Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

22 – 29 January 2020

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

Name of registrant:	Yvonne Rose Williams
NMC PIN:	01J0757E
Part(s) of the register:	Nursing, Sub Part 1 Registered Nurse – Adult (30 November 2004)
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Kenneth Caley (Chair, Lay member) Anita Underwood (Registrant member) Anne Phillimore (Lay member)
Legal Assessor:	Gelaga King
Panel Secretary:	Edmund Wylde
Yvonne Rose Williams:	Not present and not represented in her absence
Nursing and Midwifery Council:	Represented by Laura Paisley, counsel, instructed by NMC Case Preparation and Presentation Team
Facts proved:	1, 2(a), 2(b), 2(c), 3, 4(a), 4(b), 4(c), 6, 7, 8
Facts not proved:	5
Fitness to practise:	Impaired
Sanction:	Striking-Off Order
Interim Order:	Interim Suspension Order (18 months)

Details of charge:

That you, a registered nurse, on the night shift of 30-31 January 2018:

1) *At around 19:30, after a NEWS of 4, did not increase Patient A's observations.* **[PROVED]**

2) *At 22:50;*
   a) *Did not escalate Patient A to a doctor when her blood pressure was low.* **[PROVED]**
   b) *Did not complete Patient A's National Early Warning Score ("NEWS").* **[PROVED]**
   c) *Did not ask a doctor or another nurse on the ward to connect up a prescribed intravenous ("IV") blood transfusion for Patient A.* **[PROVED]**

3) *At 23:30 did not complete Patient A's NEWS.* **[PROVED]**

4) *At 00:30;*
   a) *Did not escalate Patient A to a doctor when her blood pressure was low and/or her heart rate was over 100* **[PROVED]**
   b) *Did not complete Patient A's NEWS.* **[PROVED]**
   c) *Did not ask a doctor or another nurse on the ward to connect up a prescribed IV blood transfusion for Patient A.* **[PROVED]**

5) *Did not administer prescribed Omeprazole to Patient A.* **[NOT PROVED]**

6) *Did not record any clinical justification for administering fluids instead of blood at 23:45 and/or 00:30.* **[PROVED]**

7) *Did not maintain an adequate record of the care provided to Patient A between 19:30 and 01:30.* **[PROVED]**

8) *Your conduct in Charges 1 and/or 2(a) and/or 2(b) and/or 2(c) and/or 3 and/or 4(a) and/or 4(b) and/or 4(c), above, contributed to a loss of chance of survival for Patient A.* **[PROVED]**

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

Decision on Service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Williams was not in attendance and that written notice of this hearing had been sent to her registered address by recorded delivery and by first class post on 16 December 2019. Notice of this hearing was collected and signed for in the name of "WILLIAMS" on 3 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 Williams' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Ms Paisley, on behalf of the NMC, 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 Williams 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 Williams.

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 Paisley invited the panel to proceed despite the absence of Miss Williams, on the basis that she had voluntarily absented herself. She drew the panel's attention to the correspondence between Miss Williams and the relevant NMC Case Officer, and in particular the note of a telephone call dated 16 December 2019, which states:

> [Miss Williams] *called to confirm that she will not be attending the hearing. I asked if there was any written representations that she wanted to submit to the panel for consideration and she said no.*
>
> *I asked if she was happy for the hearing to proceed in her absence and she said yes.*

Ms Paisley submitted that no adjournment of this hearing has been sought by Miss Williams, and that there is no suggestion that an adjournment will secure Miss Williams'

attendance. Ms Paisley reminded the panel of the public interest in an expeditious disposal of this 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 further noted the case of *R (on the application of Raheem) v Nursing and Midwifery Council [2010] EWHC 2549 (Admin)* and the ruling of Mr Justice Holman that:

> *"...reference by committees or tribunals such as this, or indeed judges, to exercising the discretion to proceed in the person's absence "with the utmost caution" is much more than mere lip service to a phrase used by Lord Bingham of Cornhill. If it is the law that in this sort of situation a committee or tribunal should exercise its discretion "with the utmost care and caution", it is extremely important that the committee or tribunal in question demonstrates by its language (even though, of course, it need not use those precise words) that it appreciates that the discretion which it is exercising is one that requires to be exercised with that degree of care and caution."*

The panel took into account the fact that Miss Williams has not responded to any of the email correspondence sent by the NMC, nor has she returned her Case Management Form. It bore in mind the contents of the telephone note dated 16 December 2019, as stated above.

The panel decided to proceed in the absence of Miss Williams. 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 also had regard to the overall interests of justice and fairness to all parties. It bore in mind that:

- It is clear from the telephone call, of 16 December 2019, that Miss Williams is aware of this hearing, and has chosen not to attend nor make representations in her absence;
- no application for an adjournment has been made by Miss Williams;
- there is no reason to suppose that adjourning would secure her attendance at some future date;
- two witnesses have attended today to give live evidence, and another is due to attend;
- not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- there is a strong public interest in the expeditious disposal of the case, particularly in the light of the serious nature of the charges.

There is some disadvantage to Miss Williams in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgment, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Williams' decision to absent herself from the hearing, waive her rights to attend and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Miss Williams, reserving the right to revisit this decision if circumstances within the case substantially change. The panel will draw no adverse inference from Miss Williams' absence in its findings of fact.

Background

The charges in this case arise from the events of one night shift (30/31 January 2018) on the Frome Ward (“the Ward”), an admissions ward, at Hereford County Hospital (“the Hospital”) within Wye Valley NHS Trust (“the Trust”).

Patient A had previously been admitted to Accident & Emergency with a gastric bleed from an ulcer, after an episode of meleana and hematemesis. She was operated upon and the bleeding was stopped. Post-operatively, Patient A was transferred to the Ward at around 19:30 and into the care of Miss Williams, who would have just begun her shift, in her capacity as an agency nurse.

It is alleged that, over the course of that night shift, Miss Williams failed in her duties to undertake full and proper observations of Patient A, and further failed to escalate serious warning signs in respect of Patient A. Patient A died at 04:53 on 31 January 2018. It is alleged that, had Patient A’s worsening condition been escalated to the appropriate doctors, Patient A would have had a reasonable chance of survival; Miss Williams’ actions allegedly contributed to a loss of chance of survival for Patient A.

Decision on exercise of panel's discretionary powers, as per *Ruscillo v CHRE* [2004] EWCA Civ 1356 and *Professional Standards Authority for Health and Social Care v Nursing and Midwifery Council & Jozi* [2015] EWHC 764 (Admin), and on subsequent applications

On Thursday 23 January 2020, the panel considered whether it was appropriate for it to exercise its discretionary power as laid out in the cases of *Ruscillo* and *Jozi*, in respect of obtaining witness statements from Dr 1 and Dr 2, who were on duty at the relevant time and have been repeatedly referred to in the witness evidence heard so far. The panel has no direct information from either Dr 1 or Dr 2 before it at this time.

The panel accepted the advice of the legal assessor.

The panel considered that fairness requires that Miss Williams, and the panel, have all the relevant evidence in this case available. It reminded itself of the seriousness of the charges against Miss Williams, and bore in mind the interests of fairness to an absent registrant and the public interest in a fair and expeditious disposal of this case. The panel determined that it must have the best, most complete, and rigorously tested evidence before it in respect of these charges.

In the circumstances of this case, the panel determined that it is necessary to request the NMC to obtain statements from Dr 1 and Dr 2, and discover whether they would be available to give live evidence. It also requested that Ms Paisley make enquiries as to whether there was more than one observation chart for Patient A, as Miss Williams has previously asserted in the documentation before it. This case will adjourn until 12:30 on 24 January 2020 for such enquiries to have been concluded, for any information arising from them to have been communicated to Miss Williams, and for any response from Miss Williams to have been obtained.

The hearing resumed at 12:30 on 24 January 2020. The panel was informed by Ms Paisley that Ms 3 (the first live NMC witness) had reviewed Patient A's medical records and confirmed via email that only one observation chart for Patient A existed. Dr 2 had

not responded to attempts to contact him. Dr 1 had provided a statement for the panel's consideration, which had also been sent to Miss Williams via email; no response had been received from Miss Williams in respect of this. Ms Paisley informed the panel that Dr 1 was working on-call for all of the days remaining scheduled for this hearing.

The panel considered the statement provided by Dr 1, and requested a further statement from him, specifically addressing whether the handwriting on the relevant prescription chart was his; it also directed the NMC to enquire whether Dr 1 would be available at any stage to give evidence over the telephone. The panel further requested that the NMC to continue in its attempts to contact Dr 2. The hearing was adjourned until 09:30 on 27 January 2020, for such actions to be undertaken.

The hearing resumed at 08:30 on 27 January 2020. The panel were informed by Ms Paisley that attempts to contact both Dr 2 and Miss Williams had been wholly unsuccessful. However, Dr 1 had provided a supplementary statement and was available to give evidence over the telephone from 13:00.

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To this effect, Ms Paisley made an application to hear the evidence of Dr 1 over the telephone. She submitted that the evidence he can give is clearly relevant to the charges in this case, and that it would be fair for his evidence to be heard in such a fashion; Miss Williams has had opportunity to respond to his statements, although she has not done so, and Dr 1's evidence can be appropriately tested through questioning by the legal assessor and the panel.

The panel accepted the advice of the legal assessor.

The panel considered that Dr 1's evidence is highly relevant to a number of the charges in this case. It determined that it was fair to hear the evidence of Dr 1 over the telephone; Dr 1 is not available to attend the hearing centre in person, as he is on-call,

and evidence over the telephone is the best possible evidence that this panel can hear in the circumstances of these proceedings. The panel reminded itself that Dr 1's evidence will be given under oath and may be tested by questioning.

The panel bore in mind that Miss Williams has made untested representations within the documentation before the panel; Dr 1's statements provide competing representations, and, were they to be solely relied on as hearsay evidence, would likewise be untested. The panel considered that, if it is possible, it is in the interests of justice for evidence to be tested through questioning; by hearing Dr 1's evidence over the telephone, it is possible to so test his evidence. Furthermore that evidence would be given under oath.

The panel therefore determined that it is fair and in the interests of justice to hear the evidence of Dr 1 over the telephone.

Upon the conclusion of Dr 1's evidence over the telephone, Ms Paisley reminded the panel that all of the live evidence which comprises the NMC case had been heard. She made an application for the email from Ms 3, confirming her review of Patient A's medical records and that there was only one observation chart contained therein. She submitted that this evidence was relevant to the matters at issue in this hearing, and that it was fair to admit it as hearsay evidence in the circumstances of the case.

The panel accepted the advice of the legal assessor.

The panel determined that the information within the email from Ms 3 was relevant to the case. It further determined that it was fair to admit this evidence as hearsay; the panel have previously heard live evidence from Ms 3 and had the opportunity to assess her credibility, and the information contained within the email relates to a narrow and discrete area of evidence, which is not sole and decisive in relation to any of the charges.

Ms 3’s email was therefore admitted as hearsay evidence. The panel will attach appropriate weight to it in the course of its deliberations on the charges.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel considered all the evidence in this case together with the submissions made by Ms Paisley, on behalf of the NMC. Ms Williams provided no submissions for consideration in her absence.

The panel accepted the advice of the legal assessor.

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

The panel has drawn no adverse inference from the non-attendance of Miss Williams.

The panel heard oral evidence from four witnesses tendered on behalf of the NMC.

Witnesses called on behalf of the NMC, and their job titles at the relevant time, were (in chronological order):

Ms 3 – *Ward Sister at the Hospital* [now Matron]*;*
Dr 4 – *Consultant Gastroenterologist at the Trust*;
Ms 5 – *Nurse in Charge of the Ward*; and
Dr 1 – *Foundation Year 1 Doctor at the Trust*.

The panel first considered the overall credibility and reliability of all of the witnesses it had heard from.

The panel considered Ms 3 to be a credible and reliable witness. It noted that she was not Matron at the time of the incident, but instead provided an account of the processes and procedures on the Ward and the expectations of the Trust. The panel bore in mind

that her evidence was entirely based on hearsay; however, she was able to assist the panel as regards hospital procedure and had a good understanding of the documentation before the panel. Ms 3 gave the panel confidence in her professional competence and was an important witness in providing context to the charges.

Dr 4 was a credible, reliable, and convincing witness who assisted the panel to the best of his ability. He had a clear and succinct overview of the incident and understood what should have happened, what did not happen, and why Patient A's circumstances unfolded as they did. He gave the panel confidence that he had a strong understanding of the documentary evidence involved in the case and the implications arising therefrom.

Ms 5's evidence was vague, contradictory, inconsistent, and unconvincing; she could not recall salient information, and, in answer to panel questioning, at one point confirmed that she had been told of Patient A's low blood pressure but subsequently asserted that she had not. Her evidence did not add value to the panel's evaluation of the facts, and the panel could not consider her to be either a credible or reliable witness.

The panel bore in mind that Dr 1 was not initially called by the NMC, but gave evidence at short notice voluntarily over the telephone. He answered questions clearly, explaining his position straightforwardly. He was a credible and reliable witness, in the panel's view.

The panel considered each charge and made the following findings:

Charge 1:

1. At around 19:30, after a NEWS of 4, did not increase Patient A's observations.

This charge is found proved.

The panel bore in mind that Patient A's care plan noted that Patient A was required to be observed for bleeding, and also took into account the evidence of Ms 3; namely, that the NEWS is not taken in isolation, but considered in relation to the patient's specific history and, in this case, the patient's deteriorating blood pressure.

It is clear from the documentary evidence before the panel that a NEWS of 4 was obtained from Patient A at around 19.30; there is no indication from any other evidence, either documentary or witness, that observations were increased thereafter.

The panel therefore found the charge to be proved.

Charge 2:

2. *At 22:50*

Charge 2(a):

a. *Did not escalate Patient A to a doctor when her blood pressure was low.*

This charge is found proved.

The panel considered all of the relevant evidence before it. In her written accounts, Miss Williams states that she "bleeped the on-call doctor and escalated [Patient A] to him" and that she "escalated my concerns about the patient to the nurse in charge and to the on-call Doctor who also came up to review the patient". Ms Williams does not indicate at what time she escalated Patient A to the on-call doctor at any stage in her written accounts.

Dr 1, the on-call doctor, in his live evidence stated that he does not remember Miss Williams contacting him during the night in question. He was clear that, if he had been contacted about Patient A's blood pressure being as low as it was (namely, 56/43), he

would have escalated the matter as a peri-arrest call. Dr 1 was clear that he did not recall discussing Patient A with Miss Williams at all.

Dr 4, in his oral evidence, told the panel that he had spoken to Dr 1 and Dr 2, who both told him at the time of his investigation that they had not been contacted by Miss Williams in relation to Patient A on the night in question. Dr 4 also told the panel that Dr 2's shift was due to end at 21:00, when medical staff changed over.

Dr 4 told the panel that he would expect a first-year medical student to know that a drop in blood pressure similar to that experienced by Patient A would necessitate prompt and urgent escalation. He said that he had never seen blood pressure that low "in a living person".

The evidence of Ms 5 on this point was initially that Patient A's low blood pressure was brought to her attention by Miss Williams, who she told to escalate the matter to a doctor; Ms 5 told the panel that she did not see Miss Williams escalate Patient A's low blood pressure to a doctor herself. However, later in her oral evidence, Ms 5 indicated that Miss Williams did not escalate Patient A's low blood pressure to her at all. The panel could not therefore rely on the evidence of Ms 5 on this issue as credible, due to its inconsistency.

The panel considered the relevant fluid prescription chart, where it is indicated that fluids are prescribed to begin being administered at 23:45 on 30 January 2018; this prescription is signed "FY1". The panel heard evidence from Dr 1 that, in his experience, no doctor would sign such a chart as FY1, which is in effect an anonymous signature indicating that a first-year doctor signed the chart, and that it is within a doctor's clinical training that they are told to sign and note their "bleep" number on such charts. Dr 4's evidence corroborated this point. The panel noted that all earlier entries on the relevant fluid prescription chart are marked with a doctor's signature. The panel has heard evidence from Dr 4 that, in Patient A's circumstances, an appropriate prescription would not be for fluids but for bloods.

Taking this into account, the panel considered that the entirely anonymous signature on the prescription chart does not, of itself, lead to the conclusion that whoever signed the chart was informed of Patient A's low blood pressure. The point therefore, while worthy of recognition, does not in itself go to the charge.

On this charge, therefore, the panel preferred the evidence of Dr 1 and Dr 4, tested through questioning by the panel, the case presenter, and the legal assessor, to the untested hearsay account of Miss Williams. The panel therefore found the charge to be proved.

Charge 2(b):

b. Did not complete Patient A's National Early Warning Score ("NEWS")

This charge is found proved.

The panel considered it to be clear from the documentary evidence before it that there is no information to suggest that a NEWS was completed at 22:50; no such score is recorded anywhere on the observation chart. The panel also bore in mind the evidence of Ms 3 that, having reviewed Patient A's medical records, there was only one observation chart for this patient.

The panel reminded itself of the evidence of Ms 3 and Dr 4, who having reviewed the documentation, considered that there was no information to suggest that a NEWS was completed at the relevant time. Having carefully reviewed all of the evidence before it, the panel came to the same conclusion.

The panel therefore found the charge to be proved.

Charge 2(c):

c. *Did not ask a doctor or another nurse on the ward to connect up a prescribed intravenous ("IV") blood transfusion for Patient A.*

This charge is found proved.

The panel heard evidence from Dr 4 that a blood transfusion had been prescribed for Patient A at approximately 20:30 on 30 January 2018. Ms 3 told the panel that it was Trust policy that an agency nurse, such as Miss Williams, was not permitted to connect up blood transfusions herself, as she had not been appropriately trained in Trust policy; she would have been required to ask for appropriate assistance.

On the evidence before the panel, there is nothing to suggest that the prescribed blood transfusion was administered throughout the evening of 30 January 2018; the first recording of blood being administered is at approximately 01:50 on 31 January 2018. Ms 3, having reviewed Patient A's medical notes, stated in her evidence that there was no information within the records to suggest that a nurse or doctor was asked to set up an IV blood transfusion for Patient A on 30 January 2018. Having carefully considered all of the evidence before it, the panel could not find any information to cause it to come to a different conclusion.

The panel therefore found the charge to be proved.

Charge 3:

3. At 23:30 did not complete Patient A's NEWS

This charge is found proved.

There is no information before the panel within the documentary evidence to suggest that a NEWS was completed at 23:30; no such score is recorded anywhere on the

observation chart. The panel also bore in mind the evidence of Ms 3 that, having reviewed Patient A’s medical records, there was only one observation chart for this patient.

The panel reminded itself of the evidence of Ms 3 and Dr 4, who having reviewed the documentation, considered that there was no information to suggest that a NEWS was completed at the relevant time. Having carefully reviewed all of the evidence before it, the panel came to the same conclusion.

The panel therefore found the charge to be proved.

Charge 4:

4. *At 00:30*

Charge 4(a):

a. *Did not escalate Patient A to a doctor when her blood pressure was low and/or her heart rate was over 100*

This charge is found proved.

The panel noted that the information in respect of this charge is almost entirely congruent to that in respect of charge 2(a); the primary difference is within the stem of the charge, namely the time at which it is alleged that Miss Williams did not escalate Patient A to a doctor.

The panel considered this charge separately to charge 2(a), but concluded that its observations and determination in respect of charge 2(a) apply equally; it preferred the live and tested evidence of Dr 1 and Dr 4, to the effect that Patient A was not escalated

to a doctor throughout the evening of 30 January 2018, to the untested hearsay evidence of Miss Williams.

The panel therefore found the charge to be proved.

Charge 4(b):

b. Did not complete Patient A's NEWS

This charge is found proved.

There is no information before the panel within the documentary evidence to suggest that a NEWS was completed at 00:30; no such score is recorded anywhere on the observation chart. The panel also bore in mind the evidence of Ms 3 that, having reviewed Patient A's medical records, there was only one observation chart for this patient.

The panel reminded itself of the evidence of Ms 3 and Dr 4, who having reviewed the documentation, considered that there was no information to suggest that a NEWS was completed at the relevant time. Having carefully reviewed all of the evidence before it, the panel came to the same conclusion.

The panel therefore found the charge to be proved.

Charge 4(c):

c. Did not ask a doctor or another nurse on the ward to connect up a prescribed IV blood transfusion for Patient A.

This charge is found proved.

The panel noted that the information in respect of this charge is almost entirely congruent to that in respect of charge 2(c); the primary difference is within the stem of the charge, namely the time at which it is alleged that Miss Williams did not ask a doctor or another nurse on the ward to connect up a prescribed IV blood transfusion for Patient A.

The panel considered this charge separately to charge 2(c), but concluded that its observations and determination in respect of charge 2(c) apply equally; there is no evidence before this panel to suggest that the prescribed blood transfusion was administered to Patient A, prior to approximately 01:50 on 31 January 2018.

The panel therefore found the charge to be proved.

Charge 5:

5. Did not administer prescribed Omeprazole to Patient A

This charge is found not proved.

The panel heard little evidence in relation to the administration of Omeprazole; it appears to have been prescribed on a separate page to the other relevant medications, as an infusion therapy, and on 31 January 2020 – that is, after the event. The panel considered that the evidence in relation to this charge was unclear and confusing. It concluded that the NMC have not discharged the burden of proof to the panel’s satisfaction, namely that it is more likely that Miss Williams did not administer prescribed Omeprazole to Patient A.

The panel therefore found this charge not to be proved.

Charge 6:

6. Did not record any clinical justification for administering fluids instead of blood at 23:45 and/or 00:30.

This charge is found proved.

The panel bore in mind that, on Patient A's "Nursing Evaluation/Communication/ Continuation Sheet", Miss Williams has recorded an account, timed at 23:30, which states

> *2 x units of blood prescribed but not given as yet as pts blood pressure has dropped to 54 systolic. Fluid challenge given of bolus 250 m/s N/S and BP rechecked now 56/43.*

Ms 3 and Dr 4, having reviewed the medical notes for Patient A, confirmed to the panel in their oral evidence that they considered that Miss Williams failed to record within Patient A's notes any reasoning behind her decision to administer fluids only.

Ms 3 further indicated that there was no valid reasoning behind Miss Williams' decision to administer fluids instead of blood because of Patient A's blood pressure being low; this is nowhere within the Trust's Blood Transfusion Policy. Ms 3 told the panel that, in these circumstances, the "number one priority was blood". Dr 4 told the panel that, in such circumstances, it would be inappropriate for a doctor to prescribe fluids only, and that a blood transfusion was required. The panel reminded itself of Dr 4's evidence that he had never seen a blood pressure this low "in a living person". The panel had sight of the Trust's Blood Transfusion Policy.

A simple account of events, which is not clinically justified, is not a clinical justification. According to Ms 3 and Dr 4, Miss Williams' account on the Nursing Evaluation Sheet is clinically incoherent, and so does not amount to a "clinical justification" in the accepted sense. It does not, on the evidence before the panel, stand up to scrutiny.

The panel therefore found the charge to be proved.

Charge 7:

7. Did not maintain an adequate record of the care provided to Patient A between 19:30 and 01:30.

This charge is found proved.

In Miss Williams's second written account, she appears to admit this charge, stating under the heading "Nothing documented in medical notes" that: "[u]nfortunately this is correct".

The panel nonetheless considered all of the evidence before it. It had sight of the relevant observation chart; the observations recorded at 19:35 do not note accurately Patient A's temperature or heart rate. However, aside from a number of blood pressure readings, and two dots (which the panel heard may indicate a heart rate of between 100 and 110), there are no other essential readings for Patient A recorded for the time after 19:35 and before 01:30; the final (incomplete) set of observations is recorded at 00:30. The panel heard from Ms 3 that the requisite essential readings should have been respiratory rate, oxygen saturation levels, blood pressure, temperature, heart rate, and level of consciousness. The panel accepted the evidence of Dr 4 and Ms 3, in that what was recorded was a wholly inadequate record of the care provided to Patient A.

The panel therefore found the charge to be proved.

Charge 8:

8. Your conduct in Charges 1 and/or 2(a) and/or 2(b) and/or 2(c) and/or 3 and/or 4(a) and/or 4(b) and/or 4(c), above, contributed to a loss of chance of survival for Patient A.

This charge is found proved.

The panel noted that it has found all of the charges within charge 8 to be proved on the balance of probabilities. The conduct alleged in charges 2(a) and 4(a) is analogous, in that it relates to the escalation of Patient A to a doctor when her blood pressure was low; as is the conduct alleged in charges 2(b), 3, and 4(b), in that it relates to the completion of Patient A's NEWS; as is the conduct alleged in charges 2(c) and 4(c), in that it relates to Miss Williams not asking a doctor or nurse to connect up a prescribed IV blood transfusion.

In respect of charge 1, the panel heard evidence from Ms 3 that the purpose of NEWS is to be an "early warning" score. The panel considered that, had Patient A's observations increased following a NEWS of 4, a competent nurse would have observed that the patient's condition was deteriorating. Furthermore, the mere fact of having to write down these observations would act as a trigger for a competent nurse to escalate matters in the face of such deterioration.

As regards charges 2(a) and 4(a), the panel reminded itself of the evidence of Dr 1 and Dr 4 that such a low blood pressure as Patient A's would prompt an urgent medical escalation and further review. Dr 4 described this matter as a "potentially survivable" incident, had there been earlier intervention in the care of Patient A.

In respect of charges 2(b), 3, and 4(b), the panel reminded itself of the evidence of Ms 3, namely that the purpose of an observation chart is as a communication tool so that any other nurse or medical professional has a clearer picture of the patient's condition. Ms 3 told the panel that, had NEWS been recorded throughout the evening of 30 January 2018, it is likely that they would have been higher than a NEWS of 4; this would have prompted further medical intervention. The panel reminded itself of the NEWS score guidelines provided to it.

As regards charges 2(c) and 4(c), it was the evidence of Ms 3 and Dr 4 that, in the circumstances of Patient A, a blood transfusion was a critical course of action to be undertaken. The panel reminded itself of its finding that there is no evidence that Miss Williams asked a doctor or another nurse to connect up a prescribed IV blood transfusion for Patient A throughout the evening of 30 January 2018.

The panel had sight of Dr 4's Serious Incident Report, which concluded that:

> *Patient A had a potentially survivable upper GI haemorrhage. Initial treatment appeared to be successful but at some point, probably around the time of transfer from A&E she started to re-bleed. Failure to escalate on severe hypotension or increase frequency of observation combined with a decision not to give a prescribed transfusion… contributed to a cardiac arrest from which she never recovered.*

The panel also heard Dr 4 repeat and volunteer this information under oath. It noted that it was not bound by his conclusion. However, the panel accepted the evidence of Dr 4. It has heard no other evidence in the course of this hearing to contradict that conclusion.

The panel therefore found the charge to be proved.

Submission on misconduct and impairment:

Having announced its finding on all the facts, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Williams' fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

In her submissions, Ms Paisley invited the panel to take the view that Miss Williams' actions amount to a breach of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) ("the Code"). She then directed the panel to specific paragraphs and identified where, in the NMC's view, Ms Williams' actions amounted to misconduct.

Ms Paisley referred the panel to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Paisley reminded the panel of its findings at the facts stage. She submitted that the most serious charge found proven in this case is undoubtedly charge 8. Miss Williams' conduct over the course of this shift contributed to the loss of chance of survival for Patient A; Patient A may have lived had Miss Williams undertaken her duties properly, in line with the Code. Ms Paisley submitted that this is one of the most serious allegations that can be brought against a registrant.

As regards charge 1, Ms Paisley submitted this is a serious failing. Patient A was a high risk patient when she entered into the care of Miss Williams. By failing to increase observations, Miss Williams prevented herself the opportunity from highlighting a deterioration in Patient A's condition. Ms Paisley invited the panel to consider that, had observations been increased, this would surely have brought Miss Williams' (or

another's) attention to the fact that Patient A became critically ill over the course of the evening and needed immediate intervention.

In respect of Miss Williams' A failure to escalate low blood pressure, Ms Paisley reminded the panel of the evidence heard from Dr 1, Ms 3 and Dr 4 is that Patient A's blood pressure was so low that immediate intervention was necessary, and that it should have been escalated as a peri-arrest call. She submitted that all the NMC witnesses gave evidence that someone in Miss Williams' position would have been expected to be well aware of the meaning of such a low result. Dr 4 said he had never seen a blood pressure so low "in a living person," and would have expected even a first year medical student to appreciate the gravity of this situation. Ms Paisley invited the panel to consider the fact that Miss Williams did not escalate the blood pressure results at either 22.50 or 23:30 is of serious concern. She submitted that there are a number of possible reasons for this and the panel should not speculate on such matters, but the NMC's position is that this lack of action cannot possibly be justified with any explanation.

Ms Paisley submitted that NEWS was developed to standardize the approach to detection of clinical deterioration in acutely ill patients; the fact that Miss Williams failed to undertake this task in its entirety whilst the patient was under her care is incomprehensible.

Ms Paisley submitted that there is simply *no* clinical justification for the Miss Williams inaction in asking another appropriate member of staff to connect up a prescribed blood transfusion. She invited the panel to consider that the clinical evidence before it is clear that a blood transfusion was absolutely necessary for Patient A, and not only that, it had actually already been prescribed; Miss Williams just did not administer it. Ms Paisley submitted that Miss Williams' attempts at justifying her actions are completely at odds with the medical evidence given by the other witnesses.

Ms Paisley further submitted that Ms Williams' actions as proven fell far short of what would be expected of a registered nurse; colleagues would expect that they could rely upon their other colleagues to deliver safe and effective care, including ensuring that a patient in the same clinical situation as Patient A was properly and effectively cared for. This includes close monitoring, escalation, and awareness of the seriousness of the situation.

Ms Paisley invited the panel to consider that the public would expect that the profession would properly care for friends, relatives and members of the public; they would expect nurses to uphold a professional reputation; and that they would expect that a registrant would do all they could to preserve life – and not to contribute to a loss of chance of survival.

Ms Paisley then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Ms Paisley referred the panel to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

Ms Paisley submitted that Miss Williams' current fitness to practise is unequivocally impaired, and that the first three limbs of the *Grant* "test" are engaged. She invited the panel to consider that Miss Williams made repeated errors over a shift that ultimately ended up in a patient losing their chance at survival; early intervention may well have saved Patient A's life, and Miss Williams' inactions prevented this.

Ms Paisley submitted that the behaviour of Miss Williams as found proven plainly brings the profession into disrepute; it was a wholly unsatisfactory level of care, and both "frightening and deeply concerning." Ms Paisley also submitted that Ms Williams has plainly breached fundamental tenants of the profession by failing in numerous areas of the Code of Conduct.

Ms Paisley submitted that there is exceptionally limited evidence upon which the panel could conclude that there has been any kind of insight, acceptance or remorse. She submitted that there is nothing before the panel that could convince it that Miss Williams is not at risk of repeating this behaviour, were she to continue to practise unrestricted. Ms Paisley submitted that the panel have absolutely no evidence of reflection upon the seriousness of these feelings, and reminded the panel of its finding that Miss Williams' version of events did not stand up to scrutiny. Miss Paisley concluded her submissions by inviting the panel to consider that it should be "very worried", in these circumstances, about the risk of repetition.

Ms Williams has provided no written representations for consideration in her absence.

The panel accepted the advice of the legal assessor.

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

Decision on misconduct

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) (the Code).

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services, and

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

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13 Recognise and work within the limits of your competence

To achieve this, you must:

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

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise, and if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that, both individually and cumulatively, the charges found proved in Miss Williams' case amounted to misconduct.

In considering the issue of misconduct, the panel had concerns around a number of aspects of Patient A's care; however, it considered that none of these external factors absolve Miss Williams from her responsibilities as a registered nurse.

In respect of charge 1, the panel bore in mind its earlier finding that Miss Williams' actions as charged here contributed to a loss of chance of survival for Patient A. It considered that, on Miss Williams' own account, she appeared to be aware to a degree of the potential seriousness of Patient A's condition at the handover. In accepting responsibility for a patient, it is expected that an appropriate level of observation is undertaken; Miss Williams could have instructed a Healthcare Assistant to undertake such observations, or to have done them herself – neither of which she did. Whilst the panel have concerns generally about the quality of the documentation put in evidence, and record-keeping, Miss Williams nevertheless did not fulfil her responsibilities as a registered nurse, and the panel considered that her actions in respect of this charge fell far short of the standards expected of a registered nurse and amounted to misconduct.

As regards charges 2(a) and 4(a), whose mischief are analogous in nature, the panel reminded itself of the evidence of Dr 1 and Dr 4. It considered that not escalating such a seriously low patient blood pressure to a doctor is clearly serious professional misconduct, of remarkable significance and severity. The panel considered that Miss Williams' actions in respect of these charges fell far short of the standards expected of a registered nurse and amounted to misconduct.

In respect of charges 2(b), 3, and 4(b), whose mischief are analogous in nature, the panel reminded itself of the evidence of Ms 3, who told the panel that the purpose of NEWS is to identify deterioration within a patient. Not only did Miss Williams not complete Patient A's NEWS, but there is also no evidence that she undertook any other steps to monitor Patient A throughout the evening of 30 January 2018. The panel considered that, for only one of these charges to have been proved would have amounted to misconduct but, as Miss Williams continued not to complete NEWS for Patient A throughout the evening, in worsening circumstances, her actions became

more serious – in a “snowball” effect. The panel considered that Miss Williams’ actions in respect of these charges fell far short of the standards expected of a registered nurse and amounted to misconduct.

As regards charges 2(c) and 4(c), whose mischief are analogous in nature, the panel reminded itself of the evidence of Ms 3 and Dr 4, who told the panel that blood transfusion was the critical course of action, essential in Patient A’s circumstances. In Miss Williams’ account, she indicates that she was not aware of the Trust’s blood transfusion policy, which states that agency nurses were not permitted to transfuse blood; the panel did not consider that this detracted from the severity of her actions, as she did not attempt to administer the blood transfusion herself either. Even were Miss Williams aware that she was not permitted to administer a blood transfusion, there was a roving nurse-in-charge who she could have deferred to on this issue. The panel considered that Miss Williams’ actions in respect of these charges fell far short of the standards expected of a registered nurse and amounted to misconduct.

In respect of charges 6 and 7, whose mischief are analogous in nature, the panel bore in mind that record-keeping and adequate documentation are essential responsibilities of a registered nurse; they are the bedrock of the nursing profession, as patient records determine a patient’s subsequent period of care and treatment from other professionals. The panel considered that Miss Williams’ actions in respect of these charges fell far short of the standards expected of a registered nurse and amounted to misconduct.

As regards charge 8, the most serious of the charges, the panel considered that Miss Williams’ actions were remarkable, in just how far they fell below the standard expected of registered nurse. Her conduct was simply deplorable, and the panel had no doubt that it would be recognised as such in the eyes of fellow professionals.

The panel considered that each of the charges found proved amounted to misconduct, and therefore, taken cumulatively, Miss Williams’ actions also amounted to misconduct.

Decision on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the panel considered the judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) in reaching its decision, in paragraph 74 she said:

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

Mrs Justice Cox went on to say in Paragraph 76:

> *I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from* Shipman*, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my*

view the test would be equally applicable to other practitioners governed by different regulatory schemes.

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

The panel found that the first three limbs of the *Grant* "test" were engaged in this case. Miss Williams' actions clearly put Patient A at an unwarranted risk of harm in the past, brought the nursing profession into disrepute, and breached fundamental tenets of the nursing profession – relating to adequate patient care.

The panel noted that Miss Williams has not engaged with the NMC in relation to this regulatory process, despite repeated attempts to contact her to ascertain if there was any material she wished to put before the panel for its consideration. Miss Williams has apparently made the conscious decision that there is no such material she wishes to provide. As such, the panel has no evidence of remediation, relevant training, or positive workplace testimonials before it.

As regards Miss Williams' insight into her actions, the panel bore in mind that, in Miss Williams' second written account, she accepts a degree of responsibility for her failings in relation to the lack of appropriate documentation; she writes "In hindsight I can see where I went wrong". However, she does then qualify this by blaming the deficiency in her record-keeping on not being released to take a break, which she says would have enabled her to complete the documentation as required. Other than this limited reflection on a discrete area of the regulatory concerns in this case, there is no other evidence of Miss Williams demonstrating real insight into, or remorse for, her failings. The panel considered that Miss Williams' written accounts appear to be broadly exculpatory and excusatory in tone.

Taking the above into account, the panel concluded that there was a high risk of repetition of Miss Williams' misconduct, in the absence of any evidence of remediation, remorse, or genuine insight. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that, in this case, a finding of impairment on public interest grounds was required. The charges found proved, and in particular charge 8, are of the utmost seriousness; the public would almost certainly lose confidence in the profession and the regulatory process if, in such a case (where a patient died, in circumstances which were avoidable), a finding of current impairment were not made. In coming to this decision, the panel also bored in mind that Patient A's family had raised concerns as to her deterioration throughout the evening, and no appropriate action was taken.

Having regard to all of the above, the panel concluded that Miss Williams’ fitness to practise is currently impaired.

Determination on sanction:

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case. The panel bore in mind Ms Paisley's written submissions on behalf of the NMC and the NMC Sanction Bid (Striking-Off Order), but was not bound by such a bid. Miss Williams has provided no written representations for consideration in her absence. The panel accepted the advice of the legal assessor. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance ("SG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel considered the aggravating factors in this case to be as follows:

- Miss Williams misconduct engaged failures in respect of fundamental nursing duties;
- These serious failings contributed to a loss of chance of survival for Patient A; and
- Miss Williams has demonstrated a lack of insight into her serious professional misconduct.

The panel considered that, in the circumstances of the case and in the light of Miss Williams' lack of engagement in the regulatory process in respect of potential remediation of her practice, there are no mitigating factors which this panel could identify.

As the panel has previously observed, it had concerns around a number of aspects of Patient A's care; however, it reminded itself of its finding that none of these external factors absolved Miss Williams from her responsibilities as a registered nurse.

The panel considered whether to take no action or impose a caution order but concluded that these sanctions would be manifestly inappropriate in view of the seriousness and nature of the case. Such sanctions would be neither proportionate nor in the public interest – as they would not adequately mark the seriousness of Ms Williams' misconduct or her significant breaches of fundamental tenets of the nursing profession - and would not themselves adequately protect the public.

The panel next considered whether placing conditions of practice on Ms Williams' registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel could not conceive of workable, practicable, and appropriate conditions; Miss Williams' failings are so severe that conditions of practice would not appropriately protect patients while in force. The panel also considered that, in the circumstances of Miss Williams' non-engagement with the regulatory process, it could have no confidence that Miss Williams would engage with any conditions of practice order or respond positively to retraining. Furthermore the panel concluded that the placing of conditions on Miss Williams's registration would not adequately address the seriousness of, or the public interest in, this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

Miss Williams' misconduct fell strikingly short of the professional standards expected of a registered nurse; her serious failings gave rise to severe consequences. The panel reminded itself of its finding that Miss Williams has demonstrated no remediation and minimal insight, which was itself qualified in an exculpatory fashion. There has been no

effective engagement with the process of remediation by Miss Williams, and there is no evidence before the panel of safe practice since the incident of 30 January 2018.

The panel determined that the serious breach of the fundamental tenets of the profession, particularly in relation to the failure to escalate a seriously deteriorating patient, evidenced by Miss Williams' actions is fundamentally incompatible with her remaining on the register. The seriousness of Miss Williams' misconduct, and lack of responsibility, insight and remediation, requires not only her temporary removal from the register.

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

Miss Williams' actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Williams' actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

Determination on Interim Order

The panel considered the submissions made by Ms Paisley that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest. Miss Williams provided no written representations for consideration in her absence.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.