Nursing and Midwifery Council
Fitness to Practise Committee
Substantive Hearing
26 February 2020

Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Emma Jane Rathbone
NMC PIN:	09I0641E
Part(s) of the register:	Registered Nurse Adult Nursing- September 2012
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Adrian Ward (Chair, Lay member) Carol Porteous (Registrant member) Jennifer Portway (Lay member)
Legal Assessor:	Andrew Young
Panel Secretary:	Roshani Wanigasinghe
Miss Rathbone:	Not present and not represented in absence
Nursing and Midwifery Council:	Represented by Shabana Fazal, Case Presenter
Consensual Panel Determination:	Accepted
Facts proved:	All (by admission)
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim Order:	Interim suspension order-18 months

Decision on Service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Rathbone was not in attendance and that written notice of this hearing had been sent to Miss Rathbone's registered address by recorded delivery and by first class post on 17 January 2020. The Royal Mail Track and Trace report showed that the notice was delivered on 18 January 2020. The notice was also sent to Miss Rathbone's representative at the RCN on 17 January 2020.

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

Ms Fazal submitted the NMC had complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules").

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Rathbone has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Decision on proceeding in the absence of the Registrant

The panel next considered whether it should proceed in the absence of Miss Rathbone.

The panel had regard to Rule 21 (2) states:

> (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—

(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;

(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or

(c) may adjourn the hearing and issue directions.

Ms Fazal invited the panel to continue in the absence of Miss Rathbone on the basis that Miss Rathbone, through her representative, and the NMC had agreed a provisional Consensual Panel Determination (CPD) within which Miss Rathbone stated that she did not intend to attend the hearing, and was content for it to proceed in her and her representative's absence. Ms Fazal informed the panel that Miss Rathbone would be available on the telephone if the panel needed to contact her during the hearing.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised "with the utmost care and caution" as referred to in the case of R. v Jones (Anthony William), (No.2) [2002] UKHL 5.

The panel decided to proceed in the absence of Miss Rathbone. In reaching this decision, the panel considered the submissions of the case presenter, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of Jones. It had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Rathbone;

- Miss Rathbone has engaged with the NMC and has agreed the CPD as drafted by the NMC;
- Miss Rathbone was advised by her representative throughout these proceedings and in relation to the CPD.
- Miss Rathbone has requested that the hearing proceed in her absence;
- There is a strong public interest in the expeditious disposal of the case;
- An adjournment would be unlikely to result in Miss Rathbone's attendance.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Miss Rathbone.

Consensual panel determination

At the outset of this hearing, Ms Fazal, on behalf of the NMC, informed the panel that prior to this hearing a provisional agreement of a consensual panel determination had been reached with regard to this case between the NMC and Miss Rathbone.

The agreement, which was put before the panel, sets out Miss Rathbone's full admission to the facts alleged in the charges, that her actions amounted to misconduct and that her fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a striking-off order.

The panel has considered the CPD reached by the parties.

That CPD reads as follows:

Fitness to Practice Committee

Consensual panel determination: provisional agreement

Miss Rathbone (the Registrant) is aware of the CPD hearing. The Registrant does not intend to attend the hearing and is content for it to proceed in her and her representative's absence. The Registrant will endeavour to be available on the telephone should any points need to be clarified.

The Nursing and Midwifery Council and Miss Emma Jane Rathbone (the Registrant), PIN 09I0641E ("the Parties") agree as follows:

1. The Registrant admits the following charges:

That you, a registered nurse, whilst working at The Yorkshire Clinic ("the Clinic") between 27 September 2017 and 4 November 2017;

1) Did not keep adequate records in relation to the administration/dispensing/management of codeine phosphate/co-codamol, in that you;

A) Recorded that codeine phosphate/co-codamol had been dispensed/administered to one or more Patients as listed in Schedule 1, when Patients had not been prescribed codeine phosphate/co-codamol;

B) After recording that codeine phosphate/co-codamol had been dispensed/administered in the Controlled Drugs Register, did not record a corresponding entry in one or more Prescription and Drug Administration Chart for Patients, as listed in Schedule 2;

C) In relation to Patient I;

i) Recorded that 60mg codeine phosphate had been dispensed/administered in Patient I's Prescription and Drug Administration chart on 27 September 2017 at 10.30a.m;

ii) Recorded that Patient I was discharged from the Clinic at 11a.m on 27 September 2017;

(iii) Inaccurately recorded that that Patient I had been dispensed/administered 60mg codeine phosphate in the Controlled Drugs Register on 27 September 2017 at 15:30;

D) In relation to Patient J; you inaccurately recorded the time Patient J's medication was administered, as you;

i) Recorded that Patient J had been dispensed/administered 60mg codeine phosphate in the controlled drug register on 4 October 2017 at 18.20;

ii) Recorded that 60mg codeine phosphate had been dispensed/administered in Patient J's prescription and administration chart on 4 October 2017 at 16:15;

E) In relation to Patient K;

i) Fabricated the Patient details for Patient K;

ii) Inaccurately recorded that Patient K had been dispensed/administered 60mg codeine phosphate in the controlled drug register on 15 October 2017;

F) In relation to Patient L, following Patient L declining codeine phosphate doses on 3 & 4 November 2017;

i) Inaccurately recorded that 60mg codeine phosphate had been dispensed/administered to Patient L in the controlled drugs register on 4 November 2017 at 10:00;

ii) Did not record that Patient L had refused codeine phosphate on the controlled drugs register;

iii) Did not record that you had destroyed the refused codeine phosphate;

G) In relation to Patient M, who had been administered 30mg codeine phosphate at 06:30 on 27 September 2017 by colleague 1;

i) Inaccurately recorded that 60mg codeine phosphate had been dispensed /administered to Patient M in the controlled drug register on 27 September 2017 at 08.30a.m;

ii) Inaccurately recorded that 30mg of codeine phosphate had been dispensed /administered to Patient M in the drug prescription and administration chart on 27 September 2017 at 08.30a.m;

iii) Inaccurately recorded that due to Patient M dropping his medication, a further 30mg of codeine phosphate had been dispensed/administered on 27 September 2017 at 8.40a.m. in Patient M’s care pathway/communication/variance notes;

H) In relation to Patient S, who was prescribed 15-30mg codeine phosphate to be dispensed/administered every 6 hours;

i) Recorded that 60mg codeine phosphate had been dispensed/administered to Patient S in the controlled drugs register on 11 October 2017 at 14:45;

2) Did not adequately account for codeine phosphate, in that you;

A) On 2 October 2017;

i) Recorded that Patient N had returned codeine phosphate to the pharmacy in Patient N's care pathway/communication & variance notes at 13:45;

ii) Did not ensure that the codeine phosphate was returned to the pharmacy/ward stock;

B) In relation to Patient O on 4 November 2017;

i) Recorded in Patient O's drug prescription and administration chart that they declined codeine phosphate tablets;

ii) Did not ensure that the codeine phosphate tablets were returned to ward stock/pharmacy;

3) Prescribed medication outside the scope of your competency, in that you;

A) On 27 September 2017 hand wrote a prescription of codeine phosphate for Patient P in the prescription and administration chart, including details such as;

i) The drug
ii) The dose
iii) The frequency
iv) The route

v) The start date

B) On 27 September 2017 hand wrote a prescription of codeine phosphate for Patient Q in the prescription and administration chart, including details such as;

i) The drug
ii) The dose
iii) The frequency
iv) The route
v) The start date

C) On 27 September 2017 you did not obtain a RMO/Doctor signature for Patient Q's prescription.

D) On 4 October 2017 hand wrote a prescription of codeine phosphate for Patient R, in the prescription and administration chart, including details such as;

i) The drug
ii) The dose
iii) The frequency
iv) The route
v) The start date

E) On 4 October 2017 you did not obtain a RMO/doctors' signature for Patient R's prescription;

4) Your actions in charges 1-3 above were dishonest, in that you knew that you had not dispensed/administered codeine phosphate/co-codamol to one or more patients, but sought to represent that you had;

5) Your actions in charges 1-4 above were the means by which you took codeine phosphate/co-codamol from The Clinic;

6) Your actions in charge 5 above were dishonest as you took medication belonging to your employer with an intention not to return it;

And in light of the above your fitness to practise is impaired as a result of your misconduct.

Schedule 1;

1) Patient B - 60mg codeine phosphate on 2 October 2017
2) Patient E – 60mg codeine phosphate on 23 October 2017
3) Patient F – 60mg codeine phosphate on 25 October 2017
4) Patient H – 30/500 x 2 tablets co-codamol on 4 November 2017
5) Patient G – 30/500 x 2 tablets co-codamol on 4 November 2017
6) Patient S – 30/500 x 2 tablets co-codamol on 11 October 2017
7) Patient G - 60mg codeine phosphate on 4 November 2017
8) Patient G - 60mg codeine phosphate on 5 November 2017

Schedule 2;

1) Patient A - 60mg codeine phosphate on 27 September 2017
2) Patient B - 60mg codeine phosphate on 2 October 2017
3) Patient C - 30mg codeine phosphate on 2 October 2017
4) Patient D - 60mg codeine phosphate on 4 October 2017
5) Patient E - 60mg codeine phosphate on 23 October 2017
6) Patient F – 60mg codeine phosphate on 25 October 2017
7) Patient H – 30/500 x 2 tablets co-codamol on 4 November 2017
8) Patient G – 30/500 x 2 tablets co-codamol on 4 November 2017
9) Patient G - 60mg codeine phosphate on 5 November 2017
10) Patient L - 60mg codeine phosphate on 4 November 2017

Agreed Facts:

2. The Registrant appears on the Register of Nurses and Midwives maintained by the NMC as a Registered Nurse. She registered in September 2009.

3. The NMC received a referral concerning the Registrant's fitness to practise on 27 November 2017 from the Matron at Ramsay Health Care UK.

4. At the time of the concerns raised in the referral, the Registrant was employed as a Ward Sister, Critical Care Lead and Bariatric Nurse Lead, at The Yorkshire Clinic (the Clinic), which is part of Ramsay Healthcare UK.

5. The Registrant joined the Clinic on 5 January 2015. The Clinic is an independent hospital with 56 beds. It admits both private and NHS patients on a day-case and inpatient basis. The Registrant was one of five junior nursing sisters who worked on the wards.

6. On 24 June 2017, 2 packs of 28 codeine phosphate 30mg tablets went missing from Ward 1. These tablets could not be accounted for and, as a result, it was decided that only the nurse in charge of the shift was allowed to hold the keys to the drug cupboard.

7. On 6 September 2017 following a routine stock count of the drug cupboard on Ward 2, it was apparent that 4 packets of codeine phosphate tablets were missing. The previous routine stock count on 24 August 2017 had been recorded as correct.

8. Following this incident, the Clinic commenced an investigation into the missing medication. The 4 packets of codeine remained unaccounted for and further restrictive measures were put in place. These included an instruction for all the nurses to record codeine-based medication in a "controlled drug register" and all codeine-based medication was moved from Ward 2 to Ward1.

9. On 6 October 2017, a further 6 codeine tablets were found to be missing from a packet which had been left in the clean utility room.

10. On 4 November 2017 two staff nurses found discrepancies in the Registrant's records for codeine in the controlled drug register. The Registrant had made an entry on the 4th of November 2017 recording that she had dispensed 60mg codeine and 2 x co-codamol tablets to Patient G. This was incorrect as Patient G had not been prescribed these medications.

11. On 5 November 2017, the Registrant had recorded that she had dispensed 60mg codeine to Patient G. This was not correct as Patient G had been a day case patient who was at the Clinic on 4 November 2017 only.

12. Between 27 September 2017 and 4 November 2017 the Registrant had entered a number of entries of patient names into the controlled drug register and on each occasion dispensed 60mg codeine. Following an audit check however, it became apparent that these patients had not been prescribed codeine.

13. Approximately 19 separate incidents have been identified where there were discrepancies in the Registrant's record keeping and administration of codeine and/or co-codamol.

14. There are 8 separate patients identified who were dispensed codeine when they were not prescribed this medication.

15. 18 MAR charts have been exhibited identifying discrepancies between the MAR charts and the controlled drug register.

16. On 25 October 2017 the Registrant recorded Patient K's name in the controlled drug register and recorded that she had dispensed 60mg codeine, however the investigation by the Trust was unable to identify any such patient on the hospital registration system. In addition, the Registrant had, on numerous occasions,

dispensed codeine but failed to record the administration of such in the patient's drug charts.

17. The Registrant was working outside the scope of her competence by prescribing codeine. The Trust's investigation report identified three patients (Patients P, Q and R) who were prescribed codeine by the Registrant which was in breach of the Ramsay Medicines Management Policy, the Medicines Act 1968 and Misuse of Drugs Act 1971.

18. Charges 1 to 3 set out the specifics in relation to the Registrant's inability to keep accurate records in relation to the administration/dispensing and management of codeine phosphate/co-codamol. These charges illustrate the Registrant's actions and provide details of the Registrant making numerous entries in the controlled drugs register, to mislead her employers in believing that the Registrant had dispensed/administered medication to a number of patients identified in schedule 1 and 2, when in fact this had not been done. The Registrant's entries went further in that she fabricated patient details in the controlled drugs register in order to incorrectly suggest that codeine had been dispensed and administered. The Registrant accepts that her conduct was dishonest and deliberate.

19. Charges 4 to 6 provide details of the Registrant's dishonest motivation. The Registrant was not only making incorrect entries in the controlled drugs register in an effort to conceal her dishonest intention and actions, but she was also prescribing medication to patients which was a task outside her competence. She was prescribing medication that was never given to patients and instead, was being used by the Registrant for her own personal gain. The Ward Matron has provided evidence that nurses at the Clinic are not to prescribe medication of behalf of any medical staff. The Registrant accepts that she prescribed medication on at least 3 occasions whilst she was did not have the requisite knowledge, training, or permission to do so.

20. The Parties have considered the test for dishonesty as set in the case of Ivey v Genting Casinos (UK) [2017] UKSC 67. The test determined that when dishonesty is in question, the fact finding tribunal must first ascertain the actual state of the individual's knowledge or belief as to the facts and then consider whether the conduct was honest or dishonest by applying the standards of ordinary decent people. In this case the Registrant was fully aware of her actions. She was aware that her conduct was dishonest and was for the sole reason to mislead her employers as to the whereabouts of the medication.

21. Witness statements from colleagues attest to the Registrant's frequent inaccurate record keeping within the controlled drug book. For example, the Registrant recorded many patients as having received codeine when they were actually prescribed Tramadol. All of the entries that were inconsistent had been made and signed by the Registrant. The Registrant's actions were to mislead her employers in believing that the codeine the Registrant was taking rom the Trust, had been administered to patients. The Registrant knew that this was not correct. The Parties agree that this misconduct raises fundamental concerns about the Registrant's trustworthiness as a Registered Nurse.

22. The Registrant was suspended on 6 November 2017.

23. The matter was investigated by the NMC and a report was completed in June 2019. The NMC has received and assessed all of the relevant evidence obtained during the local investigation. Witness statements have been obtained from:

- JM, Matron at the Clinic with exhibits
- CH, Ward Manager at the Clinic
- FL, Senior Staff Nurse at the Clinic
- NH, Senior Staff Nurse at the Clinic
- The local investigation report

24. The Registrant accepts the facts as outlined in the charges above.

Misconduct

25. In the case of Roylance v General Medical Council (No.2) [2000] 1 AC 311, Lord Clyde stated that:

'misconduct is 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 the medical practitioner in the particular circumstances'.

26. The Registrant admits that her conduct fell seriously short of the standards of behaviour expected of Registered Nurses. Furthermore, the Registrant accepts that her actions breached the following paragraphs of the NMC Code of Conduct:

10. Keep clear and accurate records relevant to your practise

To achieve this, you must:

10.3 complete records accurately and without any falsification;

The Registrant admits that she has, on numerous occasions, recorded incorrect information on patient records and notes. Falsification of patient notes is extremely serious as not only does it interfere with the integrity of the record of care but fundamentally, it increases risks for patients. Situation may arise where subsequent healthcare professionals may make a decision concerning a patient's treatment and medication having had sight and consideration of false and inaccurate documentation. This is an obvious risk that puts patients at great risk of harm. By virtue of not keeping accurate records the Registrant accepts that this section of the Code has been breached.

27. **13. Recognise and work within the limits of your competence**

T*o achieve this, you must:*

13.3 ask for help from a suitable qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
13.4 complete the necessary training before carrying out a new role

The Registrant's failure to handle controlled drugs in a safe manner is a serious concern as it puts at risk any patient who does not receive what is due to them. Furthermore, if a situation arises where the controlled drugs are not accounted for then the safety measures put in place by the Clinic for good reason are compromised. The Registrant was creating an environment whereby the risks increased due to management at the Clinic not being able to ascertain what was happening with the medication.

28. **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 and regulations:**
To achieve this, you must:
18.12 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

The Registrant was not qualified to prescribe medication and in this case on three separate occasions, the Registrant admits to prescribing codeine for Patient's P, Q and R. Evidence from the Ward Manager, confirms that the nurses at the Clinic do not prescribe medication and further that it would not be acceptable practice to write a prescription at a doctor's request. Acting beyond the scope of competence is serious as it puts patients at real risk if harm if a Registrant is undertaking tasks for which she has not received proper training.

29. **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

20.4 keep to the laws of the country in which you are practising

Nurses occupy a privileged position of trust in society and dishonesty is serious misconduct as it calls into question the integrity of the profession. The Registrant admits that her conduct was dishonest and that she failed to uphold the standards and values set out in the Code. Further, not only was the conduct dishonest, but the Registrant breached the trust of her employer and abused her position as a Registered Nurse. The charges represent the Registrant's failures in prescribing medication without permission and without having the requisite competence to do so and then involving patients by making inadequate record entries in Patient MAR charts, and incorrectly indicating that patients had been dispensed codeine when the patients had never been prescribed this medication. The Parties agree that this involved systematic and well thought out acts of dishonest conduct.

Current Impairment

30. The Registrant accepts that her fitness to practise is impaired by reason of her misconduct.

31. The parties have considered the questions formulated by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of CHRE v Grant & NMC [2011] EWHC 927 (Admin) ('Grant') by Cox J. They are as follows:

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

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

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.

32. The Parties agree that in this case, all four limbs are engaged.

33. <u>Has in the past acted and/or is liable in the future to act so as to put patients at unwarranted risk of harm:</u>
While there is no evidence that the Registrant caused direct harm to patients (although she was prescribing medication, there is no evidence of medication actually being administered to the patients and therefore no evidence of actual patient harm) the Parties agree that the conduct exposed patients to unwarranted risk of harm. Not only did the Registrant prescribe medication which she was not trained to do and therefore acted outside her competence and training, she also kept inadequate records in respect of a number of patients significantly raising the risk to patients. The Parties agree that, due to her misconduct, the Registrant remains liable in the future to patients at risk of unwarranted harm.

34. <u>Has in the past brought and is liable in the future to bring the medical profession into disrepute and breached fundamental tenets of the profession:</u>
The Parties agree that the Registrant's action brought the profession into disrepute. The Registrant admits that her failings were significant and substantial and her conduct fell significantly below the standards expected of a registered professional. The Registrant was falsifying patient's record over a prolonged period of time for her own personal gain. Her conduct was dishonest and significant and not only did it place patients at significant risk of harm, the Parties agree that the Registrant has

breached fundamental tenets of the profession and brought the profession into disrepute.

35. <u>Has in the past acted dishonestly and is liable to act dishonestly in the future:</u>
Acting with integrity and honesty are integral to the standards expected of a registered nurse and central to the Code. The Parties agree that the Registrant's actions were dishonest. Dishonesty is a serious misconduct. The Registrant not only breached the trust placed in nurses and the profession, but also abused her position and placed patients at risk of harm.

36. In considering the question of whether the Registrant's fitness to practise is currently impaired, the parties have considered Cohen v GMC [2007] EWHC 581 (Admin), in which the court set out three matters which it described as being 'highly relevant' to the determination of the question of current impairment:

a) Whether the conduct that led to the charge is easily remediable;
b) Whether it has been remedied;
c) Whether it is highly unlikely to be repeated:

37. The three questions set out in Cohen (above) can be answered as follows:

a) The regulatory concerns in this case are difficult to remediate as they involve acts of dishonesty and are directly linked to the Registrant's clinical practise. There are concerns in respect of public protection as the Registrant's actions had the potential of causing harm to patients. In addition to public protection concerns, there are concerns surrounding the Registrant's trustworthiness and integrity. This therefore emphasises the additional need to maintain and promote public confidence in the nursing profession. The NMC guidance is clear and states the following in respect of dishonesty *"…the public take concerns which affect the trustworthiness of nurses and midwives particularly seriously. Our research told us that the public are likely to see these cases as serious breaches of professional standards. Conduct that could affect trust in nurses and midwives*

and require action to uphold standards or public confidence include, where related to professional practice, dishonesty...". The Parties agree that such misconduct is difficult to remediate.

b) The Registrant's conduct in this case is so serious that it has not been possible for her to remediate. The failings in this case are wide ranging and involve dishonest behaviour on the part of the Registrant which was systematic, sophisticated and well thought out. This was not a single incident but involved multiple incidents of dishonest actions and as such the Parties agree that the misconduct is not remediable

c) In the absence of any remediation and full insight, the concerns are highly likely to be repeated. The misconduct in this case involved a degree of sophistication as it involved the Registrant making false and inaccurate records concerning patients to cover the fact that she was taking the medication for either her own personal use or for other reasons unknown to the Trust. Given the serious nature of the concerns and the fact that the Registrant's insight into her actions is limited, the Parties' agree that there remains a risk of repetition.

Insight

38. The Registrant has demonstrated some limited insight by engaging with the regulatory process and by admitting the charges. However, the Registrant has not provide any evidence that she understands fully the impact of her actions nor the effect on others or to the wider reputation of the profession. As a result, her insight into the failings can only be described as limited at best.

Remediation

39. The Registrant has not been referred to the NMC aside from the referral which led to this case. The Registrant has been subject to an interim suspension order since 20

December 2017 and as a result has not been able to practise as a registered nurse during this time. The Registrant has previously indicated that she no longer wishes to practise as a registered nurse. The Registrant has therefore not provided any evidence of remediation. However, given that the misconduct involved dishonesty and the NMC guidance (mentioned above) makes it clear that some concerns, which includes dishonesty, are very difficult to remediate, the Parties agree that the Registrant has not remedied the concerns and given her stated intention not to return to nursing, is unlikely to do so in the future. The Parties agree that the lack of remediation, the limited insight and the lack of remorse shown by the Registrant means that there is a real risk that the Registrant's misconduct would be repeated in the future..

40. In light of the Registrant's level of insight and the lack of sufficient remediation, the risk of repetition of future misconduct of the kind found in this case is high. Therefore a finding of current impairment is required on public protection grounds.

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

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

42. Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In order that members of the public have confidence to trust their and their loved ones care to nurses, it is important that Registrants follow the code of conduct and uphold the highest standards of behaviour. If a nurse fails to do this then she calls into question whether she and other members of the nursing profession can be trusted by patients. The damage this causes to the reputation of the profession is so serious that the NMC as

regulator must take action to maintain public confidence. In this case the Parties agree that the reputation of the nursing profession would be damaged if the Registrant were permitted to practise unrestricted and if a finding of current impairment were not made given the serious circumstances. Accordingly the Parties agree that a finding of impairment is required on both public protection and public interest grounds.

Sanction

43. The Parties agree that the appropriate sanction in this case is a **Striking-off Order**. In reaching this agreement, the Parties considered the current edition of the NMC Sanctions Guidance, bearing in mind that it provides guidance and not firm rules. In coming to this view, the parties have kept in mind the principle of proportionality and the principle that sanctions are not intended to be punitive. It is agreed that the proposed sanction is a proportionate one that balances the risk to public protection and the public interest with the Registrant's interests.

44. The Parties' have identified the following aggravating features:

    a) Abuse position of trust;
    b) Theft of medication Limited lack of insight into failings;
    c) Conduct which put patients at risk of suffering harm;
    d) Premediated and systemic deception;
    e) Dishonest conduct which was deliberate and occurred over a prolonged period of time;

    The Parties' have identified the following mitigating features:

    a) Some evidence of insight;
    b) No previous NMC findings

45. In considering what sanction would be appropriate the Parties began by considering whether this is a case in which it would be appropriate to take no further action. The Parties agree that this is not a suitable sanction given the serious nature of the misconduct and agree that public confidence in the profession would be damaged should no action be taken. Similarly, a caution order would not be a sufficient course of action to address the public protection concerns identified. Further, such a sanction would not be sufficient to maintain public confidence as the Registrant's action involved an abuse of her position of trust, and the guidance on seriousness confirms that there are some concerns, that are more difficult to put right and often mean that the Registrant's right to practise needs to be restricted.

46. The Parties considered the imposition of a conditions of practice order. The Parties agree that the misconduct is so serious that there are no conditions that could be properly formulated to alleviate the regulatory concerns identified. The Registrant took medication from the Trust without permission. She falsified patient records to mislead colleagues into believing that those patients had been prescribed medication which they had not. In weighing all of the information before it, the Parties agree that it could not formulate workable conditions of practice and that conditions would not satisfy the public protection and the public interest element.

47. The Parties considered whether a period of temporary removal from the register would adequately mark the Registrant's conduct. The Parties kept in mind the seriousness of the misconduct. The Registrant was in a position of privilege as a Registered Nurse. She deliberately falsified multiple patient records to conceal her dishonest act of taking medication and by virtue of doing so she placed patients at direct risk of harm as the unreliability of the records could have had a detrimental effect on patients. The Parties agree that temporary removal from the register would not be an appropriate or proportionate sanction given that the misconduct was not a one off incident but, to the contrary, was over a period of time and involved a level of planning and calculation. The Parties also agree that alongside the potential to cause harm to patients, her misconduct had the potential to seriously damage public confidence in the profession and the NMC as the regulator. The Parties agree that a

suspension order would not be adequate to mark the seriousness of the misconduct and the grave extent to which the Registrant departed from the standards to which she was expected to adhere as a member of the nursing profession.

48. The Parties therefore agree that the only appropriate and proportionate sanction is that of a striking-off order. This is the only sanction that will adequately protect the public interest and mark the importance of maintaining public confidence in the profession. It will send to the public and the profession a clear message about the standard of behaviour required of a registered nurse. The guidance makes it clear that this sanction is likely to be appropriate when what the nurse has done is fundamentally incompatible with being a registered professional. Key considerations are as follows: a) do the regularity concerns raise fundamental questions about their professionalism; b) can public confidence in nurses and midwives be maintained if the nurse or midwife is from removed from the register; and c) is striking off the only sanction which will be sufficient to protect patients, members of the public or maintain professional standards.

49. The Parties agree, having taken into account proportionality, and finding a fair balance between the nurse's rights and the overarching objective of public protection, taking into account the particular circumstances of this case, only a strike off would be the proportionate outcome. The dishonesty in this case is extremely concerning; it is premediated and long standing deception involving misuse of power and abuse of trust. The Registrant put patients at direct risk of harm and this was over a period of time and involved premediated and systematic dishonest conduct. The Registrant has indicated that she does not intend to return to nursing practice and so is unlikely to be able to remediate the concerns.

50. The NMC guidance makes it clear that a nurse or midwife who has acted dishonestly will always be at risk of being removed from the register. In particular relevance is the fact that cases concerning some offending illustrate the principle that the reputation of the professions is more important than the fortunes of any individual

member of those professions. Being a registered professional brings many benefits, but this principle is part of the 'price'. Bolton v Law Society [1994] 1 WLR 512. T.

51. Accordingly the Parties agree that for the reasons given above the Registrant's actions taken together are fundamentally incompatible with being a registered professional.

Interim Order

52. Finally, given that the Parties agree that there is a risk that patients would be placed at an unwarranted risk of harm and the public interest would be engaged should the Registrant be permitted to practise without any restrictions, the Parties agree that an interim order is necessary in this case to protect the public and is otherwise in the public interest.

53. It is agreed that the likelihood of appealing this determination is remote, given it has been reached by agreement. Furthermore, the public would not expect a nurse who had admitted the conduct which is the subject of these charges to frustrate the process by appealing the order.

54. For these reasons, the parties agree that an interim suspension order for a period of 18 months is necessary on the grounds of public protection and otherwise in the public interest. In the event no appeal is made, the interim order will fall away once the 28-day appeal period has elapsed, and the substantive order will take effect.

The Parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The Parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges set out at section 1 above, and the agreed statement of facts set out at section 2 above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.

Signed …………………………………….. Dated ……………………………………

Emma Jane Rathbone

Signed …………………………………… Dated……………………………………

(For and on behalf of the NMC)

Here ends the provisional CPD between the NMC and Miss Rathbone. The provisional agreement was signed by Miss Rathbone on 24 February 2020 and the NMC on 26 February 2020.

Decision and reasons on the consensual panel determination:

The panel decided to accept the CPD.

The panel heard and accepted the legal assessor's advice. He referred the panel to the Sanctions Guidance ("SG") published on the NMC's website and to the NMC's guidance on Consensual Panel Determinations, January 2013. He reminded the panel that they could accept, amend or outright reject the provisional agreement reached between the NMC and Miss Rathbone. Further, the panel should consider whether the provisional agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel noted that Miss Rathbone admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of admission as set out in the signed provisional agreement before the panel.

The panel then went on to consider whether Miss Rathbone's fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Miss Rathbone, the panel has exercised its own independent judgement in reaching its decision on impairment. In doing so the panel also considered the NMC bundle which contained statements from the witnesses, MAR charts and the evidence of the internal investigation. The panel was reassured by the robust nature of the internal investigation.

In respect of misconduct, the panel took account of the fact that Miss Rathbone acknowledges that she made numerous entries in the controlled drugs register, to mislead her employers into believing that she had dispensed/administered medication to a number of patients, when in fact she had not done so. Miss Rathbone had further fabricated patients' details in the controlled drugs register in order to incorrectly suggest codeine had been dispensed and administered. The panel took account of the fact that

Miss Rathbone acknowledges that she was dishonest in her actions. The panel agreed with the parties view that paragraphs 10, 13, 18 and 20 of the Code were engaged by Miss Rathbone's actions and that her conduct fell significantly below the standards expected of a Registered Nurse. In this respect the panel endorsed paragraphs 26 to 29 of the CPD in respect of misconduct.

The panel then considered whether Miss Rathbone's fitness to practise is currently impaired by reason of her misconduct. The panel determined that Miss Rathbone's fitness to practise is currently impaired. The panel considered that the admitted facts amount to Miss Rathbone putting patients at unwarranted risk of harm. Whilst there was no evidence of actual harm to patients, the panel found that Miss Rathbone's conduct in prescribing medication which was outside her scope of competence, and falsification of records to indicate medication had been administered when it had not been, were serious matters. The panel was of the view that Miss Rathbone has brought the reputation of the nursing profession into disrepute, that she has breached fundamental tenets of the profession and that she has acted dishonestly.

The panel was of the view that Miss Rathbone's failings were wide ranging and involved dishonest behaviour which was systematic, sophisticated and premeditated. It noted that dishonest behaviour is not easily remediable. The panel further noted that Miss Rathbone only recently admitted to her dishonesty which shows limited insight. At no point has she fully explained the reasons for her wrong doing. The panel was of the view that in the absence of any remediation or tangible insight, the behaviour is likely to be repeated. Therefore a finding of current impairment is required on public protection grounds. Further, the panel bore in mind that the wider public interest includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance and therefore a finding of impairment is also required on public interest grounds. In this respect the panel endorsed paragraphs 33 to 42 of the CPD agreement.

Having found Miss Rathbone'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. The purpose of any sanction is not intended to be punitive even though it may have a punitive effect. The panel had careful regard to the SG. Decision on sanction is a matter for the panel exercising its own independent judgement.

The panel took into account the following aggravating features:

- Abuse of position of trust;
- Theft of medication;
- Limited insight into failings;
- Conduct which put patients at unwarranted risk of suffering harm;
- Premeditated and systematic deception;
- Dishonest conduct which was deliberate and occurred repeatedly.

The panel also took into account the following mitigating features:

- Some evidence of insight;
- No previous NMC findings.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the serious nature of the misconduct. 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 serious nature of the misconduct, and the public protection issues identified, an order that does not restrict Miss Rathbone'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 Rathbone's misconduct was not at the lower end of the spectrum. 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 Rathbone's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular that the conditions are appropriate when there is:

- *No evidence of harmful deep-seated personality or attitudinal problems.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the failings in this case relate to dishonest behaviour, which included appropriating medication from the Clinic without permission and falsifying patient records to mislead colleagues into believing that those patients had been prescribed medication when they had not. The panel was of the view that this behaviour was not something that can be addressed through retraining. The panel was also of the view that her dishonest conduct was indicative of attitudinal concerns. The panel therefore concluded that placing conditions on Miss Rathbone's practice would not adequately address the serious nature of the concerns, would not protect the public, and the wider public interest would not be satisfied due to the serious nature of the misconduct found in this case. Nor would a conditions of practice order be appropriate where Miss Rathbone has indicated that she does not intend to return to nursing practice.

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

- 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 SG also indicates that a suspension order would be appropriate where:

- The seriousness of the case requires temporary removal from the register?

- A period of suspension would be sufficient to protect patients and the public interest?

This sanction may be appropriate where the misconduct is not fundamentally incompatible with continuing to be a registered nurse or midwife in that the public interest can be satisfied by a less severe outcome than permanent removal from the register. This is more likely to be the case when some or all 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 aggravating factors that the panel took into account, in particular are the potential harm to patients through the deliberate falsifying of multiple patient records to conceal her dishonest conduct. The panel further bore in mind that Miss Rathbone’s actions were premeditated and there was systematic deception. This behaviour was a significant departure from the standards expected of a registered nurse. The panel determined that in the absence of any evidence of remorse or significant insight, a suspension order would not be a sufficient, appropriate or proportionate sanction. In this regard, the panel endorsed paragraph 47 of the CPD.

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

Key considerations are:

- can public confidence in the professions and the NMC 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 the public interest?
- is the seriousness of the case incompatible with ongoing registration…?

This sanction is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional, which may involve any of the following factors.

- A serious departure from the relevant professional standards as set out in key standards, guidance and advice.
- Doing harm to others or behaving in such a way that could foreseeably result in harm to others, particularly patients or other people the nurse or midwife comes into contact with in a professional capacity. Harm is relevant to this question whether it was caused deliberately, recklessly, negligently or through incompetence, particularly where there is a continuing risk to patients. Harm may include physical, emotional and financial harm. The seriousness of the harm should always be considered.
- Abuse of position, abuse of trust, or violation of the rights of patients, particularly in relation to vulnerable patients.
- …
- …
- Dishonesty, especially where persistent or covered up.
- Persistent lack of insight into seriousness of actions or consequences.
- …

The panel considered that Miss Rathbone's misconduct was a serious departure from the relevant professional standards. Miss Rathbone had abused her position of trust in a number of ways, which required a level of planning and calculation. The panel bore in mind that her misconduct was a premeditated and repeated deception which involved misuse of her power and abuse of trust. Miss Rathbone put patients at direct risk of harm and did so systematically.

The panel bore in mind Miss Rathbone's indication of not intending to return to nursing practice. It was therefore of the view that Miss Rathbone will therefore not be able to remedy any of the concerns identified.

Being a registered nurse requires not only clinical skills but also a demonstration of the values of the nursing profession and the ability to reflect and act accordingly as a result. Miss Rathbone's behaviour fell far below the standards expected of a registered nurse and raised fundamental questions about her suitability to be a registered nurse. The panel concluded that Miss Rathbone's misconduct and limited insight are so serious as to be fundamentally incompatible with ongoing registration. It considered that a member of the public would be appalled if a nurse who had demonstrated such a serious breach of the fundamental tenets of the profession, and a lack of insight or remediation, were allowed to remain on the register.

Balancing all of these factors and after taking into account all the information before it, 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, her dishonest conduct and the effect of her actions in bringing the profession into disrepute, the panel has concluded that nothing short of this sanction 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.

Decision and reasons on 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 Rathbone's own interest until the striking-off order takes effect. The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the misconduct in this case. The panel agreed with the CPD that given the parties agree that there is a risk that patients would be placed at an unwarranted risk of harm and the public interest would be engaged should Miss Rathbone appeal this decision without there being the protection of an interim order. The panel bore in mind that the likelihood of Miss Rathbone appealing this decision is low, given the CPD agreement. However, due to the reasons already identified in the panel's determination for imposing the substantive order, the panel concluded that an interim suspension order for a period of 18 months should be imposed.

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

That concludes this determination.