Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 4 April 2022 – Tuesday, 5 April 2022
&
Thursday, 7 April 2022 – Friday, 8 April 2022
&
Tuesday, 12 April 2022 – Thursday, 14 April 2022
&
Tuesday, 19 April 2022 – Wednesday, 20 April 2022
&
Friday, 22 April 2022
&
Monday, 20 May 2022 – Wednesday, 1 June 2022

Virtual Hearing

Name of registrant:	**Deborah Julie Goulty**
NMC PIN:	04K0329E
Part(s) of the register:	Registered Nurse – Sub-part 1 Adult Nursing (Level 1) – 7 January 2005
Area of registered address:	Suffolk
Type of case:	Caution/Misconduct/Health
Panel members:	Deborah Hall (Chair, Registrant member) Lorna Taylor (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Gelaga King (4 – 22 April 2022) Michael Levy (30 May 2022 – 1 June 2022)
Hearings Coordinator:	Sharmilla Nanan (4 – 8 April 2022) Philip Austin (12 April 2022 – 1 June 2022)
Nursing and Midwifery Council:	Represented by Alfred Underwood, Case Presenter
Mrs Goulty:	Present but not represented at the hearing

Facts proved by admission:	Charges 1, 5, 7, 8a, 8b, 10b, 12, 22c, 22e and 23
Facts proved:	Charges 2, 3, 4, 10c, 13, 14, 15a, 15b and 17b
Facts not proved:	Charges 6, 9, 10a, 11, 16, 17a, 18a, 18b, 18c, 19, 20, 21, 22a, 22b and 22d
Fitness to practise:	Currently impaired by way of Mrs Goulty's police caution and misconduct. Not currently impaired by way of health
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order – 18 months**

Details of charge: (Before amendments)

That you, a Registered Nurse,

1. On 16 October 2018, accepted a caution from police for theft by consuming of morphine sulphate salutation on 23 and 24 September 2018.

2. On 23 and/or 24 September 2018, worked part of a clinical shift under the influence of morphine sulphate solution.

3. On one or more occasions between 01 August 2019 and 07 October 2019, while working at Avocet Care Home, obtained, for the use of yourself or another, Codeine to which you were not entitled.

4. Your actions at 3. above were dishonest in that you were appropriating for your or another's use property belonging to another to which you knew you were not entitled.

5. On the 26 July 2014, administered blood belonging to Patient A to Patient B

6. On the 23 February 2018, gave a double dose of chemotherapy to Patient D

7. On the 25 February 2018, gave the chemotherapy too early to Patient D

8. On 01 May 2018,

    a) copied out a prescription, without doctor approval for Patient E

    b) administered un-prescribed prescription medication to Patient E

9. On 17 May 2018, failed to re-order and/or replace a Butrans patch for Patient F

10. On 05 June 2018,

    a) failed to administer a Clexane injection to Patient F

    b) signed to say that injection had been administered when it had not

    c) left that injection unattended

11. On 22 June 2018, failed to complete a fluid balance chart for Patient G.

12. Between 02 August 2018 and 03 August 2018, failed to obtain a second signature when amending the insulin rate of the IV fluids for a patient.

13. On 01 September 2018, administered and/or second checked the incorrect bag of fluids to/for Patient I.

14. On 24 June 2019 at Avocet Care Home, failed to administer Sertraline and/or Memantaline to Resident C.

15. On 09 July 2019

    a) failed to administer a calcium tablet to D Resident

    b) failed to administer Doxazoson to Resident E

16. On 16 October 2017, drank liquid refreshment and/or looked at and/or used your mobile phone during a drug round

17. On or about 16 October 2017, when speaking with Colleague A,

a) Described Patient C with the following words or words to the effect that they were a ‘fucking cunt’

b) with reference to Patient C, used the following words or words to the effect that you would ‘go to the fucking patient and tell him what I think of him’

18. On an unknown date in approximately December 2017 – March 2018

a) shouted or said to Patient K the following words or words to the effect of ‘shut up’

b) waved your fist near to the face of Patient K

c) In the presence of Colleague A, with respect to Patient K, used the following words or words to the effect of ‘I won’t be fucking responsible for what I do to him in a minute.’

19. On one or more occasions on Somersham Ward during 2017 & 2018 other than at charge 16 above, drank liquid refreshment during drug rounds

20. On one or more occasions during 2017 and 2018 left Somersham ward without informing other staff

21. On one or more occasions on Somersham Ward during 2017 & 2018 slept on duty

22. On 29 September 2019

a) accepted an offer of money from Resident F

b) took Resident F out without first liaising with management

c) took Resident F out in a car without appropriate insurance in respect of transporting a Resident

d) took Resident F out without an escort

e) took Resident F out with your daughter

23. Have the Health condition at Schedule A

And, in light of the above, your fitness to practise is impaired by reason of your caution in respect of charge 1, and/or your misconduct in respect of charges 2 – 22, and your health condition in respect of charge 23.

Schedule A:
[PRIVATE]

Admissions

At the outset of the hearing, you admitted charges 1, 5, 7, 8a, 8b, 10b, 11, 12, 22c, 22e, 23.

The panel heard and accepted the advice of the legal assessor.

In taking account of the advice of the legal assessor, the panel found charges 1, 5, 7, 8a, 8b, 10b, 11, 12, 22c, 22e, 23 proved by way of admission.

Decision and reasons on application for hearing to be held in private

At the outset of the hearing, you made a request that the entirety of this case should be held in private on the basis that proper exploration of your case involves references to your health and personal circumstances. You expressed concern as to who was observing proceedings as you did not know if the observer would go back to your former workplaces to talk about matters raised in this hearing. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Underwood, on behalf of the Nursing and Midwifery Council (NMC), submitted that the default position is that hearings are conducted in public for transparency. He indicated that he supported the application to the extent that any reference to your health and personal circumstances should be heard in private. However, he submitted that, ultimately, it is at the panel's discretion as to whether this case should be heard entirely in private.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in relation to matters regarding your health and personal circumstances as and when such issues are raised in order to protect your right to privacy. The panel considered your submissions but determined that as this case involves a large number of people, it was in the public interest for the remainder of the hearing to be held in public.

NMC Opening

You became a registered nurse in January 2005, and you began working at Ipswich Hospital NHS Trust ("the Hospital") shortly after qualifying. You worked as a registered nurse on Somersham Ward ("the Ward") from 2012 and were seconded to a Band 6 Deputy Sister Role from March 2018 to July 2018. You later worked for Avocet Care Home ("the Home") from April 2019 to October 2019.

The concerns identified in this case relate to your health, clinical nursing practice, and your conduct and behaviour.

It is alleged that you accepted a police caution from Suffolk Police on 19 October 2018 in relation to theft of morphine sulphate salutation (Oramorph) from the Hospital on 23 and 24 September 2018. It is said that this came about as the Chief Pharmacist at the Hospital noticed that the Oramorph supply on the Ward was regularly short of the expected amount, so the Hospital began to monitor how much of the drug was being issued and how much was being used. This allegedly led the Hospital to discover that large quantities of the drug were going missing. The police were contacted, and they installed CCTV at the Hospital. You were allegedly seen consuming Oramorph at the start and end of your nursing shifts on 23 and 24 September 2018 when the police examined the CCTV footage.

You also allegedly made several clinical errors at the Hospital and the Home, including:

- Administering blood belonging to Patient A to Patient B on 26 July 2014.

- Giving a double dose of chemotherapy to Patient D on 23 February 2018 and starting chemotherapy too early for Patient D on 25 February 2018. Patient D suffered from a rare condition known as '*ALPS*' or '*Canale-Smith Syndrome*' and he was on a five-day course of chemotherapy. It is alleged that on one of the days when nurses went to administer a dose of chemotherapy, it was not there. Upon

checking the fluid balance chart for Patient D, it appeared that there was more fluid than expected, and it was thought that this might have been because chemotherapy had already been administered by you without you recording it. Furthermore, two days later, it is alleged that you administered chemotherapy to Patient D five and half hours too early.

- Failing to re-order and/or replace a Butrans patch (a painkiller medication containing buprenorphine, an opioid) at the appropriate time for Patient F on 17 May 2018. It is alleged that the Butrans patch ought to have been replaced on that date (as it was a seven-day prescription and had been applied on 10 May 2018) but was not in fact re-applied until 21 May 2018.

- Failing to administer a Clexane injection to Patient F, signing to say that it had been administered when it had not, and leaving said injection unattended on 5 June 2018. Patient F was found by Witness 3, another registered nurse on the Ward, with the full syringe of Clexane in their hand. Witness 3 noted that the Medication Administration Record ("MAR") chart had been signed to say this medication had been administered but, in her view, it had not been.

- Failing to complete a fluid balance chart for Patient G on 22 June 2018.

- Failing to obtain a second signature when amending the insulin rate of the IV fluids for a patient between 2 August 2018 and 3 August 2018.

- Administering and/or second checking the incorrect bag of fluids to/for Patient J, a chemotherapy patient, on 1 September 2018. When this is said to have occurred, you were allegedly prohibited from administering drugs or checking fluids unless you were under direct supervision at the time.

- Failing to administer Sertraline and/or Memantine to Resident C at the Home on 24 June 2019.

- Failing to administer a calcium tablet to Resident D on 9 July 2019 on 9 July 2019 and failing to administer Doxazosin to Resident E on 9 July 2019.

- Copying out a prescription for Patient E without a doctor's approval on 1 May 2018, and then administered the un-prescribed prescription medication to this patient.

In addition to the above clinical concerns, it is alleged that between October 2017 and September 2019, you conducted yourself in an inappropriate or unprofessional manner whilst on shift.

It is alleged that on or about 16 October 2017, when speaking with Colleague A, you described Patient C as "*a fucking cunt*" or words to that effect. It is alleged that you also said to Colleague A that you would "*go to the fucking patient and tell him what I think of him*".

Furthermore, it is alleged that you shouted or said to Patient K to "*shut up*" and that you also waved your fist near the patient's face. In the presence of Colleague A, with respect to Patient K, you also allegedly used words to the effect of "*I won't be fucking responsible for what I do to him in a minute*".

You allegedly left the Ward on more than one occasion without informing other staff members that you were leaving, and also slept whilst on duty on more than one occasion. You also allegedly used your mobile phone and drank coffee or soft drinks when completing drugs rounds on more than one occasion.

Additionally, when working at the Home on 5 October 2019, Witness 1, the night nurse, told Witness 2, the Clinical Care Manager, that when carrying out stock checks, they had noticed that codeine was missing. It is alleged that upon examining the MAR charts for three residents, they noticed that there were numerous discrepancies between how many codeine tablets had been administered to residents, and how much stock was remaining

on the medication trolleys or in storage. You were invariably the person who had been allegedly administering medication or signing the MAR charts. It is further alleged that Witness 2 also saw a box of codeine fall out of your pocket when you were handing over the keys to them. When asked about this in a meeting with Witness 2, you allegedly kept changing your story in respect of where the codeine had come from. It is alleged that you ultimately admitted to Witness 2 in that meeting that you had been taking codeine from the Home. It is alleged that you were dishonest in your actions, as you were appropriating property belonging to another which you knew you were not entitled to.

It is also alleged that on 29 September 2019, when you were on annual leave, you attended the Home and took Resident F out in your car for shopping and lunch with your daughter. Resident F had full capacity when this was reported to Witness 2 and the resident also allegedly reported that she had given you money to fix your car.

In respect of your health, it is alleged that you [PRIVATE].

Decision and reasons on application to amend the charges

The panel heard an application made by Mr Underwood, on behalf of the NMC, to amend the wording of charges 9, 11 and 13. The proposed amendments were to correct typographical errors in each of these charges.

Mr Underwood submitted that the proposed amendments would provide clarity and more accurately reflect the evidence before it. He submitted that the proposed amendments should be made in the interests of justice, and that no prejudice would be caused to you in allowing these amendments.

Mr Underwood proposed to amend the charges from:

"That you, a registered nurse:…

9. On 17 May 2018, failed to re-order and/or replace a Butrans patch for Patient F

10. …

11. On 22 June 2018, failed to complete a fluid balance chart for Patient G.

12. …

13. On 01 September 2018, administered and/or second checked the incorrect bag of fluids to/for Patient I."

To:

"That you, a registered nurse:

9. On 17 May 2018, failed to re-order and/or replace a Butrans patch for Patient G

10. …

11. On 22 June 2018, failed to complete a fluid balance chart for Patient H.

12. …

13. On 01 September 2018, administered and/or second checked the incorrect bag of fluids to/for Patient J."

You did not oppose the proposed amendments being made.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules, which states:

"*28.—(1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—*

(a) the charge set out in the notice of hearing; or

(b) the facts set out in the charge, on which the allegation is based,

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue."

The panel was of the view that such amendments, as applied for, were in the interests of justice. It was satisfied that in making these amendments, the charges would provide more clarity and better reflect the evidence the panel had received.

The panel noted that the substance of the charges against you will remain the same. The application was put forward to correct which patients the above charges referred too. It did not form the view that these proposed amendments would fundamentally alter the case you have to answer.

Therefore, the panel decided to amend charges 9, 11 and 13 in accordance with the proposed amendments.

Additionally, the panel, of its own volition, decided to propose the following amendments to the charges to correct more typographical errors, from:

"That you, a registered nurse:

1. *On 16 October 2018, accepted a caution from police for theft by consuming of morphine sulphate salutation on 23 and 24 September 2018.*

   …

15. *On 09 July 2019*

    a) Failed to administer a calcium tablet to D Resident

    b) Failed to administer Doxazoson to Resident E".

To:

"That you, a registered nurse:

1. *On 16 October 2018, accepted a caution from police for theft by consuming of morphine sulphate solution on 23 and 24 September 2018.*

   …

15. *On 09 July 2019*

    a) Failed to administer a calcium tablet to Resident D

    b) Failed to administer Doxazosin to Resident E".

On day four of the proceedings, the panel, again of its own volition, decided to amend the following dates set out in the charges below to provide further clarity and better reflect the evidence it had heard. The charges initially read:

“That you, a registered nurse:…

14. On 24 June 2019 at Avocet Care Home, failed to administer Sertraline and/or Memantaline to Resident C.

15. On 09 July 2019…”

To:

“That you, a registered nurse:…

14. On 25 June 2019 at Avocet Care Home, failed to administer Sertraline and/or Memantaline to Resident C.

15. On 08 July 2019...”.

The panel requested to hear submissions from you and Mr Underwood in relation to the proposed amendments. Mr Underwood indicated that he agreed with the proposed amendments as proposed by the panel, and you stated that you did not oppose these further amendments being made.

Further decision and reasons on application to amend charges

At the end of the NMC’s case, the panel heard an application from Mr Underwood to make further amendments to charges 9 and 14.

In respect of charge 9, Mr Underwood submitted that the panel has received evidence to suggest that there was no Butrans patch left in stock on the Ward on 17 May 2018 and, as such, it was not possible for you to deliver this pain relief to Patient F. He submitted that it

would be unfair to you if the charge was to remain in its current state, as you cannot administer medication to a patient that is not readily available.

Mr Underwood submitted that it would be fair in all the circumstances to make a further amendment to charge 9. He invited the panel to remove the words '*and/or replace*' so that it now reads as follows:

"That you, a registered nurse:…

9. On 17 May 2018, failed to re-order a Butrans patch for Patient F"

In addition to this, Mr Underwood submitted that now Witness 10 is not being called by the NMC to give oral evidence, there is no evidence before this panel to suggest that you failed to administer Memantine to Resident C. He submitted that it would be fair to amend this charge to more accurately reflect the evidence received.

Mr Underwood submitted that the proposed amendment does not cause you any prejudice or injustice. To the contrary, he submitted that it reduces the seriousness of the charge against you. Mr Underwood invited the panel to amend charge 14 to the following:

"That you, a registered nurse:…

14. On 25 June 2019 at Avocet Care Home, failed to administer Sertraline to Resident C."

You told the panel that you had no objections to these charges being amended. You said you had no further comments in respect of this application.

The panel heard and accepted the advice of the legal assessor.

The panel was of the view that such amendments, as applied for, were in the interests of justice. It noted that the proposed further amendments to charges 9 and 14 would amount to a reduction in the charges, which could not be said to prejudice or disadvantage you in any way.

In considering the proposed amendments, the panel noted that there are no additional words that have been included for charges 9 and 14. Therefore, allowing the amendments would not fundamentally alter the case you have to answer, as you were aware of the substance of these allegations against you.

The panel was satisfied that in making these amendments, the charges would provide more clarity and better reflect the evidence the panel had received. The panel decided to grant Mr Underwood's application to amend charges 9 and 14, as proposed.

Details of charge (as amended)

That you, a Registered Nurse,

1. On 16 October 2018, accepted a caution from police for theft by consuming of morphine sulphate solution on 23 and 24 September 2018.

2. On 23 and/or 24 September 2018, worked part of a clinical shift under the influence of morphine sulphate solution.

3. On one or more occasions between 01 August 2019 and 07 October 2019, while working at Avocet Care Home, obtained, for the use of yourself or another, Codeine to which you were not entitled.

4. Your actions at 3 above were dishonest in that you were appropriating for your or another's use property belonging to another to which you knew you were not entitled.

5. On the 26 July 2014, administered blood belonging to Patient A to Patient B

6. On the 23 February 2018, gave a double dose of chemotherapy to Patient D

7. On the 25 February 2018, gave the chemotherapy too early to Patient D

8. On 01 May 2018,

   a) Copied out a prescription, without doctor approval for Patient E

   b) Administered un-prescribed prescription medication to Patient E

9. On 17 May 2018, failed to re-order a Butrans patch for Patient F

10. On 05 June 2018,

    a) Failed to administer a Clexane injection to Patient G

    b) Signed to say that injection had been administered when it had not

    c) Left that injection unattended

11. On 22 June 2018, failed to complete a fluid balance chart for Patient H.

12. Between 02 August 2018 and 03 August 2018, failed to obtain a second signature when amending the insulin rate of the IV fluids for a patient.

13. On 01 September 2018, administered and/or second checked the incorrect bag of fluids to/for Patient J.

14. On 25 June 2019 at Avocet Care Home, failed to administer Sertraline to Resident C.

15. On 08 July 2019

    a) Failed to administer a calcium tablet to Resident D

    b) Failed to administer Doxazosin to Resident E

16. On 16 October 2017, drank liquid refreshment and/or looked at and/or used your mobile phone during a drug round

17. On or about 16 October 2017, when speaking with Colleague A,

    a) Described Patient C with the following words or words to the effect that they were a '*fucking cunt*'

    b) With reference to Patient C, used the following words or words to the effect that you would '*go to the fucking patient and tell him what I think of him*'

18. On an unknown date in approximately December 2017 – March 2018 ,

    a) Shouted or said to Patient K the words or words to the effect of '*shut up*'

    b) Waved your fist near to the face of Patient K

c) In the presence of Colleague A, with respect to Patient K, used the words or words to the effect of '*I won't be fucking responsible for what I do to him in a minute*'.

19. On one or more occasions on Somersham Ward during 2017 & 2018 other than at charge 16 above, drank liquid refreshment during drug rounds

20. On one or more occasions during 2017 and 2018 left Somersham ward without informing other staff

21. On one or more occasions on Somersham Ward during 2017 & 2018 slept on duty

22. On 29 September 2019

    a) Accepted an offer of money from Resident F

    b) Took Resident F out without first liaising with management

    c) Took Resident F out in a car without appropriate insurance in respect of transporting a Resident

    d) Took Resident F out without an escort

    e) Took Resident F out with your daughter

23. Have the Health condition at Schedule A

And, in light of the above, your fitness to practise is impaired by reason of your caution in respect of charge 1, and/or your misconduct in respect of charges 2-22, and your health condition in respect of charge 23.

Schedule A:
[PRIVATE]

Application to withdraw admission to charge 11

During your oral evidence, you told the panel that you wanted to withdraw your admission to charge 11. You made a formal application, telling the panel that you made a mistake in admitting this charge.

You stated that you were initially confused by the amount of complex paperwork before you relating to this matter. You are of the opinion that there is insufficient evidence provided in order for you to confirm whether you failed to complete a fluid balance chart for Patient H.

You invited the panel to allow you to withdraw your admission on this basis.

Mr Underwood, on behalf of the NMC, opposed this application.

Mr Underwood submitted that allowing you to withdraw your admission to charge 11 would cause prejudice to the NMC. He submitted that charge 11 was formally announced as proved by the panel and the NMC has since closed its case.

Mr Underwood acknowledged that whilst there is a considerable amount of paperwork involved in this case, the NMC has not been able to obtain the fluid balance chart for Patient H. Nonetheless, he submitted that the material the NMC intended to rely on has been with you for a significant period of time, and that you could have raised any concerns about the evidence at the case conference that you attended between you and officers of the NMC.

Mr Underwood also referred the panel to the Case Management Form (“CMF”) which you completed in advance of the substantive hearing. He submitted that in this document, you

ticked the box to indicate that you were admitting charge 11, as you believe it was "*your duty to oversee fluid balance charts*".

Furthermore, Mr Underwood submitted that there is a note of a meeting found within the paperwork which shows that the incident involving you failing to complete a fluid balance chart for Patient H was discussed between you and Witness 5, and an action plan for you was agreed moving forward.

Mr Underwood submitted that the panel will be acutely aware of the time pressures involved in this case and, should your application to withdraw your admission be granted, the NMC may need to consider recalling a witness to provide oral evidence on this matter. He submitted that the NMC are unaware of Witness 5's availability to attend this hearing.

Mr Underwood invited the panel to consider whether it would be fair to allow you to withdraw your admission to charge 11.

The panel heard and accepted the advice of the legal assessor.

The panel acknowledged that any admissions to charges should be made on an informed basis. It has been conscious throughout this hearing that the proceedings should be fair and be seen to be fair to you as you are not legally represented.

You told the panel during your oral evidence that you would be willing to admit this charge if documentation had been produced to confirm that you failed to complete a fluid balance chart for Patient H. However, the panel noted that it is now your view that this evidence has not been forthcoming, as no fluid balance chart had been obtained by the NMC and no Datix has been adduced in relation to the alleged incident. The panel considered there to be a significant amount of paperwork involved in this case, and you stated that this could have contributed to your confusion in admitting this charge.

Whilst the panel noted that you had ticked the box to indicate that you admitted the charge in the CMF document, the panel considered your written response to this charge contained within the document to be hypothetical. It also had sight of the signed file note which indicated that you accepted the allegation made by the Trust, but this file note made no specific reference to any patient or the date on which it is said to have occurred.

The panel decided to allow its finding on charge 11 to be vacated. It was of the view that it would be unfair to not give you the opportunity to withdraw your admission.

In making this decision, the panel determined that there could be some injustice caused to the NMC in you withdrawing this admission as it has already closed its case. However, in the panel's judgment, this could be remedied by an application to re-open the NMC's case to allow it to adduce further evidence.

The panel determined that it would then be able to make a decision on charge 11 at a later point in proceedings.

Therefore, the panel decided that it would be fair to allow you to withdraw your admission to charge 11.

Decision and reasons on facts

At the outset of the hearing, you admitted charges 1, 5, 7, 8a, 8b, 10b, 11, 12, 22c, 22e, 23 and the panel announced these proved by way of admission. The panel allowed you to withdraw your admission to charge 11 during the hearing.

In reaching its decisions on the disputed facts, the panel took account of all the oral and documentary evidence adduced, together with the submissions made by Mr Underwood on behalf of the NMC, and the submissions made by you in support of your case.

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

The panel heard oral evidence from the following witnesses called on behalf of the NMC who, at the time of the alleged events, were employed in the following roles:

- Witness 1: Long term agency staff nurse at the Home
- Witness 2: Clinical Care Manager at the Home
- Witness 3: Registered Nurse on the Ward at the Hospital
- Witness 5: Junior Sister on the Ward at the Hospital
- Witness 6: Sister on the Ward at the Hospital
- Witness 7: Nursing Manager on the Dementia Ward at the Hospital
- Witness 8: Clinical Nurse Specialist at the Hospital
- Witness 9: Matron for the in-patient services at the Hospital

- Colleague A: Junior Sister on the Ward at the Hospital

The panel also heard evidence from you, along with two witnesses called on your behalf.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and you.

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

Charge 2)

2. On 23 and/or 24 September 2018, worked part of a clinical shift under the influence of morphine sulphate solution.

This charge is found proved.

In reaching this decision, the panel took account of Witness 9's evidence, as well as your own evidence.

The panel had regard to Witness 9's NMC witness statement.

The panel noted that you do not dispute consuming morphine sulphate solution when working a clinical shift, but you do dispute it negatively impacted upon your ability to practise safely and effectively as a registered nurse.

The panel noted that the charge reads that you '*worked part of a clinical shift under the influence of morphine sulphate solution*'. The wording does not state that you were unfit to work as a result of consuming the medication. Instead, in order to find the charge proved,

the panel noted that it would simply need to consider whether you were '*under the influence of morphine sulphate solution*'.

The panel was of the view that, in consuming morphine sulphate solution, you would have immediately been under the influence of that medication, irrespective of whether it had a detrimental impact on your ability to perform your role. You had told the panel that the medication benefitted you as it was an effective pain relief. You said the pain disappeared after approximately 15 – 20 minutes, thereby acknowledging that the medication did have some sort of effect. The severity of what this could have meant is worthy of discussion at the next stage of proceedings.

Accordingly, the panel found charge 2 proved.

Charge 3)

3. On one or more occasions between 01 August 2019 and 07 October 2019, while working at Avocet Care Home, obtained, for the use of yourself or another, Codeine to which you were not entitled.

This charge is found proved.

In reaching this decision, the panel took account of Witness 1 and Witness 2's evidence, as well as your own evidence.

The panel had regard to Witness 1 and Witness 2's NMC witness statement.

In considering this charge, the panel found Witness 2's oral evidence to be credible and reliable. It noted that Witness 2 had accepted during her oral evidence that she had formed a pre-conceived opinion as to who had taken the codeine, and accepted that your resignation letter had been drafted in advance of the meeting by another member of staff

which you elected to sign when presented with it. However, this panel considered that the methods employed by the Home to investigate the matter had no impact on whether or not you had previously taken the codeine.

You told the panel that you had resigned under duress, stating that you had been kept in the meeting room against you will for three, then three and a half hours, until you signed the pre-prepared resignation letter.

The panel considered you to have provided the Home with several inconsistent accounts at the meeting. At the investigation meeting, you said that you had received the codeine which fell from your pocket in a separate Pharmacy delivery but then contradicted this by saying you had taken this from elsewhere. You initially denied taking the codeine but then, having changed your demeanour (tone and body language), admitted the allegation and provided an explanation for why you had taken it. You had said that you forgot to re-order codeine initially, but then decided not to highlight that it was missing because you thought you might be suspected of taking the codeine if you drew attention to the depleted stock level.

The panel had sight of the MAR charts and handwritten audit for the three residents in question which demonstrated that there was an unexplained deficit in the stock balance of codeine. You had completed all three stock balance boxes on the MAR charts on days when medication did not add up. All of the evidence suggested that codeine was being taken from the Home, and it did not consider you to have provided a credible or reliable explanation for having codeine in your pocket at work, why you did not re-order the medication when it went out of stock, or for your behaviour/admissions during the meeting.

In taking account of the above, the panel preferred the evidence of Witness 2 in comparison to yours in relation to this charge.

Therefore, on the balance of probabilities, the panel found charge 3 proved.

Charge 4)

4. Your actions at 3 above were dishonest in that you were appropriating for your or another's use property belonging to another to which you knew you were not entitled.

This charge is found proved.

In reaching this decision, the panel took account of Witness 1 and Witness 2's evidence, as well as your own evidence.

It had regard to the case of *Ivey v Genting Casinos Ltd t/a Crockfords [2017] UKSC 67* in determining whether you had been dishonest in your actions, as outlined in charge 3. In particular, the panel noted in paragraph 74:

> *"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."*

In finding that you did take the codeine from the Home, the panel considered you to have fabricated a version of events that do not match what happened on those days. You gave several inconsistent accounts at the meeting with Witness 2, and you attempted to deflect responsibility through your initial denials. The panel reminded itself that it had preferred

the clear and consistent evidence of Witness 2 to that of your evidence in this respect. It also found your explanations to be confused and inconsistent during your oral evidence.

The panel was of the view that you would have been aware that the codeine was not yours to take as it was prescribed to a particular resident. The panel was not satisfied that you had made an honest mistake in taking the codeine medication from the Home, and it determined that ordinary and decent people would consider your actions to have been dishonest. The panel determined that when you had sought to create a misleading impression.

Therefore, the panel found charge 4 proved on the balance of probabilities.

Charge 6)

6. On the 23 February 2018, gave a double dose of chemotherapy to Patient D

This charge is found NOT proved.

In reaching this decision, the panel took account of Witness 9's evidence, as well as your own evidence.

The panel had regard to Witness 9's NMC witness statement.

The panel noted that Witness 9 did not work at the Hospital at the time of the incident, yet she was the only witness called by the NMC in support of this charge. Therefore, Witness 9 was unable to say with any real certainty that a double dose of chemotherapy was administered to Patient D.

You denied giving a double dose of chemotherapy to Patient D on 23 February 2018.

Whilst there appeared to be some sort of entry in Patient D's fluid balance chart indicating a further dose of chemotherapy may have been given, it was unclear as to what this entry meant. No one saw the alleged first dose of chemotherapy in existence or being administered to Patient D, nor did the patient say that they had received two doses.

In taking account of the above, the panel found charge 6 not proved.

Charge 9)

9. On 17 May 2018, failed to re-order a Butrans patch for Patient F

This charge is found NOT proved.

In reaching this decision, the panel took account of Witness 3, Witness 5 and Witness 9's evidence, as well as your own evidence.

The panel had regard to Witness 9's NMC witness statement, in which she had stated:

> "*The butrans patch was supposed to be applied on 10 May 2018 and replaced on 17 May 2018. Deborah was the nurse looking after Patient F…In Patient F's medication chart,…there was a number 1 in the box to show that there was only one remaining butrans patch…When Deborah saw this, she should have reordered the drug and replaced the patch. She did not do this…*"[sic].

In considering this charge, the panel was of the view that in order for you to have '*failed*' to do something, there must have been a duty imposed on you to act in a certain way.

The panel noted that Patient F should have had a Butrans patch applied after seven days, but Patient F ended up waiting for eleven days for a Butrans patch due to the medication stock being depleted.

A Datix was created in relation to this incident and the internal investigation concluded that the registered nurse who had entered a '*1*' on Patient F's medication chart was deemed to be responsible for re-ordering the Butrans patch, as well as the night nurses who were on the duty on 17 May 2018. You told the panel that you also believed that it was the night nurses' responsibility to re-order the medication, but you could not recall whether you were one of the registered nurses ordering drugs that night.

From the evidence before it, the panel was not clear on who had the responsibility to re-order the Butrans patch for Patient F. None of the NMC witnesses were able to confirm that you were one of the registered nurses completing the drugs order on 17 May 2018, or that you made the entry in Patient F's medication chart. Because of this, the panel was of the view that the NMC has not been able to discharge its burden of proof.

Accordingly, the panel found charge 9 not proved.

Charge 10a)

10. On 05 June 2018,

    a) Failed to administer a Clexane injection to Patient G

This charge is found NOT proved.

In reaching this decision, the panel took account of Witness 3, Witness 5, Witness 6 and Witness 9's evidence, as well as your own evidence.

In considering this charge, the panel was of the view that in order for you to have '*failed*' to do something, there must have been a duty imposed on you to act in a certain way.

The panel had regard to Witness 9's NMC witness statement, in which she had stated that this drug was due to be withheld that evening as the patient had a planned procedure the following day. In oral evidence, your version of events concurred with that of Witness 9, in that you stated that you stopped the medication round prior to administering the Clexane to seek the advice of a doctor regarding its administration. The panel is therefore satisfied that the Clexane medication was not to be administered, and hence you had no duty to do so.

The panel could not be satisfied that you '*failed*' in your duty to administer this medication. To the contrary, there was supporting evidence to suggest this medication should not have been administered.

Accordingly, the panel found charge 10a not proved.

Charge 10c)

10. On 05 June 2018,

    c) Left that injection unattended

This charge is found proved.

In reaching this decision, the panel took account of Witness 3, Witness 5, Witness 6 and Witness 9's evidence, as well as your own evidence.

The panel had regard to Witness 9's NMC witness statement, in which she had stated:

> "*However, when [Witness 3] did the evening drug round, she found the medication on Patient G's bedside table and it had not been administered….As you can see*

from the highlighted portion of the patient notes, [Witness 3] had written that she had found the medication on the table…".

The panel noted that Patient G had full capacity, and she had informed Witness 3 that you had not administered the Clexane injection to her when she was found with it in her possession. The panel had sight of the '*Patient Notes*' for Patient G, as well as the Datix report, both of which provide a more contemporaneous record of the events which are said to have transpired. The panel noted that it has not been contested that Patient G was found with the Clexane injection at any point.

You were the registered nurse who conducted the medication round on 5 June 2018.

You stated that you had the Clexane injection on the medication trolley, you got it out and signed to say that you administered it to the patient. However, you questioned whether that dose should be withheld due to the procedure scheduled the following day, so you went to clarify this with a doctor. You said that you put the Clexane injection back on the medication trolley and took it away with you. You told the panel that you would not leave a Clexane injection unattended. The panel did not find your oral evidence to be credible in this respect, as this does not account for how the patient got hold of the Clexane injection. You had signed the MAR chart to indicate that this medication had been administered to Patient G.

In adopting a common sense approach, the panel determined that it was more likely than not that you had left the Clexane injection unattended, and this is how Patient G came to have the medication in her possession. There was no other plausible explanation offered for how Patient G came to have the Clexane injection in her possession.

Accordingly, the panel found charge 10c proved.

Charge 11)

11. On 22 June 2018, failed to complete a fluid balance chart for Patient H.

This charge is found NOT proved.

In reaching this decision, the panel took account of Witness 3, Witness 5, Witness 6 and Witness 9's evidence, as well as your own evidence.

The panel had regard to Witness 9's NMC witness statement, in which she had stated:

> "*I produce…the file note dated 22 June 2018. Unfortunately, without the name of the patient, the patient's number or the datix number, I am unable to provide any further records or evidence of this incident…".*

The panel had regard to Witness 5's NMC witness statement, in which she had stated:

> "*I am not sure when this incident occurred and I do not recall the Datix number and as such cannot produce this as evidence in my statement. This incident happened on a night shift and I would have done the file note either the next day or a few days after…*".

In considering this charge, the panel was of the view that in order for you to have '*failed*' to do something, there must have been a duty imposed on you to act in a certain way.

The panel noted that the only evidence it had to support this charge was a file note relating to the incident. There was no mention in this file note of who the patient was, nor was a Datix report ever created. The panel noted that it did not receive a fluid balance chart for Patient H, and this incident was not investigated at the time so it had minimal information before it.

Whilst you had signed a file note as a result of an incident, there was no evidence to prove that you were in charge of Patient H's care, or that this file note related to Patient H. None of the NMC witnesses were able to confirm who Patient H was, and it was not clear that the evidence adduced related to them.

In taking account of the above, the panel was of the view that the NMC had not been able to discharge its burden of proof in respect of this charge.

Accordingly, the panel found charge 11 not proved.

Charge 13)

13. On 01 September 2018, administered and/or second checked the incorrect bag of fluids to/for Patient J.

This charge is found proved.

In reaching this decision, the panel took account of Witness 6 and Witness 9's evidence, as well as your own evidence.

The panel had regard to Witness 9's NMC witness statement, in which she had stated:

> "*I was made aware of this incident by the datix being raised. This incident relates to chemotherapy patient, Patient J…*
>
> *Patient J was on a chemotherapy medicine called methotrexate. As such, we had to give Patient J fluid that included bicarbonate and check that Patient J's urine PH was above 7. Patient J had the wrong bag of fluids. Deborah was one of the members of staff who had either checked the fluids or administered the medication. It is not clear from the datix what Deborah's responsibility was. We*

were also unable to identify the second signature of the prescription. I produce the drug charts…which shows that Deborah had signed against the prescription…".

The panel noted from the Datix report that you may have been one of two registered nurses who had responsibility for this. Whilst this does not identify what your exact role was in either administering and/or second checking the bag of fluids, you accepted that your signature is on the MAR chart for Patient J. The prescription for Patient J was for 100 millimoles of sodium bicarbonate in the fluid bag and you administered a bag with 50 millimoles. You accepted during your oral evidence that you administered 50 millimoles of sodium bicarbonate to a bag of fluid that was then given to Patient J; rather than you picking up the incorrect fluid bag.

In taking a common sense approach to this charge, the panel was satisfied that this was the incorrect fluid bag and this should not have been administered to Patient J. The panel was satisfied from the prescription that a specified dose was prescribed to Patient J and you administered an incorrect dose.

Accordingly, the panel found charge 13 proved.

Charge 14)

14. On 25 June 2019 at Avocet Care Home, failed to administer Sertraline to Resident C.

This charge is found proved.

In reaching this decision, the panel took account of Witness 7's evidence, as well as your own evidence.

The panel had regard to Witness 7's NMC witness statement, in which she had stated:

"*The stock balance on the MAR chart…showed there was no dose given the previous morning for…sertraline…*

When I spoke to Deborah about the missing medication, she insisted that she had given the medication. However, upon further reflection she remembered that there was an emergency that day and so she had probably forgotten to give the medication…".

In considering this charge, the panel was of the view that in order for you to have '*failed*' to do something, there must have been a duty imposed on you to act in a certain way.

During your oral evidence, you appeared to accept that you may have simply forgotten to administer Sertraline to Resident C, although you would like to think that you would not have.

The panel noted from the letter dated 26 June 2019 that you were suspended from administering medications a day after this incident occurred. It explicitly referenced within this letter that you failed to administer one of the morning's medications on 25 June 2019.

The panel noted from the evidence before it that you were the registered nurse conducting the drug round on 25 June 2019. It had sight of Resident C's MAR chart, which appeared to show that Sertraline had not been administered to Resident C on 25 June 2019. There was no signature on the MAR chart to indicate that Sertraline had been administered to Resident C, and the stock balance for the medication remained unchanged. There is no reason documented by you to explain why Sertraline was not administered to Resident C.

In the absence of any evidence to the contrary, the panel concluded that it was your responsibility to administer Sertraline to Resident C, but you had failed to do so.

Accordingly, the panel found charge 14 proved.

Charge 15a)

15. On 08 July 2019

a) Failed to administer a calcium tablet to Resident D

This charge is found proved.

In reaching this decision, the panel took account of Witness 7's evidence, as well as your own evidence.

The panel had regard to Witness 7's NMC witness statement, in which she had stated:

> "*Resident D's calcium tablets were not given on the first day of the 28 day cycle on 8 July 2019. the senior carer who was on shift the next day, noticed this error whilst doing her medication rounds that the stock did not balance. She also noticed that there was an unopened box of calcium tablets. No pictures were taken as we don't usually take photos. The senior carer checked the medication to see if the daily stop check (which is documented on the MAR chart) was correct and realised that the medication that was meant to be given on the Monday was not given because the actual container was still sealed. It showed on the MAR chart that there was no signature and so we thought Deborah had not given the medication. we thought it was Deborah who had not given the medication because she was on a Long Day (8:00-20:00) shift according to the rota and her signatures or initials reflected on the rest of the other residents' tea time drug rounds. I wrote up an incident form…*".

In considering this charge, the panel was of the view that in order for you to have '*failed*' to do something, there must have been a duty imposed on you to act in a certain way.

During your oral evidence, you appeared to accept that you may not have administered a calcium tablet to Resident D, but you could not account for why you had not done so.

The panel noted that the evidence suggests that you were the registered nurse conducting the drug round on 8 July 2019.

The panel had sight of Resident D's MAR chart, which appeared to show that a calcium tablet had not been administered to Resident D on 8 July 2019. There was no signature on the MAR chart to indicate that a calcium tablet had been administered to Resident D, and the stock balance from 9 July 2019 also appears to support the allegation that this medication was not administered on 8 July 2019. There is no reason documented by you to explain why a calcium tablet was not administered to Resident D.

The incident form dated 9 July 2019, which was completed by Witness 7, is also corroborative of you having failed to administer a calcium tablet to Resident D on 8 July 2019.

In taking account of the above, the panel concluded that it was your responsibility to administer a calcium tablet to Resident D, but you had failed to do so.

Accordingly, the panel found charge 15a proved.

Charge 15b)

15. On 08 July 2019

    b) Failed to administer Doxazosin to Resident E

This charge is found proved.

In reaching this decision, the panel took account of Witness 7's evidence, as well as your own evidence.

The panel had regard to Witness 7's NMC witness statement, in which she had stated:

> "*Resident E was supposed to be given doxazosin twice a day…When the senior health carer reviewed the stock, there was an extra tablet than there should have been. Stock cheques were done daily and she checked the stock balance on the MAR chart against the actual physical stock.*
>
> *Resident E had been given her medication in the morning but not in the evening. When we looked at the MAR chart…Deborah had not signed for it and the running balance written showed that the tablet was not given. We know that it was Deborah that did not give the medication because she was on a Long Day (8:00-20:00) shift according to the rota and her signatures or initials reflected on the rest of the other residents' tea time MAR drug rounds. So Resident E did not get their medication…*
>
> *I spoke to Deborah about this incident and she said that the error may have been due to leftover medication being carried forward to the new cycle, so there appeared to be more medication than there should have been. I told Deborah, that this could not be the case because if there was leftover medication we would have known that it was not given. I do not recall what her response was…*"[sic].

In considering this charge, the panel was of the view that in order for you to have '*failed*' to do something, there must have been a duty imposed on you to act in a certain way.

During your oral evidence, you appeared to accept that you may not have administered Doxazosin to Resident E, but you could not account for why you had not done so.

The panel noted that the evidence suggests that you were the registered nurse conducting the drug round on 8 July 2019.

The panel had sight of Resident E's MAR chart, which appeared to show that Doxazosin had been administered to Resident E in the morning on 8 July 2019. However, there was no signature on Resident E's MAR chart to indicate that Doxazosin had been administered to them in the evening on 8 July 2019. The stock balance also demonstrated that Doxazosin was not administered to Resident E. There is no reason documented by you to explain why Doxazosin was not administered to Resident E.

Furthermore, the incident form dated 9 July 2019, which was completed by Witness 7, is also corroborative of you having failed to administer Doxazosin to Resident E on 8 July 2019, as it shows what the stock balance should have been had you administered the medication.

In taking account of the above, the panel concluded that it was your responsibility to administer Doxazosin to Resident E, but you had failed to do so.

Accordingly, the panel found charge 15b proved.

Charge 16)

16. On 16 October 2017, drank liquid refreshment and/or looked at and/or used your mobile phone during a drug round

This charge is found NOT proved.

In reaching this decision, the panel took account of Witness 8's evidence, as well as your own evidence.

The panel had regard to Witness 8's NMC witness statement, in which she had stated:

"*Patient C and the family member's wife and brother in-law (who is a GP) witnessed Deborah drinking on the drug round, looking and using her mobile phone and so the relatives spoked to the ward sister…*

When I spoke to Deborah about Patient C's concerns and about drinking whilst doing a drug round, Deborah denied that she did any of those things. Deborah eventually admitted that she had a drink but this was between patients. She said that she was on medication that was making her mouth dry and admitted to drinking costa coffee.

There was no datix raised but I documented the concern in Patient C's medical notes…I also verbally communicated the concern to the acting ward sister at the time…".

In respect of drinking liquid refreshment during a drug round, the panel considered there to be minimal evidence in support of this charge. The panel heard oral evidence from Witness 8, but it was not convinced the charge was found proved by her testimony as it largely relied on hearsay.

In respect of looking at and/or using your mobile phone during a drug round, the panel noted that, during your oral evidence, you said that you may occasionally use the calculator on your mobile phone to assist you with fluid calculations when working on the Ward. However, you did not agree that you had used your mobile phone during the drug round on 16 October 2017.

The panel noted that, aside from Witness 8, the NMC had only adduced hearsay evidence to corroborate this allegation. Patient C was not called to give evidence at this hearing, and the evidence suggests that he and/or his family were unhappy with the care you had provided. Therefore, in the absence of hearing from Patient C, and in being able to test his evidence, the panel placed little weight on what he had communicated to Witness 8 in respect of this charge.

In taking account of the above, the panel had minimal evidence before it to demonstrate that you drank liquid refreshment and/or looked at and/or used your mobile phone during a drug round on 16 October 2017. It was satisfied that the NMC had not been able to discharge its burden of proof.

Accordingly, the panel found charge 16 not proved.

Charge 17a)

17. On or about 16 October 2017, when speaking with Colleague A,

    a) Described Patient C with the following words or words to the effect that they were a '*fucking cunt*'

This charge is found NOT proved.

In reaching this decision, the panel took account of Colleague A's evidence, as well as your own evidence.

The panel had regard to Colleague A's NMC witness statement, and had sight of the contemporaneous email dated 21 October 2017, which was sent by Colleague A to Witness 13, the Acting Ward Manager. In this email, Colleague A relays the incident to Witness 13 and states that you were "*very upset and swearing a lot*", but the panel noted that there was an absence of the exact words you are alleged to have said in relation to Patient C, as outlined in the charge.

However, in her oral evidence, Colleague A was adamant that you had called Patient C a '*fucking cunt*'. Furthermore, Colleague A said that you used to use this kind of profanity all the time – it was one of your favourite words.

Colleague A explained that she did not include the words '*fucking cunt*' in the email to Witness 13 as she believed that Witness 13 would have been outraged at this being included, when asked to explain her omission.

The panel considered that despite Colleague A appearing to have a clear recollection of the words used in this instance, the contemporaneous record in the form of the email did not corroborate the language used during this incident. The panel considered that this incident was four years ago and, without any contemporaneous evidence of the exact words used, the passage of time may have impacted upon her recall.

You told the panel that you would not have used those words.

Therefore, on the balance of probabilities, the panel found charge 17a not proved.

Charge 17b)

17. On or about 16 October 2017, when speaking with Colleague A,

    b) With reference to Patient C, used the following words or words to the effect that you would '*go to the fucking patient and tell him what I think of him*'

This charge is found proved.

In reaching this decision, the panel took account of Colleague A's evidence, as well as your own evidence.

The panel had regard to Colleague A's NMC witness statement, in which she had stated:

"…she said she was going to 'the fucking patient and tell him what I think of him'. I told Deborah that she had to calm down and I asked her what was wrong. Deborah explained to me that she had not slept that day…I told her that she should have rung in and said she was too tired to come in…".

The panel had sight of the email dated 21 October 2017, which was sent by Colleague A to Witness 13, the Acting Ward Manager. In this email, Colleague A relays the incident to Witness 13 and records you having responded to the situation at the time by saying "*I aint having this Fucking shit…I aint having this and I will be speaking to him to tell him that's not right*"[sic].

The panel considered this to be supported by Colleague A's oral evidence, in which she stated that you wanted to go and see the patient despite being told to stay away from him.

You told the panel that under no circumstances were you angry with Patient C. You said you wanted to speak to him to see if your differences could be resolved. However, the panel was of the view that the evidence received appears to contradict this. The email dated 21 October 2017 was a contemporaneous record, having been completed 5 days after the alleged event. The panel therefore placed a significant amount of reliance on the contents within it.

The panel considered Colleague A to have had a clear recollection of your behaviour and the words used in reference to Patient C. Whilst the email does not state that you used the exact words '*go to the fucking patient and tell him what I think of him*', the panel found you to have used words to similar effect. The contents of the email reflects the gist of the words you are said to have used, and it was satisfied that the email was a more sanitised version of what you had allegedly said.

The panel considered Colleague A to be a credible witness and it found her account to be persuasive in specific regard to this charge due to the contemporaneous account of the email dated 21 October 2017.

The panel preferred the clear and consistent evidence of Colleague A, in contrast to your evidence, in respect of this charge.

Therefore, on the balance of probabilities, the panel found charge 17b proved.

Charges 18a) & 18b) & 18c)

18. On an unknown date in approximately December 2017 – March 2018 ,

    a) Shouted or said to Patient K the words or words to the effect of '*shut up*'
    b) Waved your fist near to the face of Patient K
    c) In the presence of Colleague A, with respect to Patient K, used the words or words to the effect of '*I won't be fucking responsible for what I do to him in a minute*'.

These charges are found NOT proved.

In reaching this decision, the panel took account of Colleague A's evidence, as well as your own evidence.

The panel had regard to Colleague A's NMC witness statement, in which she had stated:

> "*Patient K was very confused. he didn't know where he was and was unaware of his surroundings. He wasn't aware of what was happening.*
>
> *That night, Deborah was directly caring for Patient K. Patient K was distraught and was crying out for his wife. It was very difficult to pacify him or calm him down. Patient K was clearly getting Deborah agitated with his confusion and unsettled behaviour. She was getting angry with him, shouting at him to shut up and waving*

her fist in his face. It sounded like Deborah would psychically hurt him. Security had to be called. As the nurse in charge, I went to Deborah and told her to calm down and she said 'I won't be fucking responsible for what I do to him in a minute' in front of myself, [a healthcare assistant] and the security staff. Deborah called…the hospital coordinator, and said that she would not be held responsible for what she would do to the patient.

The only way I could resolve the issue was calling the patient's wife so that she could pacify him. the wife had said she was unable to come up because it was too far and it was late at night. In order to try and calm Patient K down and not to distract other patients in the bay in the middle of the night, we moved Patient K's Bed next to the nursing station to give him some rest and peace.

Deborah did eventually calm down. She was just distressed and agitated because Patient K was annoying her. Myself and [a healthcare assistant] stepped in and looked after Patient K, we told her we would deal with this patient and she could deal with the others.

I spoke to [Witness 13] and explained that I had concerns with help Deborah dealt with Patient K. as I had spoken to her, I did not write a datix and therefore I have no evidence of this incident…"[sic].

You again told the panel that this incident did not happen at all. You said that if you had behaved in this way towards Patient K, more than one person would have seen and heard you.

In considering these charges, the panel did not find Colleague A's oral evidence to be consistent. There were some inconsistencies in Colleague A's oral evidence, in contrast to her NMC witness statement. The panel considered Colleague A to have changed her stance in respect of who had gone to contact Patient K's wife, and the exact reason security were called to the incident. Colleague A said in her oral evidence that security

was called to assist staff with the patient; but the impression the panel received from her NMC witness statement was that security was called because of your behaviour, and not Patient K's.

Furthermore, had you behaved in the way alleged in the charges in front of the stated witnesses, the panel was of the mind that those involved would be duty bound to escalate this situation. The panel also noted that neither a Serious Incident Report nor a Datix report was created for this incident, so the panel had no corroborative documentary evidence to support the full extent of the allegations and the panel cannot be certain of what happened that night.

Therefore, the panel determined that, on the balance of probabilities, you did not say or shout words to the effect of '*shut up*' to Patient K, nor did you wave your fist near his face, or say the words '*I won't be fucking responsible for what I do to him in a minute*'

Accordingly, the panel found charges 18a, 18b and 18c not proved.

Charge 19)

19. On one or more occasions on Somersham Ward during 2017 & 2018 other than at charge 16 above, drank liquid refreshment during drug rounds

This charge is found NOT proved.

In reaching this decision, the panel took account of Colleague A, Witness 3, and Witness 4's evidence, as well as your own evidence.

The panel had regard to Colleague A's NMC witness statement, in which she had stated:

"*Deborah would also constantly drink red bull in front of patients, whilst doing medication rounds and she would place the drink in the medication trolley. I feel it is unprofessional to eat in front of patients when we should be 100% focused on what is being done. It doesn't set a professional tone and it can be a distraction...*".

The panel also had regard to Witness 3's NMC witness statement, in which she had stated:

"*…she would be drinking red bull constantly and would be unable to sit down...*".

Despite the inconsistencies in your oral evidence, the panel considered this charge to be very broad in its nature. You initially denied drinking liquid refreshment during drug rounds, but then stated that you may have sometimes had a carton of juice underneath the drug trolley.

Whilst two NMC witnesses attested to seeing you drink liquid refreshments during drug rounds, the panel was concerned as to the lack of specificity highlighted in the charge. The panel was not provided with a particular date or time of when you allegedly drank liquid refreshment during drug rounds, other than stating that it occurred on one more occasions over a two year period. There was no information surrounding who you were working with at the time and there is no evidence to suggest that these concerns were ever brought to your attention.

Therefore, in the absence of any specific or cogent evidence, the panel could not say with any real certainty that you drank liquid refreshment during drug rounds on one or more occasions on the Ward during 2017 & 2018.

Accordingly, the panel found charge 19 not proved.

Charge 20)

20. On one or more occasions during 2017 and 2018 left Somersham ward without informing other staff

This charge is found NOT proved.

In reaching this decision, the panel took account of Colleague A, and Witness 3's evidence, as well as your own evidence.

The panel had regard to Colleague A and Witness 3's NMC witness statement.

Again, the panel considered this charge to be very broad in its nature and it considered it to lack any real specificity. The panel was not provided with a particular date or time of when you are said to have left the Ward without informing other staff, other than to say that it occurred on one more occasions over a two year period.

A number of the NMC witnesses, in oral evidence, provided a range of legitimate clinical reasons why registered nurses would regularly need to leave the Ward. You acknowledged that you would not have told all staff on the Ward, but you would have always told someone when you were leaving the Ward. In oral evidence, you stated that this was occasionally a doctor or the Ward clerk who you speculate may have not told the nursing staff. You described the Ward as "*large and busy*" and often you could not locate other registered nurses to inform them that you needed to leave the Ward. The panel had no evidence to suggest otherwise.

Therefore, in the absence of any specific or cogent evidence, the panel could not say with any real certainty that you left the Ward without informing other staff on one or more occasions during 2017 and 2018.

Accordingly, the panel found charge 20 not proved.

Charge 21)

21. On one or more occasions on Somersham Ward during 2017 & 2018 slept on duty

This charge is found NOT proved.

In reaching this decision, the panel took account of Colleague A and Witness 3's evidence, as well as your own evidence.

The panel had regard to Witness 3's NMC witness statement, in which she had stated:

> "*Deborah was always sleepy so her practice was dangerous. She would often fall asleep at the desk on night shifts…One night, she was so tired that her eyes closed standing up and I witnessed her almost fall into her drug trolley. I can't remember if I spoke to her about it…*".

The panel also had regard to Colleague A's NMC witness statement, in which she had stated:

> "*Deborah would often fall asleep by the drug trolley…*"[sic].

Again, the panel considered this charge to be very broad in its nature and it considered it to lack any real specificity. The panel was not provided with a particular date or time of when you are said to have slept on duty, other than to say that it occurred on one more occasions over a two year period.

The panel noted from the evidence before it that the NMC witnesses were alleging that you would '*nod off*' for a few seconds whilst sitting at the desk or standing with the medication trolley. None of the NMC witnesses suggested that you did fall asleep at any point for more than a moment during your shift requiring them to wake you.

You told the panel that you would not sleep on duty and that you would go outside for a break if you were feeling tired.

Therefore, in the absence of any specific or cogent evidence, the panel could not say that you slept on duty on one or more occasions during 2017 and 2018 when working on the Ward.

Accordingly, the panel found charge 21 not proved.

Charge 22a)

22. On 29 September 2019

a) Accepted an offer of money from Resident F

This charge is found NOT proved.

In reaching this decision, the panel took account of Witness 2's evidence, as well as your own evidence.

The panel had regard to Witness 2's NMC witness statement, in which she had stated:

> "*…Resident F also has full capacity and informed me that she had given Deborah money. She said that Deborah is her friend and that she doesn't want her to get into trouble. Resident F said the Deborah had told her she needed money to fix her car otherwise it would get repossessed. Resident F is a bit low at the moment as she thought that Deborah was her close friend…*".

During your oral evidence, you were adamant that you would never accept money from a resident.

In considering this charge, the panel noted that there was no documentary evidence to corroborate Witness 2's testimony. The panel was also aware that Resident F has now sadly passed away, so she is not able to give direct evidence relating to this charge. The panel considered the evidence in support of this charge to be hearsay.

The panel did not find Witness 2's oral evidence on this issue to be reliable in respect of this charge. Her account of events varied to include money to fix your car, money to make a car repayment, and gifts for your daughter. Witness 2 was unable to recall an approximate amount, yet considered if this amount was significant, she would have remembered. Witness 2 could not recall the date the incident was said to have occurred on, and the panel found her account on this issue to be inconsistent, taking account of her NMC witness statement.

Accordingly, the panel found charge 22a not proved.

Charge 22b)

22. On 29 September 2019

b) Took Resident F out without first liaising with management

This charge is found NOT proved.

In reaching this decision, the panel took account of Witness 2's evidence, as well as your own evidence.

The panel had regard to Witness 2's NMC witness statement, in which she had stated:

"*After Deborah had resigned I became aware of another incident regarding Deborah. The resident, Resident F told me during a conversation that Deborah had turned up on Sunday 29 September 2019 to the Home and took her out with her daughter when she was on annual leave. The nurse in charge of the unit that day did not question this as Deborah was a nurse, and she thought we were aware of this. Deborah took Resident F to Bury St Edmunds for the day. They went for lunch and went shopping. I had to report the incident to safeguarding because Deborah had taken resident F out with her daughter…*".

Further, in Witness 2's supplementary NMC witness statement, she stated:

"*Before a nurse can take a resident out, they need to speak to management. This is so that we can arrange for any medication that the resident needs to be taken with them. We also need to know where the resident is, the reason for this is so we can ensure the safety of the resident…*

Deborah would have been aware of the process of taking any resident out as she had done it before.

During your oral evidence, you told the panel that you had told your direct line manager that you were taking Resident F outside the Home. The panel noted that your direct line manager helped get Resident F ready to be taken out by you.

The question that was open for the panel to consider was whether your direct line manager classifies as '*management*' for these purposes.

Whilst the panel noted that the NMC witnesses drew a distinction between your line manager and '*management*', you had sought approval from someone more senior than yourself at the Home, namely, the 'Unit Sister'. The panel received evidence to suggest that other staff, including the Sister, were aware that you were taking Resident F outside

of the Home. There is no evidence to suggest that anyone attempted to prevent you from taking Resident F out.

In addition to this, the panel noted that it was not provided with a definition of who '*management*' was in these circumstances, and the policy before the panel did not define '*management*' or say that you had to liaise with them. In the absence of this information, the panel was satisfied that you had a sufficient level of permission to take Resident F outside of the Home.

Accordingly, the panel found charge 22b not proved.

Charge 22d)

22. On 29 September 2019

d) Took Resident F out without an escort

This charge is found NOT proved.

In reaching this decision, the panel took account of Witness 2's evidence, as well as your own evidence.

The panel had regard to Witness 2's supplementary NMC witness statement, in which she stated:

> "*We will also arrange for an escort, this would be a nurse, to accompany the resident to wherever they are going…*
>
> *Deborah would have been aware of the process of taking any resident out as she had done it before. A resident wanted to go to a family members wedding and we*

had arranged for Deborah to be that residence escort, so she was well aware of the process and policies…".

However, the panel noted that in her oral testimony, Witness 2 was not able to say from the policy what it was that you would have needed to do in order to action an escort being present with Resident F. You told the panel that you were effectively Resident F's escort, and the panel had no evidence before it to explain why this could not be the case.

You informed the panel that you were previously approached by the Home Manager and asked to escort Resident F to a wedding, which you did. You asserted that no further escort was required at that time.

In taking account of the above, the panel noted that your direct line manager, the Ward Sister, was aware that you were taking Resident F outside of the Home, and there is nothing to suggest that they attempted to prevent you from doing this without an escort.

The panel had no evidence before it to confirm that Resident F required an escort upon being taken outside of the Home.

Accordingly, the panel found charge 22d not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel considered whether its findings on charges 2 to 22 amounted to misconduct and, if so, whether your fitness to practise as a registered nurse is currently impaired by reason of this misconduct. The panel also considered whether your fitness to practise as a registered nurse is currently impaired by reason of your health, as shown in charge 23, and your police caution, as outlined in charge 1.

The panel noted that there is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

In considering misconduct, the panel adopted a two-stage process in its consideration. Firstly, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must then decide whether, in all the circumstances, your fitness to practise as a registered nurse is currently impaired as a result of that misconduct.

In considering health, the panel moved straight on to consider whether your specific health condition impacts upon your fitness to practise as a registered nurse, and whether you are currently impaired as a result of your health. The same approach was adopted in respect of your police caution, where the panel moved straight on to consider whether this impacts upon your fitness to practise as a registered nurse, and whether you are currently impaired as a result of your police caution.

Submissions on misconduct

In his submissions, Mr Underwood invited the panel to take the view that your conduct amounted to breaches of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) ("the Code"). He then directed the panel to specific paragraphs and identified where, in the NMC's view, your acts and omissions amounted to misconduct.

Mr Underwood submitted that all of the charges found proved are serious. He submitted that there are multiple behavioural and clinical concerns that have been identified by the panel, all of which had the potential to significantly impact upon patients in your nursing care.

Mr Underwood submitted that there is always a risk to patient safety when a registered nurse takes unprescribed medication on shift. He submitted that whilst you told the panel that the medication did not have any effect on you, this medication had not been prescribed to you, and you had no idea of what the potential side-effects would be.

Mr Underwood also submitted that your dishonesty stemmed from the fact that you knew the medication was not yours, and yet you continued to take it from two separate employers. He submitted that this this is a significant breach of your duties, as honesty is a key tenet of the nursing profession. Mr Underwood reminded the panel that you had been dismissed for taking medication from a former employer in the previous 12 months.

Mr Underwood submitted that you had made a number of clinical errors, predominantly involving medication. He submitted that whilst there does not appear to be any evidence of significant harm caused, the potential risk to patients is cause for serious concern. Mr Underwood submitted that despite intervention from the Hospital, medication errors were sustained and continued. He submitted that there is also evidence of improper record keeping, and evidence of you prescribing medication for patients despite you not possessing the requisite qualifications to be able to do so.

Mr Underwood submitted that you spoke inappropriately about a patient to another member of staff. He submitted that it is concerning that a registered nurse would refer to any patient in this manner.

Furthermore, Mr Underwood submitted that you may not have had the proper indemnity insurance when you took Resident F out with your daughter, and you did not maintain proper professional boundaries in doing so.

Mr Underwood invited the panel to find that your acts and omissions amounted to misconduct. He submitted that your nursing practice fell below the standards expected of a registered nurse.

You stated that you accept the panel's factual determination. You did not address the panel on whether or not your actions amounted to misconduct.

Submissions on impairment (misconduct & health & police caution)

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

In assessing your level of insight, Mr Underwood submitted that you have shown a poor level of insight in relation to your clinical conduct and behavioural concerns. He submitted that you have attempted to deflect blame on to the Home's manager for your clinical deficiencies, and you gave multiple conflicting accounts to management in respect of the codeine which the panel has found that you were not entitled to take. Mr Underwood submitted that there is considerable circumstantial documentary evidence to show that you were responsible for the codeine having gone missing from the Home, and you had previously been dismissed from a nursing post for theft of medication 12 months prior to this incident. He submitted that your behaviour may be irremediable because of your repeated behaviour, increasing the chances of repetition in the future.

Mr Underwood submitted that it is a matter for the panel as to whether you have sufficiently remediated the clinical concerns identified. He drew the panel's attention to the

training you have undertaken, in particular, the online medicines management training. He submitted that this shows that you have attempted to correct some of the issues identified in your nursing practice. However, as you have not been able to work as a registered nurse, Mr Underwood said that you have not been able to implement your new-found learning into practice. He told the panel that you have remained working in a clinical environment, albeit as a health care assistant.

In respect of your police caution, Mr Underwood submitted that the theft and consumption of morphine sulphate solution on 23 and 24 September 2018 was directly linked to your clinical nursing practice. He informed the panel that you stole this medication from your employer at the time, and you admitted your dishonest behaviour to the police. Mr Underwood also reminded the panel that you provided an early admission to this charge at this hearing.

In respect of your health condition, Mr Underwood submitted that there is nothing before the panel to demonstrate that your [PRIVATE] has been sufficiently addressed. [PRIVATE]. Mr Underwood submitted that there is a continuing risk to patient safety in relation to your health.

In conclusion, Mr Underwood invited the panel to find that your fitness to practise as a registered nurse is currently impaired by way of your misconduct, your police caution and your health condition.

You told the panel that you respect its findings and you agree that your dishonesty was '*out of order*'. You said that you recognise the severity of your actions, and that you punish yourself every single day, but you do not want to be punished anymore. You stated that you have lost your nursing career, your [PRIVATE] as result of your actions, and you think about what you did and why you did it all the time. You said that you always strived to be the best registered nurse you could be and you felt obliged to work extra hours so that the ward was not short-staffed.

You told the panel that you can now see all the mistakes that you have made and you wanted to express that you are totally remorseful for them. You said that there is nobody more disgusted at your behaviour than yourself, and you know you have let people down.

You said that you do not want your career to end in this way, but you only have yourself to blame for your behaviour. You stated that you would do anything to get your nursing career back on track, but know that you '*probably do not deserve the opportunity*'.

You told the panel that these proceedings have taught you that every action has a consequence, and you do not want to go through anything like this ever again. You said that the process has definitely changed you as a person; you now stop bad practice from happening at work if you see it, and you believe that you are an honest person in your role as a healthcare assistant. You stated that you have been able to take a '*step back*' and identify where you went wrong and how you could have improved things. You said that you are highly regarded in your current role as people often call you directly to work shifts. You are a caring person and you wish you could '*turn the clocks back*'.

You informed the panel that you have attempted to keep aspects of your nursing practice up to date. You stated that you still read nursing journals, keep up to date by accessing the NMC website, and have undertaken training as part of your role as a healthcare assistant.

You told the panel that you are addressing your [PRIVATE], [PRIVATE] and working with a personal trainer. This has resulted in your [PRIVATE] reducing over time.

You provided the panel with four character references, two from former colleagues and two from organisations you have worked for, along with a letter from your personal trainer regarding your regular engagement with their service. You submitted evidence of completed training relating to your role as a healthcare assistant, and other online modules.

Decision and reasons on misconduct

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

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

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code, and *The code: Standards of conduct, performance and ethics for nurses and midwives (2008)* in respect of charge 5 alone.

The panel was of the view that your acts and omissions did fall significantly short of the standards expected of a registered nurse, and it considered them to amount to several breaches of the Code. Specifically:

"1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively

10 Keep clear and accurate records relevant to your practice

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.4 take account of your own personal safety as well as the safety of people in your care

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

To achieve this, you must:
16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

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

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…
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.4 keep to the laws of the country in which you are practising

24 Respond to any complaints made against you professionally".

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It went on to consider each charge individually in determining whether your acts and omissions were sufficiently serious so as to amount to misconduct.

In respect of charge 2, where you worked part of a clinical shift under the influence of morphine sulphate solution on 23 and 24 September 2018, the panel had no doubt that

your behaviour was serious and amounted to misconduct. It was of the view that you could have put patients in your care at a significant risk of harm by working under the influence of opiates, as this could have had a detrimental effect on you carrying out your nursing duties. Whilst you maintained that the morphine sulphate solution did not have any effect on you, the panel found that this was contradictory as you had stated it relieved your pain. The panel considered your unprescribed ingestion of morphine sulphate solution was unmonitored and covert, therefore posing a risk to your patients and yourself. The panel found charge 2 to amount to misconduct.

In respect of charge 3 and 4, where you dishonestly obtained codeine from the Home which you were not entitled to between 1 August 2019 and 7 October 2019, the panel was also in no doubt that your behaviour was serious and amounted to misconduct. The panel found that you had deliberately attempted to mislead management at the Home that you had not taken the medication. The panel considered honesty, integrity and trustworthiness to be the bedrock of the nursing profession and, in being dishonest, it found you to have breached a fundamental tenet. Your dishonesty was motivated by personal gain. To characterise your actions as anything other than misconduct would send the wrong message surrounding professional standards to the nursing profession. Therefore, the panel was in no doubt that your actions in being dishonest amounted to misconduct.

In respect of charge 5, where you administered blood belonging to Patient A to Patient B on 26 July 2014, the panel was of the view that your actions amounted to misconduct. The panel considered Patient B to have been put at a significant risk of harm by having the wrong blood administered to them. Whilst the panel noted that this was a clinical error made by you, the consequences of this could have been severe for Patient B. Therefore, the panel found charge 5 amounted to misconduct.

In respect of charge 7, where you gave chemotherapy too early to Patient D on 25 February 2018, the panel considered your actions to have had the potential to cause serious harm. The panel was of the view that a pattern appeared to be forming of you not

giving due regard to policy and procedure when performing your nursing duties. Therefore, the panel considered charge 7 was sufficiently serious to amount to misconduct.

In respect of charges 8a and 8b, where you copied out a prescription awaiting a doctor's signature and administered unprescribed prescription medication to Patient E on 1 May 2018, the panel had no doubt that your behaviour was serious and amounted to misconduct. The panel was of the view that you administering medication to Patient E that was not prescribed could have had serious ramifications for their health and wellbeing. The panel was aware that you are an experienced registered nurse, but you are not a qualified nurse prescriber. You copied out a prescription and subsequently administered the medication to Patient E despite being aware that you were not qualified to do so. Therefore, the panel found charges 8a and 8b to have amounted to misconduct.

In respect of charges 10b and 10c, where you signed to say that a Clexane injection had been administered when it had not and in leaving that medication unattended, the panel also considered your actions to amount to misconduct. The panel noted that your failure to follow the policies and procedures in place could have led to this patient causing themselves or someone else harm by being in possession of an injectable medication. Therefore, the panel considered your actions in charges 10b and 10c to be sufficiently serious to amount to misconduct.

In respect of charge 12, where you failed to obtain a second signature when amending the insulin rate for a patient between 2 August 2018 and 3 August 2018, the panel considered your actions to amount to misconduct. It was of the view that you did not appear to grasp the extent of the concern relating to this charge. The concern identified is not merely that you did not obtain a second signature to confirm that you had performed this task, another registered nurse should have been present when you were amending the insulin rate due to the serious risk of harm involved if this is amended incorrectly. Therefore, the panel considered your actions in charge 12 to be serious and amounted to misconduct.

In respect of charges 13, 14, 15a and 15b, the panel noted that it had found you to have failed to administer three medications, namely, Sertraline, Doxazosin and a calcium tablet to three separate residents. Further, it had also found you to have administered and/or second checked the incorrect bag of fluids to/for a patient. The panel was of the view that, individually, a single medication error may not be sufficiently serious to amount to misconduct on its own. However, cumulatively, it determined that a pattern of poor medication practice could amount to misconduct, as it did in these circumstances. You failed to administer multiple medications to residents and this had the potential to impact on the treatment they received. Therefore, the panel considered your actions in charges 13, 14, 15a and 15b to be sufficiently serious to amount to misconduct.

In respect of charge 17b, where you referred to Patient C using the following words or words to the effect that you would '*go to the fucking patient and tell him what I think of him*,' the panel considered this could be evidence of an underlying attitudinal concern. It had regard to Colleague A's evidence and noted that she did have concerns about your behaviour. The panel noted that registered nurses have a duty to be caring and compassionate, and in behaving in this way, you were demonstrating an attitudinal problem. Therefore, the panel considered your actions in charge 17b to be sufficiently serious to amount to misconduct.

In respect of charges 22c and 22e, where you took Resident F out in a car without the appropriate insurance needed for transporting a Resident, along with your daughter, the panel was of the view that your actions were not sufficiently serious to amount to misconduct. The evidence the panel had received in relation to this charge did not provide sufficient clarity in confirming that you were not allowed to take Resident F outside of the Home. The panel noted that there was some suggestion that the Home was aware of your plan to take Resident F out of the Home, you were not on shift at the time of the incident, and this was a personal commitment as opposed to a work commitment. Whilst the panel considered your actions may have breached professional boundaries, the panel was not satisfied that your behaviour was sufficiently serious to amount to misconduct in charges 22c and 22e, having regard to the particular circumstances in this case.

In the round, the panel was of the view that other registered nurses would consider the majority of your acts and omissions to be deplorable in the particular circumstances of this case.

The panel found that your acts and omissions above did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct in charges 2, 3, 4, 5, 7, 8a, 8b, 10b, 10c, 12, 13, 14, 15a, 15b and 17b.

Decision and reasons on impairment (misconduct and police caution)

The panel next went on to decide if, as a result of the misconduct, your fitness to practise is currently impaired.

Registered nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust registered nurses with their lives and the lives of their loved ones. To justify that trust, registered nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel considered all of the limbs above to be engaged, both as to the past and to the future.

The panel had found patients in your nursing care to have been exposed to an unwarranted risk of harm, some more so than others. It had also found you to have breached fundamental tenets of the nursing profession, including by acting dishonestly, and it found you to have brought the reputation of the nursing profession into disrepute by virtue of your acts and omissions.

The panel noted that there were multiple clinical and behavioural concerns involved in this case. Your dishonesty was directly linked to your nursing practice, and there was evidence of a pattern of poor nursing practice that had been sustained for a lengthy period of time.

The panel had regard to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)*, and considered whether the concerns identified in your nursing practice are capable of remediation, whether they have been remediated, and whether there is a risk of repetition of the incidents occurring at some point in the future.

The panel considered the concerns identified in respect of your clinical practice to be capable of remediation, in principle. It considered dishonest conduct to be more difficult to remediate than clinical concerns as it could be suggested that there is an underlying attitudinal issue present, although not impossible.

In deciding whether you have sufficiently strengthened your practice and/or remediated the dishonesty and/or attitudinal concerns identified, the panel was of the view that your level of reflection and understanding would be key in determining whether you present an ongoing risk of harm to patients.

In assessing your level of insight, the panel had regard to your oral evidence and the submissions you have made at this hearing. You did not provide a reflective piece for the panel to take account of.

The panel noted that you admitted some of the charges at an early stage of the NMC investigation, at the outset of the hearing, and during your oral evidence. It considered you to have clearly expressed some remorse for the conduct and behaviour which you have admitted, and repeatedly offered assurances to the panel that you would act appropriately in future. You also now appeared to recognise the significant impact of not taking annual leave and ensuring you take adequate breaks would result in you not being so exhausted when it came to you performing your nursing duties.

However, despite the above, the panel found you to have only demonstrated limited insight in respect of your misconduct and your police caution. It was of the view that your focus has been largely self-reflective, as you have considered the devastating effect that your behaviour has had upon yourself, but not on patients, colleagues, employers, the nursing profession, and the wider public.

Whilst you told the panel that you have '*stepped back*' to look at what went wrong, you did not articulate this to the panel, or identify what you would do differently in future should you be faced with a similar set of circumstances. You had previously sought to deflect blame, as opposed to recognising the consequences of your own behaviour. The panel did not consider you to have meaningfully reflected, and it was satisfied that you were still at the beginning in terms of developing your insight.

The panel did not consider you to have taken any meaningful steps to remediate the concerns identified in your nursing practice. It noted that you have undertaken training courses in your role as a healthcare assistant, but it considered this training to be substantially different to that of a registered nurse. You have completed online training, specifically relating to medication administration, however, you have not been able to demonstrate that this has been embedded into your nursing practice. In any event, there was evidence of you having previously addressed medication competency issues with the support of former employers, and assessed as competent, but you have still gone on to make a number of similar clinical mistakes.

The panel had sight of a number of references attesting positively to your practice as a healthcare assistant in a clinical environment. It noted that you wanted to stay in a clinical environment and you are currently caring for people with special needs in the community setting.

The panel determined that there is little evidence before it to demonstrate that you have remediated your misconduct, or developed a significant amount of insight into the concerns identified.

Furthermore, the panel had regard to the particular circumstances surrounding your police caution for theft. You had consumed morphine sulphate solution on 23 and 24 September 2018 whilst performing a nursing shift. In considering *Cohen*, specifically, the risk of repetition, the panel noted that it had found you to have dishonestly taken further medication from an employer that you were not entitled to within 12 months of having received this police caution. Therefore, the panel considered there to be a likelihood of repetition, given that a similar incident occurred within quick succession of the previous one.

In light of all the above, the panel had insufficient evidence before it to allay its concerns that you currently pose a risk to patient safety. It considered there remained a risk of repetition of the incidents found proved and a risk of harm to patients in your care, should adequate safeguards not be imposed on your nursing practice. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered there to be a high public interest in the consideration of this case. It was of the view that a fully informed member of the public would be seriously concerned by the findings at the facts and misconduct stages of proceedings, with particular regard to your dishonesty and police caution. It concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that your fitness to practise as a registered nurse is currently impaired on the grounds of misconduct.

Decision and reasons on impairment (health)

The panel heard the advice of the legal assessor. He referred the panel to Rule 31(5) of the Rules, which states:

> *"(5) In determining whether a registrant's fitness to practise is impaired by reason of physical or mental health, the Fitness to Practise Committee may take into account, amongst other matters—*
>
> *(a) a refusal by the registrant to submit to medical examination;*
>
> *(b) the registrant's current physical or mental condition;*
>
> *(c) any continuing or episodic condition suffered by the registrant; and*
>
> *(d) a condition suffered by the registrant which, although currently in remission, may be expected to cause a recurrence of the impairment of the practitioner's fitness to practise."*

The panel was aware that in order to find your fitness to practise as a registered nurse impaired by reason of your health condition, it must first establish whether you have a health condition that goes to the issue of your fitness to practise as a registered nurse. If it does not, then there can be no subsequent finding of impairment of fitness to practise as a registered nurse on the grounds of health. If it does, the panel should go on to consider whether by reason of that health condition your fitness to practise as a registered nurse is currently impaired.

In reaching its decision, the panel had regard to the totality of the evidence before it.

The panel noted that you admitted charge 23 at the outset of this hearing, that you have the health condition listed in Schedule A, [PRIVATE]. However, the panel considered there to be a lack of supporting evidence to suggest that this health condition currently impacts upon your fitness to practise as a registered nurse.

Whilst the panel was of the view that [PRIVATE] could of course limit a registrant's abilities in performing their role, it had nothing to suggest that this was the case in these particular circumstances. No evidence was presented as to how severe [PRIVATE] is, and there has been no indication that it will prevent you from performing the role of a registered nurse. Mr Underwood had submitted that the codeine you stole may have been used [PRIVATE], but again, the panel had no evidence to support this.

You told the panel that you are managing your [PRIVATE] by [PRIVATE]. You also told the panel that you regularly attend the gym and have enlisted the help of a personal trainer once a week. Your personal trainer provided the following letter to the panel, commenting:

> "*Alongside her one to one personal training sessions, where we focus on strength training, cardiovascular training, mobility , flexibility , Mrs Goulty has personalised workout programmes to meet her needs and help her improve and progress even more.*
>
> *[PRIVATE].*
>
> *Of course all of the above work hand in hand with a good nutrition, which we keep a close eye on .*
>
> *Being healthy and fit is a lifestyle and Mrs Goulty is taking her personal training sessions very seriously*"[sic].

The panel considered you to be addressing your health condition through the appropriate support mechanisms available to you. It noted that you believe you have made good progress in addressing [PRIVATE].

The panel could not be satisfied that regulatory intervention is required. There is nothing to suggest that [PRIVATE] impacts upon your fitness to practise as a registered nurse. The evidence suggested that whilst [PRIVATE] may have been an issue for you previously, this is no longer the case as it is being suitably managed by you.

There was no medical evidence adduced demonstrating how [PRIVATE] could impact upon your role as a registered nurse. In the absence of any evidence to the contrary, it did not consider there to be grounds for impairment on either public protection or public interest in respect of your health.

Preliminary discussion on Tuesday, 31 May 2022

After handing down its decision on impairment on Tuesday, 31 May 2022, Mrs Goulty informed the panel, through the Hearings Coordinator, that she did not wish to attend the hearing any further. Mrs Goulty asked whether she could provide something in writing for the panel to take account of at the sanction stage of the hearing and was informed that she could do so.

Noting that the time was 16:00 hours, the panel decided to adjourn until 09:30 hours the following day, to give Mrs Goulty the opportunity to provide written submissions in respect of sanction.

Decision and reasons on proceeding in the absence of Mrs Goulty

At 09:30 hours, the panel opened the hearing, and invited Mr Underwood to address it on proceeding in Mrs Goulty's absence. In doing so, it had regard to Rule 21 of the Rules.

Mr Underwood submitted that it is in the public interest to proceed in the absence of Mrs Goulty, with the purpose of concluding the hearing today. He submitted that Mrs Goulty had confirmed to the NMC that she did not want to attend the hearing again, and the panel adjourned until this morning to see if she had changed her mind, or send in written representations.

Mr Underwood submitted that Mrs Goulty has now sent in a '*final statement*' for the panel to take account of at the sanction stage, and she has been clear in her responses to the emails from the Hearings Coordinator that she wants the panel to proceed in her absence. He submitted that Mrs Goulty has voluntarily absented herself from the remainder of proceedings.

Mr Underwood submitted that it is in the public interest to dispose of this case expeditiously. He submitted that it is unclear at this stage when the panel may be able to return to conclude this hearing at any point in the near future given that we are approaching the end of the listing for this case.

The panel heard and 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 had sight of the email chain between the Hearings Coordinator and Mrs Goulty. From this, the panel noted that Mrs Goulty had confirmed that she would not be in

attendance on Wednesday, 1 June 2022, and she had also invited the panel to proceed in her absence. She had been informed that she could send in written representations for the panel to consider at sanction stage.

The panel also reminded itself that Mrs Goulty had previously indicated that she would not be able to attend on the final day of this hearing, that being Wednesday, 1 June 2022 due to family commitments. Mrs Goulty had been informed at that point that should this matter go into the final day, the panel has the power to proceed in her absence.

The panel decided to proceed in the absence of Mrs Goulty. In reaching this decision, the panel has considered the submissions of Mr Underwood, the e-mail correspondence, Mrs Goulty's previous remarks, 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:

- No application for an adjournment has been made by Mrs Goulty, and no reason to suppose that adjourning would secure her attendance on some future date;
- Mrs Goulty has been clear in her correspondence with the NMC that she did not want to attend any further;
- Mrs Goulty had indicated on Monday, 30 May 2022 that she would not be able to attend on Wednesday, 1 June 2022 due to previous family commitments;
- Mrs Goulty has invited the panel to proceed in her absence as she wants to bring the matter to a conclusion;
- Mrs Goulty has provided written submissions for the panel to take account of at the final stage;
- The panel did adjourn for the day on Tuesday, 31 May 2022 to allow Mrs Goulty time to consider whether she did indeed wish to attend the final day of the hearing;

- This is the final day of the current listing, and there is a strong public interest in the expeditious disposal of the case, with notable public protection concerns.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the NMC Registrar to strike Mrs Goulty's name off the NMC register. The effect of this order is that the NMC register will show that Mrs Goulty has been struck off the NMC register.

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

Submissions on sanction

Mr Underwood took the panel through aggravating factors which, in the NMC's view, were present in this case. He also invited the panel to take account of any contextual factors which may have given rise to mitigation.

Mr Underwood submitted that Mrs Goulty has had a lengthy career as a registered nurse, and that these concerns lasted over a two to three year period when Mrs Goulty was encountering issues in her personal life.

Mr Underwood informed the panel that the NMC had informed Mrs Goulty of its sanction bid prior to this substantive hearing, and this was a striking-off order. However, he submitted that this is no way meant to replace the function of the panel in having considered all of the evidence in this case. Mr Underwood invited the panel to consider the sanctions in ascending order, starting with the least restrictive. He submitted that the panel should take the appropriate action in protecting the public and addressing the public interest concerns identified.

Mr Underwood submitted that whilst Mrs Goulty's clinical deficiencies are capable of remediation, her dishonest conduct and police caution are very serious. Nonetheless, he referred the panel to Mrs Goulty's written representations at sanction and submitted that she has attempted to reflect on her behaviour.

Mr Underwood submitted that Mrs Goulty's acts and omissions are far too serious for no further action to be taken. He submitted that the same could be said for a caution order, as public confidence cannot be maintained by either of these sanctions being imposed.

Mr Underwood also submitted that a conditions of practice order would not be a sufficient sanction to reflect the severity of Mrs Goulty's conduct and behaviour. He submitted that whilst the clinical concerns identified may be capable of remediation, it would not be possible to formulate workable conditions to address Mrs Goulty's attitudinal concerns, or her police caution. Furthermore, Mr Underwood submitted that this sanction would not uphold public confidence in the nursing profession considering Mrs Goulty stole medication from two separate employers.

Mr Underwood directed the panel to consider the more serious sanctions available to it. He invited the panel to consider whether Mrs Goulty's conduct and behaviour is incompatible with her remaining on the NMC register.

Mr Underwood submitted that the concerns are so serious that the panel should consider whether temporary removal from the NMC register is sufficient to address the public

protection and public interest elements of this case. He drew the panel's attention to the NMC's guidance on dishonesty, and submitted that Mrs Goulty's behaviour in this respect was premeditated and systemic. Mr Underwood reminded the panel that Mrs Goulty dishonestly took medication from the Home, having previously been referred to the NMC for similar concerns relating to her employment at the Hospital. He submitted that Mrs Goulty took medication from several patients, and that she breached a position of trust in doing so. Mr Underwood submitted that Mrs Goulty was able to gain free access to the medication through her position as a registered nurse.

Mr Underwood submitted that the panel's findings in charges 1 – 4 raise fundamental questions about Mrs Goulty's professionalism. He submitted that there are clear attitudinal issues involved in this case, and the public would be extremely concerned to learn that Mrs Goulty took medication from two employers, in relatively quick succession. Mr Underwood submitted that Mrs Goulty's behaviour could be considered as irremediable, and therefore a striking-off order is the only appropriate sanction in this case.

However, Mr Underwood submitted that if the panel were not minded to agree with the NMC's primary submission, he invited the panel to consider imposing a suspension order for 12 months, subject to review. He submitted that this would allow Mrs Goulty a period of time to demonstrate further insight and remediation in respect of the concerns identified.

Mrs Goulty provided the following submissions to the panel in respect of sanction:

> "*I sincerely apologise for not being able to attend the last day of the hearing and appreciate that you have given me the opportunity to email my final statements regarding my hearing.*
>
> *That my actions of taking the oramorph solution and being under the influence was an unforgivable act of dishonesty whereby it is serious misconduct, putting my patients that I cared for at potential risk and my colleagues. Putting the nursing profession in disrepute is something I never intentionally aimed to ever do and*

failed to put patients and colleagues first and this was a selfish act to which I totally regret and have feelings of the utmost of remorse. I wish to genuinely apologize for my dishonest ways, for failing as a registered nurse, to my patients that could have been at serious risks and my colleagues all due to being selfish and not taking the appropriate action to resolve the rationale as to why this was consumed by myself, for having accepted a police caution for theft. I am seriously sorry for my actions again and had failed to see the 'knock on effect' it had on my personal life and that this will have resulted in the public losing faith in the nursing profession and as myself as a professional person. In moving forward from this incident, due to the suspension it has not been possible to be able to prove that I have taken this action seriously as unable to work and be trusted with medication as a nurse, although this still is a serious concern to the public and the panel may feel this can or will be repeated, it is my wish to express that it would be possible to trust me as a nurse again, the panel are aware of the steps taken to resolve [PRIVATE] as this was the rationale as to why it was taken and again I apologise for this action of mine, and knowing it is an action that was dishonest, it is something that would never happen again because I do not want to be dishonest, put the nursing profession in to disrepute or ever to put patients or colleagues at risk like I had done before.

My actions have caused the public to not trust the nursing profession and have put them at serious risks. On reflection of all the misconduct charges, I would like the panel to be aware that all of the misconduct actions were never meant to be intentional, or to hurt my colleagues. My employer or ever to put patients and the wider public at risk, and for this I am truly and deeply sorry and remorseful for my actions. It is so important to take annual life, not to work extra hours where you do get tired, concentrations reduced greatly and therefore mistakes are made, drug errors are made and peoples lives are put at risk and this is due to myself being unprofessional, when my intention was to be professional. On reflection knowing my nursing limitations, ensure I seek guidance of others more knowledgeable than myself and any tasks not completed during my shift that the nursing profession is 24/7 and every nurse is working tirelessly to ensure patients are looked after to the

best of their ability and tasks roll on from each shift, ensure communication is better relayed to each shift if a drug could not be got hold off and to ensure the proper channels with regards to policy and procedures are carried out correctly, thus ending in the correct and professional way and following correct protocol. As a nurse never to step over and know the limits of my profession and to ensure the correct medical staff are called in a timely manner to ensure my workload is being addressed, again to sufficiently and effectively document anything that has not been achieved and to verbally ensure the next shift is aware, as again patients have been put in harm's way due to myself not either documenting effectively or the lack of communication with my colleagues, to which I am very sorry for. For colleagues and the public to have faith in the profession and myself, I would need to practice within my skills as a nurse, continue to get guidance from seniors/peers, continue to be communicative throughout the shift and seek assistance from others to effectively work as a team.

I love being a nurse and am still compassionate about wanting to reenter the nursing profession. Getting complacent is not an option which I do feel that I have taken for granted, being a nurse is a privilege, not just a job, it's an amazing, caring profession and one to be proud of, I want to get back involved within this proud profession, for the public to have faith in nursing and to continue working as a nurse. Having had 33 years in this profession in total, gaining all these years of knowledge and experience, I really do not want to be thrown away. Helping the public is the only profession I have wanted to achieve, I am deeply remorseful for all of the misconduct concerns and I take full responsibility for my actions, If it is at all possible for sanctions to be put in place in order to continue working as a nurse, considering working for example 111 where continuous training and development is ongoing, this would enable my skills and knowledge to be helpful if the panel thought working in a more clinical setting is not possible at present.

To conclude, anything the panel can offer to ensure my registration would be so gratefully received and taken on board, any further training or support package an

employer would require to put i9n place I would be willing to do, to achieve, to prove that I can and have learnt from this experience"[sic].

Decision and reasons on sanction

The panel heard and accepted the advice of the legal assessor.

Having found Mrs Goulty'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 and the guidance issued by the NMC on dishonesty and cases involving convictions or police cautions. The decision on sanction is a matter for the panel independently exercising its own judgement.

In respect of aggravating factors, the panel has considered the following as relevant:

- There were two counts of pre-meditated dishonest conduct relating to the theft of medication from employers (more specifically vulnerable patients), one of which resulted in Mrs Goulty receiving a police caution.
- Mrs Goulty took medication from the Home whilst she was already subject to an NMC investigation for acting in a similar way at the Hospital.
- Mrs Goulty breached fundamental tenets of the nursing profession; and breached her duty of trust as a registered nurse.
- There was a pattern of repeated clinical errors that lasted for a significant period of time; despite repeated attempts to rectify these concerns.
- Mrs Goulty's conduct and behaviour put patients in her care at a risk of unwarranted harm, particularly in respect of charges 5, 7 and 12, where the consequences could have been grievous.

- Overall, Mrs Goulty has not demonstrated sufficient scope and depth of insight or remediation.

In respect of mitigating factors, the panel has considered the following as relevant:

- Mrs Goulty has demonstrated some remorse for her conduct.
- Mrs Goulty informed the panel of the family pressures she was enduring at the time of the incidents, and made reference to underlying health issues throughout her evidence.

The panel noted that Mrs Goulty has engaged with the NMC process and the panel at this hearing, despite working night shifts whilst the hearing was ongoing. It considered her to have attempted to demonstrate further insight on her conduct and behaviour, but noted that her reflection is limited to the charges that she was willing to admit to. Mrs Goulty does not appear to address the panel on the matters relating to the theft of codeine, or the behaviour demonstrated in respect of Patient C. Nor was Mrs Goulty able to provide the panel with sufficient reassurance that she understood the significance of her repeated dishonesty or how she would plan to address this in future. Therefore, the panel was of the view that Mrs Goulty may not have moved any further forward, despite demonstrating a willingness to improve.

The panel first considered whether to take no action but concluded that this would be wholly inappropriate in view of the seriousness of this case. Taking no further action would place no restriction on Mrs Goulty's nursing registration, and would therefore not protect the public. Further, it would not address the public interest concerns identified.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 was of the view that Mrs Goulty's misconduct and police caution were not at the

lower end of the spectrum of fitness to practise 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 a conditions of practice order on Mrs Goulty's nursing registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the concerns identified. Whilst the panel had determined that the clinical deficiencies were capable of remediation, it was not satisfied that a conditions of practice order was sufficient to address Mrs Goulty's dishonesty or police caution, having regard to the public protection and public interest elements of this case. The panel was also mindful of the repeated re-training Mrs Goulty had undergone in respect of medication administration where Mrs Goulty went on to make similar errors despite passing the assessment set by her employer. The panel had found Mrs Goulty to be lacking insight. It is not clear at this stage whether Mrs Goulty does indeed truly acknowledge the full extent of the panel's findings. Currently, there is limited evidence that Mrs Goulty appreciates the serious ramifications of her acts and omissions, and the impact this could have had on patients and their families, colleagues, employers, the nursing profession and the wider public as a whole.

In taking account of the above, the panel determined that placing a conditions of practice order on Mrs Goulty's nursing registration would not adequately address the seriousness of this case, nor would it satisfy the public interest considerations.

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

The panel considered whether the seriousness of this case could be addressed by temporary removal from the NMC Register and whether a period of suspension would be

sufficient to protect patients and satisfy the wider public interest concerns. When considering seriousness, the panel took into account the extent of the departure from the standards to be expected of a registered nurse and the risk of harm to the public interest caused by that departure.

The panel noted that Mrs Goulty had engaged in multiple instances of misconduct across a wide range of areas from clinical deficiencies to concerns about her conduct and behaviour, which are attitudinal and dishonest in nature. It had found Mrs Goulty to have attempted to minimise the concerns previously, and determined that she had sought to deflect blame.

Mrs Goulty had only offered the beginnings of insight into her misconduct and police caution. She had articulated how these concerns had impacted upon her livelihood, but she had not expanded her insight beyond this in any great detail. Further, Mrs Goulty had shown little attempt to alleviate any outstanding concerns in respect of her general nursing practice; despite having a substantial amount of time to reflect on her acts and omissions. The panel could not be satisfied that Mrs Goulty would not go on to repeat her dishonesty, noting that she had already done so once in relation to stealing medication from her employer. The panel also found that it could not be satisfied that Mrs Goulty would not repeat her clinical deficiencies which she had repeated on a number of occasions despite re-training. The panel determined that there was an underlying attitudinal issue in this case; one that raises fundamental concerns about Mrs Goulty's level of professionalism.

Taking account of the above, the panel determined that Mrs Goulty's dishonesty, misconduct and police caution was not merely a serious departure from the standards expected of a registered nurse and a serious breach of the fundamental tenets of the nursing profession, it was fundamentally incompatible with her remaining on the NMC register. In the panel's judgment, to allow someone who had behaved in this way to maintain her NMC registration would undermine public confidence in the nursing profession and in the NMC as a regulatory body.

In reaching its decision, the panel bore in mind that its decision would have an adverse effect on Mrs Goulty both professionally and personally. However, the panel was satisfied that the need to protect the public and address the public interest elements of this case outweighs the impact on Mrs Goulty in this regard.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Goulty's dishonesty, misconduct and police caution in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, 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.

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 is in Mrs Goulty's own interest until the striking-off order takes effect.

Submissions on interim order

Mr Underwood invited the panel to impose an interim suspension order for a period of 18 months. He submitted that this interim order is necessary on the grounds of public protection and it is also in the public interest, having regard to the panel's findings.

Decision and reasons on interim order

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 concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. Owing to the seriousness of the police caution and misconduct in this case, along with the risk of repetition identified, it determined that Mrs Goulty's acts and omissions were sufficiently serious to justify the imposition of an interim suspension order until the striking-off order takes effect. In the panel's judgment, public confidence in the regulatory process would be damaged if Mrs Goulty were to be permitted to practise as a registered nurse prior to the substantive order coming into effect.

The panel decided to impose an interim suspension order in the circumstances of this case. To conclude otherwise would be incompatible with its earlier findings.

The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.