Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 11 – Wednesday 13 January 2021
Friday 15 January 2021

Virtual Hearing

Name of registrant:	Susan Joan Hawthorne
NMC PIN:	87H0028S
Part(s) of the register:	Nursing Sub part 1 RN1 Registered Nurse – Adult 27 September 1990
Area of registered address:	Ayrshire
Type of case:	Misconduct
Panel members:	Christina McKenzie (Chair, registrant member) Jenny Childs (Registrant member) Bill Mathews (Lay member)
Legal Assessor:	Bruce Erroch
Panel Secretary:	Catherine Acevedo
Nursing and Midwifery Council:	Represented by Stephen Earnshaw, Case Presenter
Ms Hawthorne:	Not present nor represented in absence
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Hawthorne was not in attendance and that the Notice of Hearing letter had been sent to Ms Hawthorne's registered email address on 18 November 2020.

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

Mr Earnshaw, on behalf of the Nursing and Midwifery Council (NMC), submitted that it 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 Ms Hawthorne has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Hawthorne

The panel next considered whether it should proceed in the absence of Ms Hawthorne. It had regard to Rule 21 and heard the submissions of Mr Earnshaw who invited the panel to continue in the absence of Ms Hawthorne.

Mr Earnshaw referred the panel to the correspondence between Ms Hawthorne and the NMC dated 22 September 2020 which stated *"I am just confirming that neither me or a*

representative will be attending the hearing and I accept that the hearing can and will go ahead".

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 has decided to proceed in the absence of Ms Hawthorne. In reaching this decision, the panel has considered the submissions of Mr Earnshaw, and the advice of the legal assessor. 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 Ms Hawthorne;
- Ms Hawthorne has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses will attend today to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred between 2011 and 2018.
- 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.

There is some disadvantage to Ms Hawthorne in proceeding in her absence. Although the evidence upon which the NMC relies was sent to her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, 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 Ms Hawthorne's decisions 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 Ms Hawthorne. The panel will draw no adverse inference from Ms Hawthorne's absence in its findings of fact.

Details of charge

That you, a registered nurse, whilst working for NHS Ayrshire and Arran Trust:

1. *On 24 December 2011, in relation to Patient D:*
    a) *Signed the second checker entry in the controlled drugs register with Colleague 1's signature;*
    b) *Initialled the second checker entry on the MAR chart with Colleague 1's signature.*

2. *On 10 June 2015, in relation to Patient C, failed to ensure that a prescription of IV fluids was administered and/or that hourly observations were carried out.*

3. *On 3 July 2018, in relation to Patient A, failed to take observations and/or carry out care and comfort checks at:*

a) *2am;*
b) *4am.*

4. *In relation to charge 3, recorded that these observations and/or checks had been carried out.*

5. *On 3 August 2018, in a meeting and/or within a written statement suggested that you had carried out observations on Patient A at 3am.*

6. *In relation to Patient B on 2 July 2018:*
   a) *At 20.00 incorrectly recorded the NEWS as 0 in the nursing notes;*
   b) *At 23.55 incorrectly calculated on the observations chart that 12 hourly observations were required as opposed to 4 hourly observations.*

7. *Your actions at charge 1 were dishonest in that you intended to create the impression that Colleague 1 had been present as second checker when this was not the case.*

8. *Your actions at charges 4 and/or 5 were dishonest in that you intended to create the impression that the observations and/or checks had been done when this was not the case.*

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

Decision and reasons on application to admit written statements of Witness 2, Witness 3, Witness 4, Witness 5, Witness 6, Witness 7 and Witness 8

The panel heard an application made by Mr Earnshaw under Rule 31 for admission of the written statement of Witness 2 into evidence. Witness 2 was not present at this hearing and, whilst the NMC had made efforts to ensure that this witness was present, Witness 2

would be unable to attend the hearing; [PRIVATE] and is not well enough to give video evidence. Witness 2, he submitted, therefore had a good reason for not attending the hearing. Her evidence was not the sole or decisive evidence in respect of any of the charges.

Mr Earnshaw also made an application under Rule 31 for admission of the written statements of Witness 3, Witness 4, Witness 5, Witness 6, Witness 7 and Witness 8. He submitted that the NMC had decided at an early stage not to call these witnesses to give oral evidence. Their evidence was not the sole or decisive evidence in respect of any of the charges.

In advance of this hearing, the NMC had indicated to Ms Hawthorne that it was their intention to have Witness 2 provide live evidence to the panel. Her statement and those of Witness 3, Witness 4, Witness 5, Witness 6, Witness 7 and Witness 8 had been provided to Ms Hawthorne ahead of the hearing. Despite knowledge of the nature of the evidence to be given by Witness 2, Witness 3, Witness 4, Witness 5, Witness 6, Witness 7 and Witness 8, Ms Hawthorne had made the decision not to attend this hearing. She had not indicated that there was a challenge to the contents of any of the witness statements. Mr Earnshaw submitted that each of the witness' statements supported each other, were relevant and were not the sole evidence against Ms Hawthorne. On this basis Mr Earnshaw advanced the argument that there was no lack of fairness to Ms Hawthorne in allowing all of the written statements to be admitted into evidence.

The panel accepted the advice of the legal assessor who referred in particular to the case of *Thorneycroft v NMC [2014] EWHC 1565(Admin).*

The panel noted that all of the statements had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by each witness.

The panel first considered the application in relation to Witness 2. It considered whether or not her evidence was relevant and whether or not it would be fair to admit it. The evidence was plainly relevant, since it had a bearing on the facts at issue, particularly in relation to Patient A. In relation to fairness, the panel took into account the factors suggested in the case of *Thorneycroft*. The panel considered it to be significant that Witness 2's evidence was not the sole or decisive evidence in relation to any of the charges: The panel was of the view that Witness 2's written statement was concise and appeared to be consistent with other evidence in the case. There was no indication that Ms Hawthorne challenged any of Witness 2's evidence. There was no suggestion that Witness 2 had any reason to lie in her statement. The panel was satisfied that the NMC had taken reasonable steps to secure Witness 2's attendance and was further satisfied that her health was a good reason for not attending.

The panel next considered the application in respect of Witness 3, Witness 4, Witness 5, Witness 6, Witness 7 and Witness 8. The panel considered whether or not their evidence was relevant and whether or not it would be fair to admit it. The evidence was plainly relevant, since it had a bearing on the facts at issue. In relation to fairness, the panel took into account the factors suggested in the case of *Thorneycroft*. The panel considered it to be significant that the evidence of these was not the sole or decisive evidence in relation to any of the charges: the panel was of the view that their evidence was part of a jigsaw and that elements of each supported the other. There was no indication that Ms Hawthorne challenged any of these witnesses. There was no suggestion that any of these witnesses had any reason to lie in their statements. The panel was conscious of the fact that the NMC had chosen not to ask these witnesses to attend. It reminded itself that the admission of witness statements is not automatic. However, it was satisfied that in all of the circumstances it was fair to admit the statements of Witness 3, Witness 4, Witness 5, Witness 6, Witness 7 and Witness 8.

The panel reminded itself, in relation to both applications, that there was a public interest in the issues being explored fully. This consideration gave further support to the admission of the evidence into proceedings. The panel made it clear that, at this stage, it was making

a decision only on admissibility of the witness statements: it would decide what weight to place on them once all of the evidence had been considered.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Ms Hawthorne.

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

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

- Patient A: Patient A
- Colleague 1: Staff Nurse at the Trust

Background

The charges arose whilst Ms Hawthorne was employed with NHS Ayrshire and Arran Trust (“the Trust”) at Ayrshire Central Hospital ("the Hospital") in older peoples' services.

On 24 December 2011, Ms Hawthorne is alleged to have inserted a colleague's signature in the controlled drugs register and the medicine recording sheet for two doses of Oxycontin while working on Pavilion 3 at the Hospital. On 10 June 2015, Ms Hawthorne

was alleged to have not carried out observations or administered IV fluids as prescribed in relation to Patient C.

In July 2015, Ms Hawthorne was re-deployed to work at the Acute Stroke Unit ("ASU") Crosshouse and undertook a competency training programme. On the night of 2 - 3 July 2018 Patient A was admitted to the ASU at Crosshouse. Ms Hawthorne was alleged to have failed to take observations or care and comfort checks for Patient A as required and to have falsely recorded that these observations and checks had been undertaken.
A disciplinary hearing held by the Trust took place on 19 February 2019 and the allegations against Ms Hawthorne were upheld. Ms Hawthorne was dismissed from her role with immediate effect.

Although in contact with the NMC Ms Hawthorne has not engaged nor provided any written submissions in relation to this hearing.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

The panel considered the evidence of the witnesses and made the following conclusions:

Patient A: The panel considered the evidence of Patient A to be credible and reliable. Patient A answered questions openly and was consistent with her witness statement.

Colleague 1: The panel considered the evidence of Colleague 1 to be credible and reliable. Colleague 1’s account was consistent and she was able to clarify evidence for the panel when required. She could recall events well.

Having admitted the witness statements into evidence, the panel went on to consider what weight to attach to them.

The panel considered Witness 2's statement to be credible. Her statement was detailed and painted the most complete picture of events for the panel.

Witness 3's statement was brief and spoke to a specific charge and was consistent with other witness statements. Witness 4's statement was consistent with her contemporaneous statement made in 2015 and was able to describe the event and the environment at the ASU. Witness 5's statement provided the panel with detail about the incident and the impact Ms Hawthorne's actions would have had on the patient involved. Witness 6's statement gave an account of the internal investigation which took place close to the events. The panel considered Witness 7's statement to be professional and detailed his interactions with Ms Hawthorne regarding the two hourly observations. The panel considered Witness 8 provided a professional statement and assisted the panel with detail about specific incidents.

The panel considered all of these written statements to be credible and reliable but gave more weight to the statements of Witness 2, Witness 7 and Witness 8 because of the detail contained within them which described personal interactions they had had with Ms Hawthorne.

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

Charge 1

That you, a registered nurse, whilst working for NHS Ayrshire and Arran Trust:

1 *On 24 December 2011, in relation to Patient D:*
   a) *Signed the second checker entry in the controlled drugs register with Colleague 1's signature;*
   b) *Initialled the second checker entry on the MAR chart with Colleague 1's signature.*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 1. Colleague 1 said in her witness statement that upon return to duty on 26 December 2011, she noticed her signature inserted on the controlled drugs register on 24 December 2011. She also stated that the initials in Patient D's MAR chart on the same date had also not been written by her.

The panel found Colleague 1's evidence to be supported by the rota for this shift which shows that Colleague 1 was on day shift and that Ms Hawthorne had been on the night shift.

The panel also took into account the witness statement of Witness 3. Colleague 1 reported the incident to Witness 3. Witness 3 said that when she spoke to Ms Hawthorne on the telephone on 27 December 2011, Ms Hawthorne had admitted to forging the signatures on the controlled drug book and the initials on the MAR chart and she accepted that it was wrong for her to have done so.

The panel therefore concluded that Ms Hawthorne did sign the second checker entry in the controlled drugs register with Colleague 1's signature and Initialled the second checker entry on the MAR chart with Colleague 1's signature.

Charges 1a and 1b are therefore found proved.

Charge 2

> *On 10 June 2015, in relation to Patient C, failed to ensure that a prescription of IV fluids was administered and/or that hourly observations were carried out.*

This charge is found proved.

In reaching this decision, the panel took into account the statements of Witness 4 and Witness 5, both Advanced Nurse Practitioners (ANP) who had been on duty.

Witness 5 said in the written statement that Witness 4 handed the instructions regarding Patient C's prescription of IV fluids to Ms Hawthorne.

Witness 4 said in her statement that she did not speak to Ms Hawthorne about the IV fluids but Witness 5 *"had left the prescription on the MEWS chart at the bottom of Patient C's bed. The protocol is that nursing staff should check the chart at the bottom of the bed when caring for patients".* When she returned to review Patient C with Witness 5 to at 3pm he was sick and it became apparent to her that no IV fluids had been administered because there was no evidence of IV giving sets beside Patient C. She also found that hourly observations of the patient had not been undertaken.

The panel also took into account the statement from Ms Hawthorne given at the local investigation. She explains that she did not repeat observations because Patient C appeared to be comfortable and had just been attended to. Ms Hawthorne accepts in her statement that this was an oversight on her part.

The panel concluded, on the balance of probability that Ms Hawthorne did fail to ensure that a prescription of IV fluids was administered and/or that hourly observations were carried out.

Charge 2 is therefore found proved.

Charge 3

> *On 3 July 2018, in relation to Patient A, failed to take observations and/or carry out care and comfort checks at:*
> *a) 2am;*
> *c) 4am.*

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written statements of Patient A. The panel took into account that Patient A had provided a contemporaneous report at the time of the events which she disclosed to Witness 2. Patient A says in her evidence that Ms Hawthorne told her that she would not be taking her observations at 2am or 4am because *"she did not believe in it".* The panel was of the view that Ms Hawthorne intended not to do the observations every two hours. The panel found this to be supported by Witness 2's statement saying that the observations had been recorded as having taken place at 12am, 2am, 4am and 6am but Patient A had informed her that Ms Hawthorne had not disturbed her throughout the night at 2am or 4am.

Patient A stated that she knows Ms Hawthorne did not check on her between 12am and 6am and that she had been awake for most of the night as she is a poor sleeper and did not feel comfortable sleeping in a strange bed.

The panel was of the view that Ms Hawthorne had intentionally not done the observations every two hours. It concluded that in relation to Patient A, Ms Hawthorne failed to take observations and/or carry out care and comfort checks at 2am or 4am.

Charges 3a and 3b are therefore found proved.

Charge 4

> *In relation to charge 3, recorded that these observations and/or checks had been carried out.*

This charge is found proved.

In reaching this decision, the panel accepted the evidence of Patient A.

Patient A stated in her evidence that she told her daughter who visited her at lunch hour that she had not been woken up overnight for her observations. *"My daughter was concerned and said that the observation charts had been filled in overnight".*

This was supported by the charts where it is recorded that the observations were carried out at 2am and 4am and also the ASU's quick guidelines for nursing staff for acute stroke which states what is expected in relation to observations.

The panel concluded that Ms Hawthorne did record that these observations and/or checks had been carried out.

Charge 4 is therefore found proved.

Charge 5

> *On 3 August 2018, in a meeting and/or within a written statement suggested that you had carried out observations on Patient A at 3am.*

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 6. Witness 6 stated that an entry was made on Patient A's notes at 2am and 4am but that Ms Hawthorne admitted to the errors, and alleged that she had taken an observation at 3am. The panel found this to be supported by Patient A's notes which show the entries as 2am and 4am.

The panel also took into account Witness 6's notes of the investigation interview with Ms Hawthorne and her responses. Ms Hawthorne says in this interview that she took observations at 3am and admits that the entries at 2am and 4am were incorrect.

The panel concluded that in a written statement Ms Hawthorne did suggest that she had carried out observations on Patient A at 3am.

Charge 5 is therefore found proved.

Charge 6

In relation to Patient B on 2 July 2018:

c) *At 20.00 incorrectly recorded the NEWS as 0 in the nursing notes;*

d) *At 23.55 incorrectly calculated on the observations chart that 12 hourly observations were required as opposed to 4 hourly observations.*

This charge is found proved.

In reaching this decision, the panel took into account statement of Witness 6. Witness 6 stated that Ms Hawthorne made a handwritten note that Patient B's NEWS score was 0 However, his NEWS score was in fact a score of 2 and so required four hourly observations.

The panel found this to be supported by Patient B's nursing notes dated 2 July 2018.

The panel also took into account Witness 6's notes of the investigation interview with Ms Hawthorne's and her responses. Witness 6 told Ms Hawthorne in this interview that the NEWS score actually calculated as 2 and observations were taken 12 hourly but with this calculation they should have been 4 hourly. Ms Hawthorne responded *"Don't know why I have written 12 hourly regardless of this score he would have been 4 hourly as per stroke protocol."*

The panel concluded that in relation to Patient B on 2 July 2018, Ms Hawthorne at 20.00 incorrectly recorded the NEWS as 0 in the nursing notes and at 23.55 incorrectly

calculated on the observations chart that 12 hourly observations were required as opposed to 4 hourly observations.

Charges 6a and 6b are therefore found proved.

Charge 7

> *Your actions at charge 1 were dishonest in that you intended to create the impression that Colleague 1 had been present as second checker when this was not the case.*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 1. Colleague 1 stated that Ms Hawthorne admitted to her that she had forged her signature and it had been a 'spur of the moment' thing and that she understood that it was wrong. Ms Hawthorne also said to Colleague 1 that if given the chance she would not do it again. The panel was of the view that this demonstrated that Ms Hawthorne knew that what she was doing was wrong but still did it.

The panel concluded that by the standards of ordinary, decent people, Ms Hawthorne's actions were dishonest.

Charge 7 is therefore found proved.

Charge 8

> *Your actions at charges 4 and/or 5 were dishonest in that you intended to create the impression that the observations and/or checks had been done when this was not the case.*

This charge is found proved.

In reaching this decision, the panel took into account Patient A's evidence that Ms Hawthorne told her that she never intended to take observations.

It also took into account in the local investigation that Ms Hawthorne stated that she had carried out observations at 3am when she knew she had not. The panel was of the view that Ms Hawthorne was aware that these observations should have been carried out and intentionally tried to cover up that she had not done them.

The panel concluded that by the standards of ordinary, decent people, Ms Hawthorne's actions at charges 4 and/or 5 were dishonest in that she intended to create the impression that the observations and/or checks had been done when this was not the case.

Charge 8 is therefore found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Ms Hawthorne's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the

facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Ms Hawthorne's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Earnshaw invited the panel to take the view that the facts found proved amount to misconduct.

Mr Earnshaw identified the specific, relevant standards where Ms Hawthorne's actions amounted to misconduct. He submitted that Ms Hawthorne's conduct fell short of what would be proper in the circumstances. These failures had the potential to expose patients to a risk of harm. By falsifying records Ms Hawthorne deliberately intended to mislead colleagues into believing something had been done when it had not. Patients and colleagues expect to be able to rely on registered nurses to deliver safe and effective care.

Mr Earnshaw submitted that the individual charges in this case could well amount to serious misconduct but, if there were doubt, the cumulative effect of the proven charges is such that this is serious professional misconduct.

Submissions on impairment

Mr Earnshaw moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of

Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin), *Cohen* v *General Medical Council* [2008] EWHC 581 (Admin) and *Cheatle* v *General Medical Council* [2009] EWHC 645 (Admin).

Mr Earnshaw submitted that the panel must consider whether Ms Hawthorne's conduct is easily remediable and whether or not there is a risk of Ms Hawthorne behaving in a similar way in the future. He submitted that the 2015 charge occurred after a training course. He submitted that there has been no information from Ms Hawthorne to assist the panel as to her current impairment and the registrant has made it clear she does not intend to continue to practise.

Mr Earnshaw submitted that Ms Hawthorne has brought the profession into disrepute by her behaviour. She has breached a number of the tenets of the Code of Conduct. She has acted in such a way that means her integrity could no longer be relied upon.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

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

Charge 1 came under 'The code: Standards of conduct, performance and ethics for nurses and midwives 2008' (the Code 2008):

"The people in your care must be able to trust you with their health and wellbeing

To justify that trust, you must:

• …

• …

• provide a high standard of practice and care at all times

• be open and honest, act with integrity and uphold the reputation of your profession.

21 You must keep your colleagues informed when you are sharing the care of others.

27 You must treat your colleagues fairly and without discrimination.

Keep clear and accurate records

42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.

43 You must complete records as soon as possible after an event has occurred.

44 You must not tamper with original records in any way.

45 You must ensure any entries you make in someone's paper records are clearly and legibly signed, dated and timed.

The remaining charges found proved fell under 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code 2015):

"1 Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

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

Practise effectively

6 Always practise in line with the best available evidence

To achieve this, you must:

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

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

8 Work co-operatively

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13 Recognise and work within the limits of your competence

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

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

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

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

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

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, treating people fairly and without discrimination, bullying or harassment

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it considered that Ms Hawthorne's failings were serious and repeated.

Patient A required close observation and treatment and Ms Hawthorne failed to ensure appropriate observations for Patient A. Ms Hawthorne clearly intended not to disturb Patient A throughout the night to take observations. Ms Hawthorne then fabricated observations which put Patient A at risk of harm. The panel was of the view that Ms Hawthorne acted dishonestly to cover up that she had not taken the observations when she knew that she ought to have taken them.

The incident with Patient B involved Ms Hawthorne recording the patients NEWS score incorrectly and calculating incorrectly that 12 hourly observations were required when in fact 4 hourly observations were required. The panel was of the view that this had the potential to cause Patient B harm if more frequent observations were not taking place as required.

Patient C required close observation and treatment. Ms Hawthorne did not ensure that a prescription of IV fluids was administered or that hourly observations were taken and, in the panel's view, this omission seriously impacted upon him.

The incident with Patient D involved Ms Hawthorne forging the signature and initials of a colleague as second checker in the controlled drugs register. The panel was of the view that Ms Hawthorne's conduct indicated a disregard for the importance and need for protocols regarding controlled drugs. The panel was of the view that Ms Hawthorne's dishonesty was premeditated and intended to mislead colleagues into thinking that there had been a second checker.

The panel was of the view that Ms Hawthorne's conduct would be regarded as deplorable by fellow practitioners. Ms Hawthorne's conduct involved repeated failures in record

keeping over a period of time. These included forging a colleagues' signature on controlled drugs records and falsely recording patient observations. Her conduct had the potential to cause serious harm to patients and did cause harm to one patient. In the panel's view, Ms Hawthorne's dishonest conduct was particularly serious and had the potential to cause serious harm to patients in her care.

The panel found that Ms Hawthorne's actions individually and collectively fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Hawthorne's 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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her 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 all four limbs of *Grant* to be engaged in this case.

The panel found that patients were put at risk with at least one patient being caused physical harm as a result of Ms Hawthorne’s misconduct. Ms Hawthorne’s misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel carefully considered the evidence before it in determining whether or not Ms Hawthorne has remedied her practice. The panel was of the view that although dishonesty is difficult to remediate, the clinical concerns in this case are potentially capable of remediation. However, the panel has received no information that Ms Hawthorne has attempted to remediate her misconduct. The panel saw evidence that Ms Hawthorne had already received significant support and retraining through her employer but despite this she repeated her clinical failings. She has not provided any evidence for this hearing of reflection, updated training or references and testimonials.

The panel took into account that Ms Hawthorne has previously repeated her conduct despite support and training and in the absence of evidence of any remediation, there is a risk of repetition of that conduct. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel concluded that the charges found proved are serious and public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Hawthorne's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Submissions on sanction

Mr Earnshaw informed the panel that in the Notice of Hearing, dated 18 November, the NMC had advised Ms Hawthorne that it would seek the imposition of a striking-off order if it found her fitness to practise currently impaired. Mr Earnshaw submitted that a striking-off order is the only proper order in the circumstances. Ms Hawthorne's misconduct was serious and repeated and involved multiple breaches. There has been no evidence of remediation to assist the panel. Ms Hawthorn has also expressed that she has made the decision not to carry on in the nursing profession.

Decision and reasons on sanction

Having found Ms Hawthorne'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 panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Ms Hawthorne conduct was repeated over a period of time and put patients at potential risk of harm and caused actual harm;
- Ms Hawthorne has previously received support and retraining from her employer which was unsuccessful;
- Ms Hawthorne's lack of insight and remorse into failings;
- Ms Hawthorne's lack of meaningful engagement with these proceedings.

The panel was of the view that there are no mitigating features:

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and would not protect the public. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Hawthorne'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 Ms Hawthorne's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel is of the view that there are no practicable or workable conditions that could be formulated, given the nature of the charges in this case. Some of the misconduct identified, which included fabricating observations and forging a colleagues signature, could not be addressed easily through retraining. Given the lack evidence of insight or remediation, the panel was of the view that it would be difficult to formulate conditions at this stage that would ensure the safety of the public. The panel concluded that the placing

of conditions on Ms Hawthorne's registration would also not adequately address the seriousness of the dishonest conduct in this case.

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

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

The panel determined that Ms Hawthorne's actions were not a single instance of misconduct and Ms Hawthorne has repeated her behaviour despite support and retraining. The panel has seen no evidence that Ms Hawthorne has insight or remorse for her misconduct which raises questions about attitudinal problems. The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse.

The panel also noted the NMC guidance for dealing with serious cases, including those involving dishonesty. It found that Ms Hawthorne had deliberately breached her professional duty of candour and there was potential for harm to patients.

The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Ms Hawthorne's actions is fundamentally incompatible with Ms Hawthorne remaining on the register.

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

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

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

Ms Hawthorne's 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 Ms Hawthorne's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This decision will be confirmed to Ms Hawthorne in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Earnshaw. He submitted that an interim order is necessary for a period of 18 months.

Decision and reasons on interim order

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

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

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

That concludes this determination.