Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday 8 March 2021

Virtual Meeting

Name of registrant:	**Deborah Ann Cook**
NMC PIN:	81K2027E
Part(s) of the register:	Nursing - Sub part 1 RN1: Registered Nurse - Adult (August 1996) Nursing - Sub part 2 RN2: Registered Nurse - Adult (December 1983)
Area of registered address:	Lancashire
Type of case:	Misconduct
Panel members:	Deborah Jones (Chair, Lay member) Helen Eatherton (Registrant member) Claire Clarke (Registrant member)
Legal Assessor:	Paul Housego
Panel Secretary:	Christine Iraguha
Consensual Panel Determination:	Accepted
Facts proved:	All
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel received advice from the legal assessor concerning service of the Notice of Meeting. It agreed that the hearing should proceed as a meeting and as a Consensual Panel Determination (CPD). The panel noted that the CPD agreement was signed by Mrs Cook's representative at the Royal College of Nursing (RCN).

In response to the current Covid-19 crisis, emergency changes were made to the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules). The emergency changes allow for the Notice of Meeting (the Notice) to be sent by the Nursing and Midwifery Council (NMC) by email instead of by recorded delivery post. This email must be sent securely to a confirmed email address for the registrant and/or representative.

The panel was informed that the Notice of Meeting had been sent to Mrs Cook's registered email address on 25 February 2021. The Notice was also emailed to Mrs Cook's representative at the RCN on 25 February 2021.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date and the nature of the meeting. The Notice made clear that the case would be considered at a meeting on Monday 8 March 2021.

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

Details of charge

'That you, a registered nurse:

1. On 6 December 2016:
a. failed to document Patient A's transfer from EDU to Ward 12;
b. failed to provide a verbal handover to colleagues at the end of your shift as per the Trust's policy;
c. failed to update the handover sheet to provide an accurate record of patients on the Ward;
d. failed to include Patient A's details on the handover sheet;
e. failed to complete a risk assessment for Patient A;
f. failed to draft a plan of care for Patient A;
g. left Patient B's notes at Patient A's bedside table;
h. failed to update the handover notes to show that Patient B had been discharged;

2. In a written statement dated 6 December 2016 said that you had provided a verbal handover to colleagues prior to completing your shift;

3. Your actions at Charge 2 were dishonest as you knew that you had not provided a handover to colleagues and you sought to mislead your employer into believing that you had;

4. On 8 December 2016:
a. informed Colleague 1 that you had handwritten Patient A's details on a note that you had passed to Colleague 2;
b. informed Colleague 1 that you had provided a handover;

5. Your actions at Charge 4(a) and (b) were dishonest as you knew that you had not provided Patient A's details to Colleague 2 and had not provided a handover and sought to mislead Colleague 1 into believing that you had;

6. Between 11-13 September 2018, at the inquest into Patient A's death, provided evidence by way of a written statement in which you said that prior to completing your shift on 6 December 2016 you had asked Colleague 2 if she required any further information from you;

7. Your actions at Charge 7 were dishonest as you knew that you had not had a conversation with Colleague 2 and had sought to mislead the Coroner;

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

Consensual Panel Determination

At the outset of this meeting, the panel was made aware that a provisional agreement of a CPD had been reached with regard to this case between the NMC and Mrs Cook.

The agreement, which was put before the panel, sets out Mrs Cook's full admissions to the facts alleged in the charges, that her actions amounted to misconduct, and that her fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be striking off order. Parties agree that an interim suspension order for a period of 18 months is necessary in order to protect the public from harm and is also in the public interest to cover the appeal period.

The panel has considered the provisional CPD agreement reached by the parties, this being the NMC, Mrs Cook and her representatives from the RCN.

That provisional agreement, which was signed by the RCN on behalf of Mrs Cook on 11 February 2021, reads as follows:

'Mrs Cook ('the Registrant') is aware of the CPD hearing. The Registrant does not intend to attend the hearing and is content for it to proceed in her absence. The Registrant will endeavour to be available by the telephone should any clarification on any point be required.

The Nursing and Midwifery Council and Mrs Deborah Cook, PIN 1412924E ('the Parties') agree as follows:

The Charges:

The Registrant admits the following charges:

1. On 6 December 2016:
a. failed to document Patient A's transfer from EDU to Ward 12;
b. failed to provide a verbal handover to colleagues at the end of your shift as per the Trust's policy;
c. failed to update the handover sheet to provide an accurate record of patients on the Ward;
d. failed to include Patient A's details on the handover sheet;
e. failed to complete a risk assessment for Patient A;
f. failed to draft a plan of care for Patient A;
g. left Patient B's notes at Patient A's bedside table;
h. failed to update the handover notes to show that Patient B had been discharged;

2. In a written statement dated 6 December 2016 said that you had provided a verbal handover to colleagues prior to completing your shift;

3. Your actions at Charge 2 were dishonest as you knew that you had not provided a handover to colleagues and you sought to mislead your employer into believing that you had;

4. On 8 December 2016:
a. informed Colleague 1 that you had handwritten Patient A's details on a note that you had passed to Colleague 2;
b. informed Colleague 1 that you had provided a handover;

5. Your actions at Charge 4(a) and (b) were dishonest as you knew that you had not provided Patient A's details to Colleague 2 and had not provided a handover and sought to mislead Colleague 1 into believing that you had;

6. Between 11-13 September 2018, at the inquest into Patient A's death, provided evidence by way of a written statement in which you said that prior to completing your shift on 6 December 2016 you had asked Colleague 2 if she required any further information from you;

7. Your actions at Charge 6 were dishonest as you knew that you had not had a conversation with Colleague 2 and had sought to mislead the Coroner;

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

<u>The Agreed Facts</u>

The agreed facts are as follows:

1. The Registrant appears on the Register of Nurses and Midwives maintained by the NMC as a Registered Nurse. She registered in December 1983.

2. This case represents the first time the Registrant has come to the attention of her regulator.

3. The NMC received an anonymous referral concerning the Registrant's fitness to practise on 26 January 2017. At the time of the concerns raised in the referral, the Registrant was a Band 7 Senior Sister and Ward Manager of Ward 12 at the Royal Preston Hospital. Ward 12 is a 32 bed surgical unit within the Surgical Division at the Royal Preston Hospital. The Ward provides care to adult patients with a wide range of surgical needs specialising in Lower Gastro Intestinal conditions.

4. The regulatory concerns in this case revolve around events that occurred on 6 December 2016, specifically in relation to the care provided to Patient A. On 6 December 2016 the Registrant was covering an early shift on Ward 12 and was responsible for the care of male patients. The Registrant was not only the Nurse in charge of this particular shift but also the Ward Manager. The Registrant, upon conclusion of her shift, refused to provide a handover to incoming staff and in particular, to the nurse in charge of the subsequent shift. The evidence indicates that despite repeated requests by the Registrant's colleague, a handover was not provided. These facts provide evidence of Charges 1(a) and 1(b).

5. When asked to provide a handover, the Registrant had told colleagues that she was too tired from the shift as it had been extremely busy and as such, she was not in a position to provide a handover. The Registrant left the building without providing either a verbal or written handover. The nurse in charge of the Ward decided that she would have to rely on the handwritten notes for each patient, however, it transpired that the handover notes had not been updated and were in fact inaccurate. These facts provide evidence of Charges 1(c) and 1(d).

6. It was the responsibility of the Registrant as a senior Nurse in charge and Ward Manager to ensure that the handover notes were completed and accurate.

7. In particular, the notes made no mention of Patient A, an 83 year old male who suffered from dementia and who had arrived at Ward 12 earlier that day during the Registrant's shift. These facts provide evidence of Charges 1(e) and 1(f). There

were additional inaccuracies in the handover notes. For instance, Patient B's medical notes had been left at Patient A's bedside table and the handover sheet had not been updated to record that Patient B had been discharged. These facts provide evidence of Charges 1(g) and 1(h).

8. Patient A arrived at Ward 12 shortly after midday on 6 December 2016 and had arrived from EDU. It would appear that Patient A was not seen by anyone and at around 18:00 hours it became apparent that Patient A had taken his belongings and left the hospital without notifying anyone. At this stage the staff on Ward 12 were still not aware that Patient A was vulnerable and it was not until an hour later that this information came to light. A search was initiated and Patient A was reported as missing. Unfortunately, Patient A, having left the hospital, was involved in a road traffic accident and died from his injuries two days later.

9. An internal investigation took place and the Registrant provided a statement in which she said that although she had not given a walk round handover as she had been expected to, she had in fact provided a verbal handover to colleagues prior to completing her shift. These facts provide evidence of Charges 2 and 3. The Registrant also suggested that she had written down Patient A's details and passed them to a college when this was not correct. These facts provide evidence of Charges 4(a), 4(b) and 5.

10. The Registrant initially denied refusing to provide a handover. However, later accepted that this was not correct and that she had failed to provide any form of handover, be it verbal or written. In addition, during the inquest into Patient A's death, the Registrant provided a further statement to the Coroner, in which she suggested that she had tried to provide a handover to the nurse in charge but that it was the nurse that had refused to take the handover information. These facts provide evidence of Charges 6 and 7.

11. On 14 March 2017 following a disciplinary hearing, the Registrant was dismissed.

12. An inquest surrounding the circumstances of Patient A's death was held between 11-13 September 2018. The Registrant did not attend the inquest to give evidence but did provide a statement. Having heard the evidence, the coroner's report concluded:

'Patient A's death was contributed to by neglect in that the staff on the afternoon shift on Ward 12 at the Royal Preston Hospital were not aware of his presence on the ward. This was a direct result of the failure to provide a handover at the end of the morning shift and by a failure to risk assess him for enhanced care'.

13. It is right to note that despite the conclusion of the inquest and the above comments, the Case Examiners did not consider that the Registrant should be charged with causing or contributing to the death of Patient A. The NMC has considered its own charging guidance in cases involving serious clinical outcomes which says 'If a patient died or suffered serious harm because of a nurse, midwife or nursing associate's clinical failings we may include the fact that the nurse, midwife or nursing associate caused that in the charges. Our guidance on investigating what caused the death or serious harm of a patient explains when we will do this, and why. It explains why we will not charge a nurse, midwife or nursing associate with causing death or serious harm to patients unless they deliberately chose to take a risk with the safety of patients or service users in their care'. The NMC considers that the evidence does not suggest that the Registrant was aware that her failures would give rise to a risk of Patient A absenting himself from the ward and being involved in a fatal road traffic accident yet that she still deliberately chose to take such a risk. As such the NMC considers it would not be within its own guidance to charge the Registrant with causing or contributing to the patient's death. The parties agree that the charges as set out above, which include the

Registrant's failure to record adequate notes or to provide handover to colleagues, adequately capture the seriousness of the clinical misconduct in this case.

14. Following the referral, the matter was investigated by the NMC and a report was completed in September 2019. The NMC has received and assessed all of the relevant evidence obtained during the local investigation.

15. The areas of regulatory concerns identified were failure to provide a handover of patients and inadequate record keeping. The Case Examiners considered the investigation report and determined that there was a case for the Registrant to answer in respect of both regulatory concerns.

16. The Registrant has engaged with her regulator and has provided a letter earlier on in the proceedings expressing her deep regret and submitted a reflective statement recently expressing her remorse. The Registrant admits that following on from the incident on 6 December 2016, the Registrants actions were dishonest and not only had she sought to mislead her colleagues but also to mislead the coroner during the inquest into Patient A's death. The Registrant has provided no justification for this behaviour.

17. The facts as detailed in the above charges are admitted by the Registrant.

<u>Misconduct</u>

18. In the case of Roylance v General Medical Council (No.2) [2000] 1 AC 311, Lord Clyde stated that: 'misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by the medical practitioner in the particular circumstances'.

19. The Registrant admits that her conduct fell seriously short of the standards of behaviour expected of Registered Nurses. Moreover, the Registrant accepts that her action breached the following paragraphs of the 2015 NMC Code of Conduct:

Keep clear and accurate records relevant to your practise *and in particular 10.1* ***complete records at the time or as soon as possible after an event. Work in partnership with people to make sure you deliver care effectively*** *and standard* ***3, make sure that people's physical, social and psychological needs are assessed and responded to****. The Registrant failed to update the handover notes on 6 December 2016. Her failure to update the notes resulted in colleagues taking over the care of patients, not being aware of Patient A, his vulnerabilities and his specific needs. By not providing a handover and not completing notes accurately the Registrant created a situation where subsequent healthcare professionals may have had to make a decision concerning a patient's treatment and medication having had sight and consideration of incomplete documentation. This is an obvious risk that puts patients at great risk of harm and unfortunately in this case, the situation created by the Registrant resulted in serious harm to Patient A. The Parties also agree that by virtue of not keeping accurate records, the Registrant has breached this section of the Code.*

Work cooperatively *and in particular standard 8.2* ***maintain effective communication with colleagues*** *and 8.3* ***keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*** *and standard 8.6* ***share information to identify and reduce risk****. The Registrant clearly failed to maintain effective communication with colleagues and failed to keep colleagues informed about patients that the Registrant had been responsible for. This failure resulted in colleagues not being aware of Patient A and his presence on Ward 12.*

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

particular standard 14.1 which provides ***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****.*

Uphold the reputation of your profession at all times *and in particular standards 20.1* ***Keep to and uphold the standards and values set out in the Code; 20.2 act with honesty and integrity at all times; 20.3 be aware at all times how your behaviour can affect and influence the behaviour of other people.***

20. The Parties agree that all of these standards identified have been breached. The Registrant in her capacity as a registered Nurse was under a duty to provide colleagues with a handover which should have included details of all patients on the Ward that the Registrant was responsible for. The Registrant's blatant refusal to provide a handover to colleagues resulted in colleagues taking over the care of patients on Ward 12, not being fully informed of each patient's needs. The risk to patient harm is significant where handover notes are incomplete or inadequate.

21. Nurses occupy a privileged position of trust in society and dishonesty is serious misconduct as it calls into question the integrity of the profession. The NMC guidance on seriousness and dishonesty makes it clear that not all dishonesty is equally serious. The guidance emphasises that the most serious kind of dishonesty is 'when a nurse or midwife deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone's care'. The Registrant admits that her conduct was not only dishonest but also falls into the most serious category as she not only provided a dishonest account during the course of the local investigation but also did the same during the inquest. The Registrant admits that this failure to uphold the duty of candour is in direct conflict with the standards and values set out in the Code.

22. The concerns identified in this case are extremely serious. The Registrant accepts that her actions were a serious departure from the standards expected of

nurses and accepts that her failings resulted in the nursing profession being brought into disrepute and that the facts, individually and collectively, amount to serious misconduct.

Current impairment

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

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

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

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
d) Has in the past acted dishonestly and/or is liable to act dishonestly in the future;

25. The Parties agree that in this case, all four of the limbs as identified in the case of Grant are engaged. Dealing with each limb in turn:

Unwarranted risk of harm:
By virtue of not providing a handover to colleagues, the Registrant clearly put patients at unwarranted risk of harm. Where a Nurse fails to provide a handover or

provides inaccurate or inadequate information relating to patients, there is a clear risk that the health care professional taking over will not have a clear and accurate picture of the patient's needs as the information would not be reliable. This presents a real issue and increases the risk of harm to patients.

Bringing the profession into disrepute:
Failing to provide a handover and inadequate record keeping is serious misconduct as identified above, it could lead to inaccurate and unreliable information concerning a patient's health which could subsequently result in harm. This in itself is serious misconduct, however, it is the Registrant's actions following on from the incident which engage the other limbs of the test as set out in Grant. The Duty of Candour has long been a fundamental part of nursing. It is reflected in the Code – Standard 14 and the following provision is relevant: 'Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place.'

The NMC and the GMC have also produced a joint statement setting out the steps should be taken in their document 'Openness and Honesty when things go wrong: the professional duty of candour'. This acknowledges that patients (or their guardians) have the right to know when a mistake has been made in their care. They should be told what happened, what can be done to deal with harm caused, and what will be done to prevent someone else being harmed.

Ensuring that that the public believe and have confidence that should a mistake be made in their care, or the care of a loved one/family member, they will be told that the mistake happened and therefore that steps will be/have been taken to mitigate the effect of the mistake on the health of the affected person, is essential to preserve the trust and confidence between the profession and its patients.

Conduct such as that of the Registrant in not being immediately open and honest and later suggesting that it was a colleague that had refused to take the handover,

erodes that trust and confidence. Such erosion and distrust might cause patients, or their families to be reluctant to seek health care opportunities because they are not sure that the healthcare professionals will be honest with them and act to put things right, if things go wrong.

The Parties agree that the Registrant's failure to immediately be open and honest about her actions brought the nursing profession into disrepute and breached one of the fundamental tenets of the nursing profession.

Has in the past breached fundamental tenets of the profession:
Nurses are required to promote professionalism and trust. These are fundamental tenets of the profession. The parties agree that various sections of the Code, as identified above, have been breached by the Registrant as a result of refusing a handover of patients in her care, inadequate record keeping and subsequent dishonesty.

Has in the past acted dishonestly:
Acting with integrity and honesty are integral to the standards expected of a registered nurse and central to the Code. The Parties agree that the Registrant's actions were dishonest. Dishonesty is serious misconduct. The Registrant not only breached the trust placed in nurses and the profession, but her actions also led to a vulnerable patient suffering serious harm. Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In order that members of the public have confidence to trust their and their loved ones care to nurses, it is important that Registrants follow the code of conduct and uphold the highest standards of behaviour.

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

relevant' to the determination of the question of current impairment and they are as follows:

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

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

a) *Some types of conduct are identified as more easily remediable than others as they can be objectively and universally identified, meaning focused, objective and targeted remediation is possible. The failure to update the handover notes may in itself be capable of remediation as it is a recognised area of practise capable of targeted improvement. It is the Registrant's refusal to provide a handover which raises attitudinal concerns which are more difficult to put right and the subsequent associated dishonesty which is more difficult to remediate as it involves an act of dishonesty directly linked to the Registrant's practice.*

It has been identified above that there was a risk of harm to the public, and in this case unfortunately, the risk of harm to Patient A was realised as a result of the Registrant's failure to provide a handover and to update the relevant notes. In addition there are concerns surrounding the Registrant's trustworthiness and integrity. This concern emphasises the need to maintain and promote public confidence in the nursing profession. The NMC guidance is clear in respect of concerns that call into question a registrant's honesty and integrity and state: '…the public take concerns which affect the trustworthiness of nurses and midwives particularly seriously. Our research told us that the public are likely to see these cases as serious breaches of professional standards. Conduct that could affect trust in nurses and midwives and require action to uphold standards or public confidence include, where related to professional practice, dishonesty...'

The parties agree that such misconduct is difficult, to remediate.

*b) As mentioned above, attitudinal concerns and dishonesty are more difficult to remediate. Although the Registrant admits the charges and has shown some remorse, the Registrant has still not fully explained why she acted as she did. There is some evidence of insight in the reflective statement provided by the Registrant (**Appendix 1**) in which she said:*

'I never left the ward before I ensured the patients who were to be discharged had their paperwork completed…it was out of character for me to leave the ward without giving a handover.

I admit I didn't handover the patient to the staff coming on duty…I did not act maliciously or in any was this deliberate & I fully regret my actions. I understand the seriousness of the regulatory concerns as outlined'.

The Registrant accepts that she failed to complete the required documentation for Patient A and in her reflective statement she explains that the Ward was very busy and that she was trying to complete more than one task at a time which led to her feeling overwhelmed. The Parties agree that by failing to provide a handover and ensuring that the handover notes were accurate it could be said that the Registrant put her own interests before that of her professional duty to ensure patient safety. In terms of remediation, as such has been unable to remediate the concerns identified in respect of her record keeping. It would therefore appear to be the case that the concerns identified remain very much in existence and there is a real risk that the misconduct would be repeated in the future.

c) As mentioned previously, although the Registrant has co-operated with the regulatory process and has provided a reflective statement and made admission to the charges, she has not been able to fully explain why she acted the way she did.

Given that the Registrant has not worked in a nursing capacity since her dismissal from the Trust, there is a real risk that this misconduct will be repeated in the future.

Impairment on public interest grounds:

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

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

29. Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In order that members of the public have confidence to trust their and their loved ones care to nurses, it is important that Registrants follow the code of conduct and uphold the highest standards of behaviour. If a nurse fails to do this then she calls into question whether she and other members of the nursing profession can be trusted by patients. The damage this causes to the reputation of the profession is so serious that the NMC as regulator must take action to maintain public confidence. In this case the Parties agree that the reputation of the nursing profession would be damaged if the Registrant were permitted to practise unrestricted and if a finding of current impairment were not made given the serious circumstances.

30. In this case the Parties agree that the reputation of the nursing profession would be damaged if the Registrant were permitted to practise unrestricted and if a finding of current impairment were not made given the serious circumstances.

Accordingly the Parties agree that a finding of impairment is required on public interest grounds.

Insight

31. The Registrant is engaging with the NMC and has demonstrated, by way of her full acceptance of the charges, that her fitness to practise is currently impaired by reason of her misconduct. The Registrant's agreement to this provisional agreement is in itself evidence of insight. However, although there is evidence of some insight, the Registrant has not been able to fully demonstrate sufficient insight into the seriousness of her actions and the impact that this had on Patient A, his family and the Registrant's colleagues.

Sanction

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

33. The Parties have identified the following aggravating features:
- direct harm/risk to patients;
- attitudinal concerns;
- dishonesty;
- breach of duty of candour

34. The Parties have identified the following mitigating features:
- some level of insight;

- early admissions;
- no previous regulatory findings;

35. The Registrant has shown some insight and acceptance into her failings. In considering what sanction would be appropriate the Parties began by considering whether this is a case in which it would be appropriate to take no further action. The Parties agree that this is not a suitable sanction given the serious nature of the misconduct and agree that public confidence in the profession would be damaged should no action be taken. Similarly, a caution order would not be a sufficient course of action to address the public interest considerations in this case. Further, such a sanction would not be sufficient to maintain public confidence as the Registrant's subsequent actions involved dishonest conduct, and the guidance on seriousness confirms that there are some concerns, that are more difficult to put right and often mean that the Registrant's right to practise needs to be restricted.

36. The Parties considered the imposition of a conditions of practice order. The Parties agree that the misconduct is so serious that there are no conditions that could be properly formulated to alleviate the regulatory concerns identified. In weighing all of the information before it, the Parties agree that it could not formulate workable conditions of practice and that conditions would not satisfy the public interest element.

37. The Parties considered whether a period of temporary removal from the register would adequately mark the seriousness of the Registrant's conduct and agreed that it would not. The guidance on seriousness and dishonesty emphasises that the most serious kind of dishonesty is 'when a nurse or midwife deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone's care'. The guidance states that not all dishonesty is equally serious and provides a helpful list of situations which are considered more serious by their nature. From this list the following factors have been identified as relevant to the circumstances of this case:

- deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients;
- direct risk to patients;

38. While the Registrant does show some insight, she does not seem to acknowledge the seriousness of the failings nor is she able to provide reassurance that such conduct would never happen again.

39. The Parties considered whether a striking-off order would be appropriate in this case and agree that the misconduct in this case is so serious that it is fundamentally incompatible with ongoing registration. The Registrant failed to provide a handover to colleagues of patients in her care resulting in limited information being available to those taking over the care of a number of patients. Patient A was an elderly, vulnerable gentleman who was not included in the handover notes and neither was he seen to during the time that he was admitted onto Ward 12. The Registrant's failure to provide a handover resulted in those taking over care of patients on Ward 12, at the conclusion of the Registrant's shift, not being aware of Patient A. Neither were they immediately aware of Patient A's vulnerabilities. The Registrant was in a senior position as a Nurse and Ward Manager and subsequent to this incident, she failed to uphold the duty of candour and failed to be honest about what had occurred.

40. Following on from the incident, the Registrant did not accept that she had failed to provide a handover. The evidence indicates that throughout the investigation process, the Registrant provided different versions of events and initially suggested that she had provided a handover but later accepted that this was not the case. The Registrant subsequently suggested that she had tried to give a handover to her colleague and it was the colleague that had refused to take the handover. Furthermore, the Registrant's action in refusing to provide a handover raises an additional question as to whether there exists underlying attitudinal concern – such

concerns are more difficult to remediate. We are aware that patient care and patient safety is one of the most basic principles of nursing care and the Registrant cleared failed in her duty of care. The Parties agree that the only sanction that is appropriate and proportionate in this case is a striking off order.

41. Finally, given that the Parties agree that the misconduct is serious due to the dishonesty and that the appropriate sanction is one of a striking off, the Parties agree that an interim suspension order for a period of 18 months is necessary in order to protect the public from harm and is also in the public interest to cover the appeal period.

42. It is agreed that the likelihood of appealing this determination is remote, given that it has been reached by agreement. Furthermore, the public would not expect a nurse who had admitted the conduct which is the subject of these charges to frustrate the process by appealing the order. Nonetheless the Parties agree that an interim suspension order is necessary as identified above.

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

Here ends the provisional CPD agreement between the NMC and Mrs Cook. The provisional CPD agreement was signed by Mrs Cook's representative on her behalf and the NMC on 11 February 2021.

Decision and reasons on the CPD

The panel decided to accept the CPD.

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

The panel noted that they had been a public hearing in a Coroner's Court and so there was no public interest in holding a public hearing in respect of these charges. The panel noted that Mrs Cook admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of Mrs Cook's admissions as set out in the signed provisional CPD agreement and signed by the RCN, her solicitors, on her behalf, on 11 February 2021.

Decision and reasons on impairment

The panel then went on to consider whether Mrs Cook's fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Mrs Cook, the panel has exercised its own independent judgement in reaching its decision on impairment. It considered the guidance by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of *CHRE v Grant & NMC [2011] EWHC 927 (Admin) ('Grant') by Cox J*.

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
d) Has in the past acted dishonestly and/or is liable to act dishonestly in the future;

The panel determined that all four of the limbs as identified in the case of Grant have been engaged.

In respect of misconduct the panel was of the view that Mrs Cook's conduct fell far below the standards expected of a registered nurse, who was also the nurse in charge on that shift. The panel endorsed paragraphs 18 to 22 of the provisional CPD agreement in respect of misconduct.

The panel then considered whether Mrs Cook's fitness to practise is currently impaired by reason of misconduct. The panel determined that Mrs Cook's fitness to practise is currently impaired. The panel considered that her actions clearly put patients at unwarranted risk of harm, specifically Patient A. The panel took into account that Mrs Cook was not charged for causing or contributing to the death of Patient A.

Mrs Cook's failure to provide basic nursing care has breached a fundamental tenet of the nursing profession when she failed to provide a handover and to update the relevant notes, and consequently, brought the profession into disrepute.

The panel noted that whilst Mrs Cook has accepted, through her representative, that her fitness to practise as a registered nurse is currently impaired, it had no evidence before it to demonstrate sufficient insight, remorse, or remediation. The panel recognised that such attitudinal concerns which involve dishonesty are difficult to remediate in the particular circumstances of the case. In this case Mrs Cook was repeatedly dishonest, and by doing

so attempted to cast blame on her nursing colleagues, and deceived the Court. Mrs Cook has provided no explanation for her actions and has not worked in a nursing capacity since her dismissal from the Trust. The panel determined that the reputation of the nursing profession would be damaged if she were permitted to practise unrestricted.

The panel therefore determined that there remains a risk of repetition and a consequent risk of unwarranted harm to patients, and therefore potential damage to the reputation of the nursing profession if a finding of impairment were not made.

In this respect the panel endorsed paragraphs 23 to 30 of the provisional CPD agreement.

The panel bore in mind that the overarching objectives of the NMC is 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. It determined that a fully informed member of the public would be appalled by Mrs Cook's misconduct, and extremely concerned should a finding of no current impairment be made in light of her actions.

Having regard to all of the above, the panel was also satisfied that Mrs Cook's fitness to practise as a registered nurse is currently impaired on public protection and public interest grounds.

Decision and reasons on sanction

Having found Mrs Cook's fitness to practise currently impaired, the panel went on to consider whether the sanction proposed in the CPD was the appropriate sanction in this case in the light of the information provided by the NMC and Mrs Cook in that document.

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 took into account the following aggravating features:

- direct harm/risk to patients;
- attitudinal concerns;
- dishonesty;
- breach of duty of candour.

The panel also took into account the following mitigating features:

- some level of insight;
- early admissions;
- no previous regulatory findings.

The panel decided that it would be neither proportionate nor in the public interest to take no further action.

Due to the serious nature of the misconduct, and the public protection issues identified, an order that does not restrict Mrs Cook'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 Mrs Cook's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Cook's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of

the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. The panel noted that Mrs Cook has not worked in a nursing capacity since she was dismissed from the Trust and it has no evidence to show that she has addressed the misconduct identified. Furthermore, the panel concluded that the placing of conditions on Mrs Cook's registration would not adequately address the seriousness of this case and would not protect the public. The panel determined that there are no conditions that could be properly formulated to alleviate the regulatory concerns identified which involve dishonesty.

The panel considered whether the concerns identified could be addressed by temporary removal from the register and whether a period of suspension would be sufficient to protect patients and satisfy the wider public interest concerns. It considered that Mrs Cook has not offered any evidence by way of insight or remediation for this panel to take account of in making its determination. The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction to address the public protection and public interest concerns identified.

This conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel agreed that the serious breach of the fundamental tenets of the profession evidenced by Mrs Cook's actions is fundamentally incompatible with her remaining on the register.

The panel was of the view that the agreed facts in this particular case demonstrate that Mrs Cook'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 agreed with the CPD 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 Mrs Cook'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.

Accoringingly the panel accepts the CPD agreement.

Interim order

In confirming the CPD the panel noted, and agreed, that an interim order for 18 months should be imposed. The panel considered this was appropriate for the reasons set out in the CPD.

That concludes this determination.