an antibiotic prescribed. The evidence was that blood in urine had been a longstanding condition of Resident A.

The panel concluded that given the actions taken on 23 October by the day nurses there was no clinical justification for Ms Harrison to call a GP on the night shift.

**The panel therefore found this charge not proved.**

*c. 28-29 October 2015*

Ms Harrison's note in the daily records at 22:40 reads "Resident A wanted…commode but could not get up…very cold, not clammy and breathless, given oxygen, distressed BS 9.7". The oxygen, which was not prescribed for Resident A, appears to have settled her. Then at 02:30 Resident A was doubly incontinent.

All three experts agree that a GP should have been called at 22:40 when Resident A was cold and breathless, and Ms Harrison was sufficiently concerned to administer oxygen.

**The panel therefore found this charge proved.**

*2. Failed to take or, in the alternative, failed to record Resident A's:*

*a. Physiological observations on the night shift(s) of:*

*iii. 28-29 October 2015*

*b. Vital signs observations every 15 minutes on the night shift(s) of:*

*iii. 28-29 October 2015*

Both medical experts are of the opinion that at 22:40 there was a significant deterioration in Resident A's condition and that physiological observations and vital signs should have commenced. Dr E states "on balance of probabilities, had a

record of her vital signs been kept it would have showed a steady deterioration". Dr F states ""observations should have been performed including pulse and blood pressure. It is likely on the balance of probability that pulse would have been elevated and blood pressure reduced…signs of a GI bleed are low blood pressure and a high pulse".

Although Ms Harrison was sufficiently concerned to administer oxygen and to check on Resident A 20 minutes later, she did not take or record taking physiological observations and/or vital signs.

**The panel therefore found these charges proved.**

3. *Failed to commence, or in the alternative failed to record that you had commenced, a pain monitoring chart for Resident A on the night shift(s) of:*

    c. *28-29 October 2015*

Resident A had a number of health conditions which caused generalised and constant pain; she had for some time been prescribed a number of medications to manage her long-term pain. In particular she suffered from arthritis and had been in hospital to have an arthritic shoulder drained.

The panel accepted that there was no specific note of increased pain during Ms Harrison's shift. However, in light of Resident A's apparent distress which she noted at 22:40, Ms Harrison should have commenced a pain monitoring chart at that time.

**The panel therefore found this charge proved.**

4. *Failed to carry out night time checks on Resident A every two hours or, in the alternative, failed to record that you had done these, on the night shift(s) of:*

a. *23-24 October 2015*

b. *26-27 October 2015*

c. *28-29 October 2015*

The panel has seen the Home policy on Night-time checks which states: “As a general rule all service users will be checked every two hours throughout the night, unless specifically requested otherwise”. The admission document for Resident A records that she consented to two-hourly checks.

The daily records for these three shifts do record some checks on Resident A by Ms Harrison, but they are not regular two hourly checks. The panel is satisfied that Ms Harrison failed to carry out two-hourly checks.

**The panel therefore found this charge proved.**

5. *Failed to increase, or alternatively failed to record that you had increased, the frequency of your night time checks on Resident A when it was clinically appropriate to do so on the night shift(s) of:*

    c. *28-29 October 2015*

The panel has seen the Home policy on Night-time checks which states: “Service Users who are ill will be checked more frequently if the circumstances demand”

There is evidence of a deterioration of Resident A’s health on 28-29 October 2015. At 22:40 Ms Harrison recorded Resident A as being cold, breathless and distressed and she administered oxygen. She went to check on Resident A later and concluded that she had benefitted from the oxygen. Later that evening at 02:20 Resident A was doubly incontinent.

The panel considers that there is evidence before it that Resident A's condition deteriorated on the night shift 28-29 October when Ms Harrison was the nurse on duty, caring for Resident A and that the deterioration indicated that it was clinically appropriate for Ms Harrison to increase the frequency of night-time checks. The panel is satisfied she did not do so.

**The panel therefore found this charge proved.**

6. *Administered oxygen to Resident A without a doctor's prescription and / or without medical advice on the night shift of 28-29 October 2015.*

Ms Harrison has recorded administering oxygen to resident A at 22:40 when she was breathless. The panel checked the list of prescribed medications for Resident A and noted that oxygen was not on the list. The panel noted that at the disciplinary hearing following the death of Resident A Ms Harrison stated that there was oxygen in Resident A's room and she therefore assumed it had been prescribed for her. There is no evidence that Ms Harrison sought medical advice prior to administering oxygen to resident A.

**The panel therefore found this charge proved.**

7. *Your actions at one or more of 1-6 above contributed to Resident A's death, or in the alternative, contributed to a loss of chance to prevent the death of Resident A.*

When considering this charge the panel took into account that Ms Harrison was the nurse on duty when Resident A died and that she had been directly involved in her care throughout the shift. She had been caring for her at 22:40 which is the time at which her deteriorating condition became obvious and prompted Ms Harrison to

administer oxygen. The panel took into account the medical evidence of both experts and the various other factors which might have produced a different outcome. These include the speed with which any outside medical response would have been available.

Having looked carefully at all the charges found proved the panel concluded the evidence is insufficient to establish that Ms Harrison's actions contributed to Resident A's death.

However, it found that Ms Harrison's actions on the shift of 28-29 October in failing to call an out of hours GP, failing to take physiological observations and vital signs observations every 15 minutes, failing to commence a pain monitoring chart, failing to carry out two-hourly checks and failing to increase the night time checks all contributed to a loss of chance to prevent the death of Resident A. The ultimate outcome for Resident A would have depended on many unknown factors such as how quickly a GP had attended, how quickly she had been admitted to hospital, accurately diagnosed and treated, and the success or otherwise of that treatment. On one scenario, if a GP had attended promptly, if she had been admitted, accurately diagnosed and a decision had been made to treat her, there was a chance that she could have survived. The panel therefore found that Ms Harrison's actions, or lack of action, contributed to a loss of chance to prevent the death of Resident A.

The panel concluded the administration of oxygen did not contribute to a loss of chance to prevent the death of Resident A. Although Ms C stated that the administration of oxygen could have damaged Resident A's lungs both medical experts agreed that it would not have caused any harm and would have been beneficial. The panel preferred their evidence.

**The panel therefore found this charge proved in relation to charges 1c, 2aiii, 2biii, 3c, 4a-c and 5c.**

**Determination on misconduct and impairment**

The panel went on to consider, on the basis of the facts found proved, whether Ms Harrison's fitness to practise is impaired under Rule 24 (12) of the Nursing and Midwifery Council Fitness to Practise Rules 2004.

The panel approached its deliberations as a two stage process. It considered firstly whether as a matter of judgment, there has been misconduct, and secondly, if so, whether, in the light of all the material before it, Ms Harrison's fitness to practise is currently impaired by that misconduct.

**Determination on misconduct and impairment**

The panel first considered whether the facts proved amount to misconduct. It bore in mind the case of *Roylance v General Medical Council (No 2) [2000] 1 A.C. 311*, where misconduct was defined by Lord Clyde as:

> *…a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances.*

The panel took into account other cases relating to misconduct, including the case of *Nandi v GMC [2004] EWHC 2317 (Admin)* which refers to conduct which would be regarded as deplorable by fellow practitioners, and the case of *Calhaem v General Medical Council [2007] EWHC 2606 (Admin).*

The panel also had regard to the Nursing and Midwifery Council publication *The Code: Professional standards of practice and behaviour for nurses and midwives* (effective from 31 March 2015, revised January 2019) (the Code).

The panel took into account the submissions of Mr Edwards and all of the evidence before it. There is no new information from Ms Harrison at this stage of the proceedings.

The panel concluded that Ms Harrison had breached the following provisions of the Code:

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

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

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

The panel is aware that not all breaches of the Code are sufficiently serious to reach the threshold for a finding of misconduct. The panel considered each charge separately.

The panel first considered charge 1c which related to Ms Harrison's failure to call an out of hours GP and/or other appropriate medical professional for an urgent examination of Resident A when it was clinically appropriate to do so on the night shifts of 28-29 October 2017. The panel took into account that Ms Harrison was sufficiently concerned about Resident A to administer oxygen to her. Further she recorded Resident A as "…very cold, not clammy and breathless…distressed". Although Resident A was a residential client she had a number of complex medical conditions. The panel considered that Ms Harrison made a serious clinical misjudgement in failing to call for a GP or other medical professional for an urgent examination and this misjudgement was sufficiently serious to amount to misconduct.

The panel next considered charge 2 which was that Ms Harrison failed to take or record Resident A's physiological or vital signs observations on the shift of 28-29 October 2015. The evidence of both doctors in this case, Mr E and Dr F, was that if observations had been taken it was likely that a deterioration would have become obvious. In particular, there was a likelihood of an increased pulse rate and a fall in blood pressure, caused by the gastric haemorrhage which most likely started around 22:40. The panel considered that Ms Harrison made a serious clinical misjudgement in failing to take any observations and this misjudgement was sufficiently serious to amount to misconduct

The panel next considered charge 3c which was that Ms Harrison failed to commence or record a pain monitoring chart for Resident A on the shift of 28-29 October 2015.The panel took into account that evidence of both doctors that it was likely that Resident A's gastric haemorrhage had begun at about 22:40 but this was unlikely to have caused any pain. However, given that Ms Harrison records the patient as "very cold, not clammy and breathless, given oxygen, distressed" the panel concluded that it would have been appropriate for her to commence a pain monitoring chart. The panel considered that Ms Harrison made a serious clinical

misjudgement in failing to commence a pain monitoring chart and this misjudgement was sufficiently serious to amount to misconduct.

The panel next considered charge 4a which was that Ms Harrison failed to carry out night time checks on Resident A every two hours on the night shifts of 23-24 October, 26-27 October and 28-29 October 2015. The panel took into account the Home's policy to check residents every two hours and that Resident A had consented to these checks. The panel noted that the records indicate that on the shift of 23-24 October Resident A was checked at midnight and then not till after 07:00, and that on 26-27 October she was checked at 19:00, 03:00 and 06:30. On the shift of 28-29 October checks were more frequent but did not consistently meet the two-hour frequency. The panel concluded that this was a failing in Ms Harrison's duty, which fell below proper standards and was sufficiently serious to amount to misconduct.

The panel next considered charge 5 which was that Ms Harrison failed to increase the frequency of night time checks on Resident A when it was clinically appropriate to do so on the shift of 28-29 October 2015. At 22:40, Ms Harrison administered oxygen to Resident A because she was in distress. She checked at 23:00 and the oxygen seemed to have helped Resident A who was relaxed and settled. However, the panel concluded that Ms Harrison should have continued to check on Resident A on a more frequent basis throughout the night, which she did not do. The panel considered that Ms Harrison made a serious clinical misjudgement in not increasing the frequency of her checks on Resident A and this misjudgement was sufficiently serious to amount to misconduct.

The panel next considered charge 6 which was that Ms Harrison administered oxygen to Resident A without a doctor's prescription and/or without medical advice on the shift of 28-29 October 2015. The documentation indicates that Ms Harrison believed that Resident A had been prescribed oxygen because there were oxygen

cylinders in her room and this is why she administered it. The evidence of Ms C was that she believed the oxygen would cause harm to Resident A's lungs. However, both doctors, Mr E and Dr F, disagree with Ms C's conclusion. They were both of the opinion that Resident A may have benefited from the oxygen and, indeed, Ms Harrison recorded shortly after the administration that Resident A was relaxed and settled. The panel concluded that Ms Harrison administered oxygen in an attempt to help Resident A and the oxygen may have benefitted her. The panel was mindful that in other circumstances the administration of medication in the absence of a prescription or medical advice may be regarded as extremely serious. However, in the panel's judgment, in the particular circumstances of this case her actions in administering oxygen without a prescription were not so serious as to amount to misconduct.

The panel next considered charge 7 which was that Ms Harrison's actions in the charges found proved above contributed to a loss of chance to prevent the death of Resident A. The panel has earlier concluded that in failing to call an out of hours GP, failing to take physiological observations and vital signs observations every 15 minutes, failing to commence a pain monitoring chart, failing to carry out two-hourly checks and failing to increase the night time checks all contributed to a loss of chance to prevent the death of Resident A. This is a very serious charge. Any nurse would consider clinical behaviour which contributed towards the loss of a chance of a life to be deplorable and far below the standards expected. The panel therefore concluded that Ms Harrison's actions in relation to this charge amounts to misconduct.

**Determination on impairment**

Having found that Ms Harrison's behaviour amounted to misconduct, the panel went on to consider whether her fitness to practise is currently impaired by reason of that misconduct.

The panel was mindful that a registrant's impairment should be judged by reference to her suitability to remain on the register without restriction.

In deciding this matter the panel has exercised its independent professional judgement.

The panel took into account the submissions of Mr Edwards and all of the evidence before it.

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

The panel considered the case of *CHRE v NMC and Grant [2011] EWHC 97* and took into account the guidance provided by Dame Janet Smith and approved by Cox J. When deciding whether fitness to practise is impaired, it should be aware of the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.

The panel reminded itself of the guidance formulated by Dame Janet Smith in her Fifth Shipman Report, as cited in *Grant*, regarding the proper approach to be taken when considering impairment:

a) *Whether the registrant 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;*
b) *Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;*

c) *Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.*

d) *…not relevant…*"

The panel concluded that in the past Ms Harrison's misconduct had engaged limbs (a) to (c) above. Her misconduct in not reacting appropriately to a change in her patient's condition had the potential to put Resident A at unwarranted risk of harm. This misconduct would have also brought the profession into disrepute. Finally, Ms Harrison had breached a fundamental tenet of the profession in that she did not preserve patient safety.

The panel next considered whether Ms Harrison's fitness to practise is currently impaired and considered her likely future behaviour. In doing so, it took into account the guidance in the case of Cohen v General Medical Council [2008] EWHC 581 (Admin):

> "… It must be highly relevant in determining if a [nurse's] fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."

The panel concluded that the misconduct, all of which relates to clinical practice, was potentially remediable.

However, the panel has received no information from Ms Harrison in relation to these charges. There is some documentary information in the NMC bundle but this relates to the disciplinary hearing and the coroner's inquest. Ms Harrison has stated in correspondence to the NMC about this hearing that she retired in November 2017. In the circumstances the panel has no evidence of remediation and no evidence of any insight. In all the circumstances the panel concluded that, without evidence of remediation and insight, there was a risk of repetition of similar misconduct in the future, if Ms Harrison were return to work as a nurse. The panel has therefore

concluded that her fitness to practise is currently impaired on the basis of public protection.

The panel also considered the public interest in upholding standards in the profession and in maintaining confidence in the NMC as regulator. The panel concluded that members of the public would expect nurses to be proactive if there appeared to be a decline in a patient's condition. The panel has therefore concluded that Ms Harrison's fitness to practise is currently impaired on public interest grounds also, to ensure that proper standards of conduct and behaviour are maintained and to preserve public confidence in the nursing profession and in the NMC as regulator.

**Determination on sanction**

Having determined that Ms Harrison's fitness to practise is impaired, the panel went on to consider what sanction, if any, it should impose on her registration.

The panel took into account the submissions made by Mr Edwards and all of the evidence before it. He informed the panel that there had been no previous regulatory concerns in respect of Ms Harrison.

The panel accepted the advice of the legal assessor.

Under Article 29 of the Nursing and Midwifery Council Order 2001, the panel can take no further action or impose one of the following sanctions: make a caution order for one to five years; make a conditions of practice order for no more than three years; make a suspension order for a maximum of one year; or make a striking off order. The panel has borne in mind that the purpose of a sanction is not to be

punitive, though it may have a punitive effect.  It took into account the NMC publication, *Sanctions Guidance (*the SG*)*.

The panel considered the sanctions in ascending order of seriousness.

The panel has applied the principles of fairness, reasonableness and proportionality, weighing the interests of patients and the public with Ms Harrison's own interests and taking into account the mitigating and aggravating factors in the case. The public interest includes the protection of patients, the maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

The panel concluded that the aggravating features in this case are:

- Ms Harrison's misconduct was particularly serious in that it contributed to a loss of chance to prevent the death of Resident A
- Ms Harrison has not produced a reflection or any other material and therefore the panel has no evidence before it of remediation, insight or remorse.

The panel identified no mitigating factors in this case and none were put forward by Ms Harrison.

The panel first considered taking no further action but determined that this would be inappropriate. It would not address the seriousness of the misconduct which contributed to a loss of chance to prevent the death of Resident A. In those circumstances it would not be in the public interest to take no further action as it would neither be sufficient to maintain public confidence in the profession nor would

it uphold the standards of behaviour expected of a registered nurse. Moreover, to take no further action would not provide sufficient public protection from a nurse who has not remediated the shortcomings in her practice.

The panel then went on to consider whether a caution order would be appropriate. The panel concluded that a caution order was not appropriate as the matters of concern were too serious and could not be described as being at the lower end of the spectrum of impaired fitness to practise. A caution order would not be in the public interest as it would not maintain confidence in the profession, it would not provide sufficient public protection and it would not uphold the standards of behaviour expected of a registered nurse. Further, the panel has identified that there remains a risk of repetition and a caution order would allow Ms Harrison to practise without restriction.

The panel next considered a conditions of practice order. Although the panel has earlier concluded that the misconduct is remediable, Ms Harrison has stated that she retired in November 2017 and her engagement with these proceedings has been minimal. Taking these factors into account the panel concluded that Ms Harrison has not demonstrated a willingness or ability to comply with a conditions of practice order. Further, the panel concluded that conditions of practice would not be appropriate given the seriousness of the charges found proved in this case. Conditions of practice would not address the public interest in maintaining standards and public confidence in the profession and in the NMC as regulator.

The panel considered whether a suspension order would be appropriate in this case. The panel took into account the factors listed in the SG which render a suspension appropriate and concluded

- this was not a single instance of misconduct as some of the misconduct occurred on more than one shift

- whilst there has been no repetition of the misconduct Ms Harrison has not been working as a nurse since November 2017
- the panel has no evidence of insight and has identified a risk of repetition.

These factors, and the seriousness of the charges, suggested to the panel that it needed to consider a striking off order.

The panel then considered a striking-off order. The panel concluded that the charges, and in particular charge 7, were a serious departure from the relevant professional standards.

The panel considered that this was a case where the regulatory concerns about Ms Harrison do raise fundamental questions about her professionalism. Further, as she has not demonstrated any remorse, remediation or insight the panel concluded that public confidence in the profession, and in the NMC as its regulator, would be undermined if Ms Harrison were allowed to remain on the register.

Taking into account the context in which the misconduct occurred, the panel concluded that a striking off order was the only sanction which will be sufficient to protect patients, the public and to address the public interest in maintaining standards and confidence in the profession. The panel concluded the issues raised in this case are so serious that they are incompatible with on-going registration.

**Determination on Interim Order**

Pursuant to Article 29 (11) of the Nursing and Midwifery Order 2001, this panel's decision will not come into effect until after the 28 day appeal period, which begins on the date that notice of the striking off order has been served. Article 31 of the

Nursing and Midwifery Order 2001 outlines the criteria for the imposition of an interim order. The panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, or is otherwise in the public interest or in Ms Harrison's own interest. The panel may make an interim conditions of practice order or an interim suspension order for a maximum of 18 months.

Mr Edwards made an application that the panel impose an interim suspension order on the grounds of public protection and in the public interest for an 18 months period to cover the appeal period and any possible appeal.

The panel has accepted the advice of the legal assessor. It has also had regard to the NMC's guidance to panels in considering whether to make an interim order. The panel has taken into account the principle of proportionality, bearing in mind the interests of the public and Ms Harrison's own interests.

The panel has taken into account its reasons for making a striking off order. For those same reasons, the panel is satisfied that it is necessary for public protection and it is in the public interest for Ms Harrison's registration to be subject to an interim order. The panel considered whether an interim conditions of practice order would be appropriate and proportionate and determined that it would not be for the same reasons given in the substantive order. The panel therefore imposes an interim suspension order.

The period of this order is for 18 months to cover any potential appeal, but if at the end of a period of 28 days, Ms Harrison does not lodge an appeal the interim order will lapse and be replaced by the substantive order. On the other hand, if Ms Harrison does lodge an appeal, the interim order will continue until the appeal is concluded.