Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Consensual Panel Determination
Friday 17 September 2021

Virtual Hearing

Name of registrant:	Glenda Jayne Grafton
NMC PIN:	76J0950E
Part(s) of the register:	Registered Nurse – Sub Part 2 RN2: Adult Nurse (December 1978)
Area of registered address:	Cumbria
Type of case:	Misconduct
Panel members:	Andrew Harvey (Chair, Lay member) Marcia Smikle (Registrant member) Jacqueline Metcalfe (Registrant member)
Legal Assessor:	Jeremy Barnett
Panel Secretary:	Safa Musad
Nursing and Midwifery Council:	Represented by Michael Smalley, Case Presenter
Miss Grafton:	Not present and unrepresented
Consensual Panel Determination:	Accepted
Facts proved:	All
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim Suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

As of 31 March 2020, a number of amendments to 'The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004' (as amended) (the Rules) came into force, in response to the current Covid-19 pandemic.

As a result of these amendments the Nursing and Midwifery Council (NMC) is now able to serve notice of hearings by email and has the ability to hold hearings virtually.

The panel was informed at the start of this hearing that Miss Grafton was not in attendance and that the Notice of Hearing had been sent to Miss Grafton's registered email address on 19 August 2021.

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

Mr Smalley, on behalf of the NMC, submitted that it had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Grafton 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 Miss Grafton

The panel next considered whether it should proceed in the absence of Miss Grafton. It had regard to Rule 21 and heard the submissions of Mr Smalley who invited the panel to continue in the absence of Miss Grafton. He submitted that Miss Grafton had voluntarily absented herself.

Mr Smalley informed the panel that a provisional Consensual Panel Determination (CPD) agreement had been reached and signed by Miss Grafton on 15 May 2021. He drew the panel's attention to the first page of the CPD which states that Miss Grafton is aware of the CPD hearing and does not intend to attend the hearing and is content for it to proceed in her absence.

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 Miss Grafton. In reaching this decision, the panel has considered the submissions of Mr Smalley, the signed CPD agreement, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Miss Grafton has engaged with the NMC and has signed a provisional CPD agreement which is before the panel today;

- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

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

Details of charge

'That you, a registered nurse:

1) On 11 September 2018, you;

    a) Moved Resident A contrary to his care plan/moving and handling care document and/or moving and handling procedures in that you:

        i. did not use a hoist, and/or
        ii. did not have the assistance of a second member of staff;

    b) Your conduct at charge 1(a) caused Resident A to sustain an injury and/or cut to his:
        i. Head;
        ii. Elbow;

    c) Failed to undertake a full examination of Resident A following his fall in that you did not conduct:
        i. a Post Fall Assessment;
        ii. neurological observations;
        iii. an assessment of vital signs;

iv. a detailed assessment of his appearance and/or head;

d) Following Resident A's fall, moved Resident A in an unsafe manner and/or contrary to the moving and handling care document/instruction in that you:

i. Moved Resident A when it was unsafe to do so;
ii. Did not use a hoist/handling aid;
iii. Physically handled and/or lifted Resident A by putting your hands under or around his arms and/or shoulders and lifted him from the floor;
iv. Was aggressive and/or rough in your handling of Resident A;

e) Failed to recognise that Resident A had sustained a head injury;

f) Did not escalate Resident A's fall and/or head injury to a medical professional and/or call for an ambulance;

g) Did not undertake and/or did not ensure that observations were undertaken of Resident A for 24 hours post-fall;

h) Your actions resulted in a delay of appropriate treatment and care to Resident A;

i) Gave incontinence care to Resident A whilst he was on the floor and/or without assistance from another member of staff;

j) Failed to complete relevant records in that you did not:
i. document that Resident A had suffered a fall in his observation sheet;
ii. complete an Incident Form;
iii. complete an Accident/Incident Report Form;

iv. record Resident A's fall in the Accident Book;
v. complete a body map
vi. document your assessment of injury;

k) In referring to Resident A, stated "there's nothing wrong with him", or words to that effect;

l) Stated to Colleague A that "I shouldn't have moved him on my own " and "we'll have to say the two of us were with him" and/or "we'll have to say we did him on his bed", or words to that effect;

m) Did not handover to staff that Resident A had suffered a fall during the night shift;

2) On 13 September 2018, following the discovery that Resident A had suffered an injury, you:

a) Telephoned Colleague A on one or more occasions;

b) On speaking with Colleague A, you said:

i. "next time you go in, say you don't know that he had fallen and you don't know how it happened" , or words to that effect;
ii. for Colleague A to not say anything about Resident A's fall, or words to that effect;
iii. for Colleague A to say that Resident A had been changed on the bed, or words to that effect;

c) Sent Colleague A one or more text messages as set out in Schedule A;

3) Your conduct at one or more of the charges and sub- charges above at charges 1(j), 1(k), 1(l) and 1(m), 2(a), 2(b) and/or 2(c) was dishonest in that you attempted to conceal your conduct and/or Resident A's fall;

4) Your conduct at charge 1(l) and/or 2(a) and/or 2(b) and/or 2(c) above were carried out to pressure and/or persuade and/or intimidate Colleague A to conceal your conduct and/or Resident A's fall;

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

Schedule A

1. At approximately 10.42, "because you haven't been on shift you don't know when he banged his head its only because I told you. I'm probably worried for nothing let me know what's said", or words to that effect;

2. At approximately 18.14, "you didn't say anything to [Colleague B] did you? If you did can you tell her not to say anything because I could loose my job if they find out", or words to that effect;

Consensual Panel Determination

At the outset of this hearing, Mr Smalley informed the panel that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the NMC and Miss Grafton.

The agreement, which was put before the panel, sets out Miss Grafton'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 a striking off order.

Mr Smalley submitted that the events that occurred involved the inappropriate use of moving and handling techniques and resulted in a subsequent fall which caused injuries to a service user. Further, he submitted that Miss Grafton attempted to involve others in the cover up of the incident and this was the most serious. He submitted that the four limbs as set out in the case of *Council for Healthcare Regulatory Excellence v NMC (2) Grant* [2011] EWHC 927 (Admin) are engaged in this case.

Mr Smalley submitted that there remains a risk of repetition and that current impairment is required to uphold proper standards of conduct and to maintain public confidence in the profession.

Mr Smalley outlined the aggravating and mitigating features as set out in the CPD agreement. He submitted that Miss Grafton has demonstrated a lack of remediation, the conduct caused harm and put a patient at risk of harm and there was an attempt to cover up the conduct. Mr Smalley told the panel that the agreed sanction is one of a striking-off order and there is also an application for an interim suspension order for a period of 18 months to cover the period before which the order comes into effect and to cover any appeal period.

The panel has considered the provisional CPD agreement reached by the parties, which reads as follows:

'The Nursing and Midwifery Council and Miss Glenda Jayne Grafton ('the Registrant'), PIN 76J0950E, ('the Parties') agree as follows:

1. *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 telephone should any clarification on any point be required, or should the panel wish to make any amendment to the provisional agreement. The Registrant understands that if the panel wishes to make amendments to the provisional agreement that she doesn't agree with, the panel will reject the CPD and refer the matter to a substantive hearing.*

The charge

2. *The Registrant admits the following charges:*

   That you, a registered nurse:

   1) *On 11 September 2018, you;*

      a) *Moved Resident A contrary to his care plan/moving and handling care document and/or moving and handling procedures in that you:*
         i. *did not use a hoist, and/or*
         ii. *did not have the assistance of a second member of staff;*

b) *Your conduct at charge 1(a) caused Resident A to sustain an injury and/or cut to his:*

   i) *Head;*

   ii) *Elbow;*

c) *Failed to undertake* a *full examination of Resident A following his fall in that you did not conduct:*

   i) a *Post Fall Assessment ;*

   ii) *neurological observations ;*

   iii) *an assessment of vital signs;*

   iv) a *detailed assessment of his appearance and/or head;*

d) *Following Resident A's fall, moved Resident A in an unsafe manner and/or contrary to the moving and handling care documentation/instruction in that you:*

   i) *Resident A when it was unsafe to do so;*

   ii) *Did not use a hoist/handling aid;*

   iii) *Physically handled and/or lifted Resident A by putting your hands under or around his arms and/or shoulders and lifted him from the floor;*

   iv) *Was aggressive and/or rough in your handling of Resident A;*

e) *Failed to recognise that Resident A had sustained a head injury;*

f) *Did not escalate Resident A's fall and/or head injury to a medical professional and/or call for an ambulance;*

g) *Did not undertake and/or did not ensure that observations were undertaken of Resident A for 24 hours post-fall;*

h) *Your actions resulted in a delay of appropriate treatment and care to Resident A;*

i) *Gave incontinence care to Resident A whilst he was on the floor and/or without assistance from another member of staff;*

j) *Failed to complete relevant records in that you did not:*
   - i) *document that Resident A had suffered a fall in his observation sheet;*
   - ii) *complete an Incident Form;*
   - iii) *complete an Accident/Incident Report Form;*
   - iv) *record Resident A's fall in the Accident Book;*
   - v) *complete a body map;*
   - vi) *document your assessment of injury;*

k) *In referring to Resident A, stated "there's nothing wrong with him'; or words to that effect;*

l) *Stated to Colleague A that "I shouldn't have moved him on my own "and "we'II have to say the two of us were with him" and/or "we'll have to say we did him on his bed'; or words to that effect;*

m) *Did not handover to staff that Resident A had suffered a fall during the night shift;*

2) *On 13 September 2018, following the discovery that Resident A had suffered an injury, you:*

   a) *Telephoned Colleague A on one or more occasions;*

   b) *On speaking with Colleague A, you said:*

      i) *"next time you go in, say you don't know that he had fallen and you don't know how it happened", or words to that effect:*

      ii) *for Colleague A to not say anything about Resident A's fall, or words to that effect;*

      iii) *for Colleague A to say that Resident A had been changed on the bed, or words to that effect;*

   c) *Sent Colleague A one or more text messages as set out in Schedule A;*

3) *Your conduct at one or more of the charges and sub- charges above at charges 1(j), 1(k), 1(l) and 1(m), 2(a), 2(b) and/or 2(c) was dishonest in that you attempted to conceal your conduct and/or Resident A's fall;*

4) *Your conduct at charge 1(l) and/or 2(a) and/or 2(b) and/or 2(c) above were carried out to pressure and/or persuade and/or intimidate Colleague A to conceal your conduct and/or Resident A's fall;*

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

Schedule A

1. *At approximately 10.42, "because you haven't been on shift you don't know when he banged his head its only because I told you. I'm probably worried for nothing let me know what's said': or words to that effect;*

2. *At approximately 18.14, "you didn't say anything to [Colleague B] did you? If you did can you tell her not to say anything because I could loose my job if they find out", or words to that effect;*

Agreed Facts

3. *The Registrant first entered onto the NMC's Register in 1978. She started working at Croft Care Nursing Home (the "Home") in May 2001.*

4. *The NMC received a referral from the Home on 20 November 2018. At the relevant time the Registrant was working as a staff nurse at the Home.*

5. *The Registrant was working a night shift at the Home on the night of 10/11 September 2018. The Registrant entered Resident A's room at around 04:00 and activated the room's bell/light system which indicated she was in there, but not requiring help.*

6. *Resident A had been incontinent of urine and faeces. The Registrant moved Resident A to a sitting position, before standing them up to change the bed sheets. In doing so, the Registrant ignored Resident A's care plan, which stipulated that they are to be moved by two people, or a hoist can be used. Resident A's Personal Handling Risk Assessment also indicated that Resident A needed two carers when moving such as when standing up, walking and bathing and showering. See exhibit* ***SH/02****.*

7. *The Registrant moved Resident A by herself. Whilst the Registrant was moving Resident A, Resident A fell. The Registrant stated at a local level that she attempted to stop the fall, but being alone, could not prevent Resident A falling to the floor.*

8. *A Health Care Assistant, Colleague A, at the Home had been caring for residents on the floor above but had finished their rounds. Colleague A saw that Resident A's light was on and went to assist the Registrant. When they entered the room, they found that the Registrant was tending to Resident A, who was on the floor. The Registrant then said to Colleague A, "I shouldn't have tried to move (Resident A) on my own, we'll have to say the two of us were with (Resident A)," and "there's nothing wrong with him".*

9. *The Registrant proceeded to change Resident A's incontinence pads while they were still on the floor, before assisting Resident A back to bed with the help of Colleague A. The Registrant lifted Resident A by putting her hands under Resident A's arms and lifting him from the floor.*

10. *Colleague A has given evidence that the Registrant was aggressive and rough in her handling of Resident A. The Registrant also checked Resident A over in a superficial manner. The Registrant did not complete any observations on Resident A, record anything in their care records or complete the necessary steps for when a resident has a fall.*

11. *The Registrant has confirmed that she did not take any observations of Resident A or perform any neurological observations as she was unaware that Resident A had sustained a head injury. See exhibit* ***SH/05****.*

12. *Failing to undertake observations of a resident following a fall is contrary to the Home's policies. See exhibits **SH/10, SH/11, SH/13**. The policy says that a resident should be checked for any pain, and visible injuries or deformities, which may indicate a fracture. General observations such as blood pressure and pulse should also be taken as well as neurological observations. Observations should also have been undertaken of Resident A for 24 hours post-fall.*

13. *The Home's General Manager has given evidence that the Registrant should have called '999' as Resident A had sustained a cut to their head that would have been bleeding. The Registrant should have also documented Resident A's fall, which she failed to do. The General Manager states that:*

    "The Registrant should have completed an accident/incident form and a body map to say whether or not Resident A had had any injuries. The Registrant should also have filled in an incident form to notify management so we could consider whether or not Resident A needed extra support."

14. *The following morning, the Registrant did not handover to oncoming staff that Resident A had fallen. The Registrant admitted at a local level that she did not do so but knew that she should have.*

15. *Two HCA's caring for Resident A in the morning found a large wound on the back of Resident A's head. A wound was also discovered to Resident A's elbow. See exhibit **SH/04** for a photo of the head injury sustained.*

16. *The two nurses present that morning, Colleague B and Colleague C, were informed and took the appropriate steps including undertaking observations. There was no lasting harm to Resident A and he did not require further medical attention.*

17. *On 13 September 2018, the Registrant contacted Colleague A by phone and text, asking them not to talk about the incident, and for them to say that they didn't know how the injury could have happened and that Resident A had been changed on the bed. The Registrant then told Colleague A that she might lose her job if anyone found out. A copy of these text messages are exhibited at* ***HT/01*** *and* ***SH/08****.*

18. *Colleague A has given evidence that she felt intimidated and upset. Colleague A gives evidence that:*

    "I felt that the Registrant was trying to get me to say that I wasn't aware of how (Resident A) has sustained his injuries if I was questioned about it."

19. *Colleague A filled out a complaint form accordingly.*

20. *At an investigation meeting held on 24 September 2018, the Registrant admitted all of the concerns. The Registrant admitted to moving Resident A without the assistance of another person or a hoist, despite Resident A's care plan stating this and accepts that she did not take appropriate action following Resident A's fall. The Registrant admitted that she did not recognise that Resident A had sustained a head injury. The Registrant also admitted that she had phoned and texted Colleague A on 13 September 2018 and attempted to persuade her to conceal her actions. The Registrant also admitted that she did not record the fall in Resident A's care notes or complete the necessary paperwork needed following the fall. A copy of the notes of the investigation meeting and disciplinary hearing is exhibited at* ***SH/05*** *and* ***SH/14****.*

21. *The Registrant is not currently working in a nursing capacity.*

Misconduct

22. *Both parties agree that the facts amount to misconduct.*

23. *Whether the facts found proved amount to misconduct is a matter entirely for the panel's professional judgment. There is no burden or standard of proof (per Council for the Regulation of Health Care Professionals v (1) General Medical Council (2) Biswas [2006] EWHC 464 (Admin)).*

24. *The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:*

> *'[3318-E] 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 rule and standards ordinarily required to be followed by a [nursing] practitioner in the particular circumstances'.*

As may the comments of Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), respectively

> *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'.*

And

'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner.

25. *Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Nursing and Midwifery Council's Code of Conduct.*

26. *Our Code of Conduct (2015 version) sets out the professional standards that nurses must uphold. These are the standards that patients and members of the public expect from health professionals. On the basis of the charges found proved, it is agreed that the following parts of the Code are engaged in this case:*

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:
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

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

To achieve this, you must:
14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.
14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

To achieve this, you must:

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

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

To achieve this, you must:

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

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

27. *The Parties agree that the Registrant failed to comply with Resident A's care plan, causing them harm. The Registrant did not take sufficient or any appropriate action following Resident A's fall in failing to undertake observations and assessment, failing to recognise that Resident A had suffered a head injury. She then acted dishonestly in an attempt to cover up her failings in failing to record Resident A's fall and handing this over to staff so that observations could be undertaken. She then attempted to pressure a junior colleague into covering up her conduct.*

28. *The Registrant deliberately chose to take an unreasonable risk to Resident A's safety prior to his fall and then by not acting appropriately aftewards (sic).*

The Registrant acted dishonestly and breached her professional duty of candor to be open and honest when things went wrong. The Registrant's actions following Resident A's fall intended to mislead and attempted to cover up her actions. The Registrant then attempted to obstruct, hinder and pressure a more junior colleague not to tell the truth, suppressing openness and patient safety. Because of the importance of honesty and candour to a registrant's practice, dishonesty will always be considered serious.

29. *It is agreed that these failings, and subsequent misconduct can properly be characterised as very serious and fellow professionals would consider the Registrant's actions deplorable.*

30. *NMC guidance explains at FtP-3a that there are a small number of concerns which are serious and so serious that it might be less easy for the registrant to put right the conduct and raises concerns about a registrant's attitude. The Registrant's conduct are examples of such concerns.*

31. *Accordingly, the Registrant accepts that her actions in this case amount to misconduct.*

<u>Impairment</u>

32. *The Registrant's fitness to practise is currently impaired by reason of her misconduct.*

33. *Current impairment is not defined in the Nursing and Midwifery Order 2001 or The Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (Sl2004/1761). The question of current impairment is often approached by addressing the questions posed by Dame Janet Smith in her Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of Council for*

Healthcare Regulatory Excellence v NMC (2) Grant [2011] EWHC 927 (Admin):

"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

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

ii) *has in the past, and/or is she liable in the future to bring the professions into disrepute;*

iii) *has in the past, and/or is she liable in the future to breach one of the fundamental tenets of the professions;*

iv) *has in the past, and/or is she liable in the future to act dishonestly."*

Also said when considering impairment

"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"

34. *The Parties agree that all four limbs above are engaged in this case.*

Actual physical and emotional harm was caused to Patient A through the Registrant's disregard of proper moving and handling techniques. The Registrant exhibited risk-taking behavior (sic) by ignoring the care plan and causing harm to Resident A as a result. The head injury was not recognised by the Registrant, leading to several hours passing before this injury was properly assessed and treated. It is likely that Resident A would have been in some pain and distress. Furthermore, by failing to properly observe, record, or report the fall, and a failure to pass on information to colleagues at the handover could have resulted in further harm occurring to Patient A.

35. *The Parties agree that the Registrant has acted in such a way so as to bring the profession into disrepute. It is agreed that this behavior (sic) would be viewed as deplorable by both other nurses and the general public. Further, it shows a number of breaches to the fundamental tenets of nursing, namely care and integrity. The health and safety of patients is an essential and vital component of high quality nursing care. Nurses have a professional duty to ensure that patients in their care are safe in the environment where they are being cared for. Nurses also have a duty of candour and should always act with honesty and integrity. The Registrant failed to do so.*

36. *Moreover, the Registrant then acted dishonestly in an attempt to cover up her failings, and attempted to pressure a junior colleague into silence.*

37. *Impairment is a forward thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.*

38. *The clinical concerns are remediable however it is acknowledged that attitudinal and dishonesty concerns are very difficult to remediate.*

39. *The Parties agree that the concerns in this case have not been remedied. The misconduct involves a serious failing in both essential skills and responsibilities in care, record-keeping, and integrity. The allegations also raise attitudinal concerns, and fundamental concerns about the Registrant's trustworthiness and professionalism.*

40. *The Registrant accepts that she has not demonstrated remorse or insight beyond acceptance of the charges, and has not taken steps to remediate her conduct. The Registrant has not worked in a similar clinical setting since the incident.*

41. *Consequently, the concerns are not easily remediable, have not been remediated, and as such, there is a risk that they may be repeated.*

Impairment - public protection

42. *The Parties agree that due to the Registrant's attitudinal concerns, lack of insight / reflection, and the fact that the concerns have yet to be remediated, there remains a risk of the concerns being repeated in the future. If the Registrant's actions were to be repeated, they would place patients at serious risk of harm.*

43. *The Parties agree that in these circumstances a finding of current impairment is necessary on public protection grounds.*

Impairment - public interest

44. *In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:*

    "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."

45. *The full seriousness of the regulatory concerns has been identified and is accepted by the Parties. A member of the public would be shocked and offended to learn that the Registrant acted in the way she did. This is also conduct which members of the public may not feel that they are able to trust registrants and may take risks with their own well-being and health by avoiding treatment or care. Accordingly the Parties agree that this is a case where a finding of current impairment is also required to declare and uphold proper professional standards and protect the reputation of the nursing profession.*

46. *The Parties agree that a finding of current impairment is also required on public interest grounds.*

Sanction

47. *The Parties agree that the appropriate sanction in this case is a* ***Striking Off order****.*

48. The aggravating features of the case are as follows:

a. Taking of unreasonable risks;

b. Lack of insight and remorse;

c. Lack of remediation;

d. Non-engagement with the NMC;

e. Conduct which put patients at risk of suffering harm;

f. Attempt to cover up conduct, which could have caused harm to Resident A, taking several steps to conceal her conduct, pressurised a junior colleague, and breached duty of candour;

49. The mitigating features are as follows:

a. No previous referrals to the NMC,

b. A long, unblemished career.

50. The Parties considered the appropriate sanction to impose, beginning with the least restrictive sanction. Given the seriousness of this case, the Parties agree that taking no further action, a caution order, or a conditions of practice order would clearly fail to adequately deal with the public protection and public interests grounds.

51. Further, the Parties agree that a suspension order would not be appropriate either. The Registrant has not engaged with the NMC or shown remorse, insight, or attempts to remediate her failings. Her conduct suggests serious attitudinal issues, underpinned by concerns surrounding her integrity, professionalism, and trustworthiness. If she were to stay on the register, this would risk substantially undermining public confidence in the profession. Moreover, in light of the lack of insight and remediation, it is agreed that a period of suspension would not adequately deal with the protection of the public concerns, especially given the serious attitudinal concerns.

52. *The Parties agree that the only order appropriate in the circumstances is a striking off order. The concerns in this case are extremely serious, and no other sanction would maintain public confidence in the profession or provide adequate protection for the public. NMC guidance at SAN-2a expressly addresses the seriousness of dishonesty cases by outlining factors that indicate whether a nurse should remain on the register. Amongst those factors are deliberate cover-ups, especially if it could cause harm to patients; misuse of power; vulnerable victims; not isolated or one-off dishonesty; and direct risk to patients. These factors are all relevant in this case. Because of the importance of honesty to a registrant's practice, dishonesty will always be considered serious and a registrant is always at risk of being removed from the register. The Parties agree that the Registrant's dishonesty is the most serious kind of dishonesty and her conduct is fundamentally incompatible with remaining on the register. It is agreed that they further show that a striking off order is the only appropriate sanction.*

Interim Order

53. *Finally, the Parties agree that an interim order is required in this case. The order is necessary for the protection of the public and is otherwise in the public interest (for the reasons given above). The order should be for a period of 18 months to guard against the risk to the public in the event that the Registrant seeks to appeal against the substantive order. The interim order should take the form of an interim suspension order.*

54. *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 and the*

agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegations, provided that it would be relevant and fair to do so.'

Here ends the provisional CPD agreement between the NMC and Miss Grafton. The provisional CPD agreement was signed by Miss Grafton on 15 May 2021 and by the NMC on 24 May 2021.

Decision and reasons on the CPD

The panel decided to accept the CPD.

The panel heard and accepted the legal assessor's advice. Mr Smalley referred the panel to the 'NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. He reminded the panel that it could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Miss Grafton. 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 Miss Grafton admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of Miss Grafton's admissions, as set out in the signed provisional CPD agreement.

Decision and reasons on impairment

The panel then went on to consider whether Miss Grafton's fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Miss Grafton, the

panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of misconduct, the panel determined that the conduct was very serious in this case. The panel noted that the conduct involved Miss Grafton undertaking an activity that she should not have done alone which resulted in an accident where a vulnerable older patient was caused direct significant harm. It noted that Miss Grafton could have taken steps to seek support and treatment for the patient but instead attempted to get another colleague to cover up the incident. The panel concluded that this element of dishonesty is significant and serious. The panel was of the view that Miss Grafton's conduct breached several areas of the Code as highlighted within paragraph 26 of the CPD agreement. The panel therefore determined that Miss Grafton's actions amounted to misconduct.

In this respect, the panel endorsed paragraphs 22 to paragraph 31 of the provisional CPD agreement in respect of misconduct.

The panel then considered whether Miss Grafton's fitness to practise is currently impaired by reason of misconduct. The panel determined that Miss Grafton's fitness to practise is currently impaired. The panel noted that although there has been some remorse, there was no information before the panel to demonstrate that Miss Grafton has remediated her practice. It noted that despite Miss Grafton's unblemished career and that she has not had any previous referrals to the NMC, there are no reflections or any information to suggest that Miss Grafton has understood the gravity of what occurred, has addressed any of the concerns identified or demonstrated what she would do differently if she faced similar circumstances in the future. The panel therefore determined that there remains a high risk of repetition and Miss Grafton's fitness to practise remains impaired on the grounds of public protection and the wider public interest.

In this respect the panel endorsed paragraphs 32 to paragraph 46 of the provisional CPD agreement.

Decision and reasons on sanction

Having found Miss Grafton'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 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:

- Taking of unreasonable risks;
- Lack of insight and remorse;
- Lack of remediation;
- Non-engagement with the NMC;
- Conduct which put patients at risk of suffering harm;
- Attempting to cover up conduct, which could have caused harm to Resident A, taking several steps to conceal her conduct, pressurising a junior colleague, and breaching the duty of candour;

The panel also took into account the following mitigating features:

- No previous referrals to the NMC.
- A long, unblemished career.

The panel first considered whether to take no action but concluded that this 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 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 and public interest issues identified, an order that does not restrict Miss Grafton's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Grafton'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 Miss Grafton'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 and seriousness of the charges in this case. Furthermore, the panel concluded that the placing of conditions on Miss Grafton's registration would not adequately address the seriousness of this case and would not protect the public.

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Grafton's actions is fundamentally incompatible with Miss Grafton 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?*

Miss Grafton'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 Miss Grafton'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 Miss Grafton'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 will be confirmed to Miss Grafton in writing.

Decision and reasons on interim order

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

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the 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 agreed with the CPD 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 to allow time for the striking off order to come into effect or to cover the period for any appeal.

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

That concludes this determination.