Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
22 February 2022– 25 February 2022
1 March 2022 – 4 March 2022
17 October 2022 – 21 October 2022
14 November 2022- 18 November 2022

Virtual Hearing

Name of registrant:	**Alison Bradwell**
NMC PIN:	15F1753E
Part(s) of the register:	Registered Nurse – Adult Nurse Level 1 (September 2015)
Relevant Location:	Greater Manchester
Type of case:	Lack of competence/Misconduct
Panel members:	Nicola Jackson (Chair, Lay member) Esther Craddock (Registrant member) Jude Bayly (Registrant member)
Legal Assessor:	Michael Levy (22 February 2022 – 25 February 2022 1 – 4 March 2022) Charles Conway (17 October 2022 – 21 October 2022, 14 November 2022- 18 November 2022)
Hearings Coordinator:	Safa Musad (22 – 25 February 2022 1 – 4 March 2022) Roshani Wanigasinghe (17 October 2022 – 21 October 2022) Renee Melton-Klein (14 November 2022- 18 November 2022)
Nursing and Midwifery Council:	Represented by Iulia Saran, Case Presenter
Miss Bradwell:	Present and represented by Laura Bayley, Counsel instructed by The Royal College of

	Nursing (RCN) until 4 March 2022. Thereafter not present and unrepresented.
Facts proved by admission:	2a, 3a, 6a, 7a, 7c, and 9b
Facts proved:	1, 2b, 3b, 4a, 4b, 5a, 5b, 6b, 6c, 6d, 7b, 8a, 8b, 9a, 10, 11a, 11b, 13,14a, 14b, 15a, 15b, 15c, 15d and 15e.
Facts not proved:	12a and 12b.
Fitness to practise:	**Impaired**
Sanction:	**Suspension Order (12 months)**
Interim order:	**Interim Suspension Order (18 months)**

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

At the outset of the hearing, Ms Bayley on your behalf made an application that parts of this case be held in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Saran on behalf of the Nursing and Midwifery Council (NMC) indicated that she supported the application to the extent that any reference to [PRIVATE] should be heard 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 as and when matters relating to [PRIVATE] and private matters are raised in order to protect your privacy.

Details of charge (as amended)

'That you a registered nurse, between 30 July 2018 and 9 October 2018, failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a Band 5 nurse, in that you:

1. On 30 July 2018, did not carry out observations on an unknown patient every four hours as required.

2. On 6 August 2018, whilst subject to supervised practice, you:
    a) Did not know the difference between Clexane and Calci-Hep medications**.**

b) Attempted to administer the wrong medication (Clexane) to an unknown patient.

3. On 7 August 2018; in respect of one or more unknown patients you:
    a) Incorrectly calculated a MEWS score at 0 when it should have been recorded at 1.
    b) Did not offer a patient Verapamil during the teatime medication slot.

4. On 13 August 2018, in respect of one or more unknown patients you:
    a) Did not carry out observations and/or record observations at 17:00 until prompted to do so by Colleague A.
    b) Did not record the amount of fluids consumed on the fluid balance chart between 07:00 and 20:00.

5. On 14 August 2018, in respect of one or more unknown patients you:
    a) Did not give any medications until you were reminded to do so at 19:00 by Colleague A.
    b) Did not give Colleague A 30 minutes notice that a patient's intravenous infusion of Dopamine was running out and needed to be changed.

6. During a medication assessment on 14 August 2018 you:
    a) Did not know the different purposes of a number of common cardiac medications including Ticagrelor and Candesartan.
    b) Failed to check the allergy status for an unknown patient before administering medication.
    c) Failed to change your gloves when drawing up Heparin medication for an unknown patient.
    d) Retrospectively recorded that you administered laxatives to a patient on 13 August 2018

7. On or around 21/22 August 2018, in respect of one or more unknown patients you:
   a) Incorrectly calculated and recorded a MEWS score of 0 when it should have been recorded as 3.
   b) As a result of your miscalculation, did not complete observations every 30 minutes in accordance with the MEWS policy.
   c) Altered your entry on the observations chart without recording that the entry had been retrospectively amended.

8. On 27 August 2018:
   a) Failed to administer medication and/or failed to record in the medication chart that medication was administered for patients in Beds 7 to 9.
   b) Failed to administer any medication including Warfarin and/or failed to record in the medication chart that medication including Warfarin was administered to Patient A in bed 10.

9. On or around 28 August 2018, during a conversation with Colleague B:
   a) Incorrectly informed Colleague B that Patient A had received his Warfarin medication.
   b) Upon being informed by Colleague B that Patient A had reported that he had not received his Warfarin medication you subsequently admitted you had not administered the medication.

10. Your actions as set out in charge 9 (a)-(b) above were dishonest in that you attempted to cover up your error.

11. During a medication assessment on 28 August 2018,
   a) Were involved in a near miss incident, in that you omitted to give an unknown patient their prescribed medication (Movicol) until prompted.
   b) Demonstrated a lack of knowledge of various medicine.

12. On 9 September 2018, in respect of one or more unknown patients you:
    a) Incorrectly calculated and recorded a MEWS score as 0 when it should have been recorded as 1 or 2.
    b) Did not complete a skin bundle for a patient with grade 2 pressure sores at 13:00 and/or in the alternative did not record that a skin bundle had been performed

13. During a medication assessment on 11 September 2018, demonstrated a lack of knowledge of various medicines.

14. After 30 July 2018 you,
    a) Did not return in a timely manner a reflective piece originally requested to be returned by 30 July 2017.
    b) Did not complete within two weeks mandatory training including fast track IV training.

15. Between 30 July 2018 and 9 October 2018 failed to demonstrate competency in the following areas:
    a) Administration of medication;
    b) General knowledge of medicines;
    c) MEWS calculations;
    d) Record keeping;
    e) Carrying out observations.

AND in light of the above your fitness to practise is impaired by reason of your lack of competence in respect of charges 1-8 and 11-15, and your misconduct in respect of charges 9 and10.'

Decision and reasons on application to amend the charge

The panel heard an application by Ms Saran to amend the wording of charges 3b, 8a and 8b and charge 14.

The proposed amendment to charge 3b was to amend the spelling of Verapamil. The proposed amendment to charge 8a was to change it to beds 7-9 instead of 7-10 and to remove 'Patient A' for accuracy. The proposed amendment to charge 8b was to include additional wording to also reflect the charges clearly. Finally, charge 14 was amended to particularise the details of what was alleged.

Therefore, the charges as amended read:

> "That you a registered nurse, between 30 July 2018 and 9 October 2018, failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a Band 5 nurse, in that you:
>
> …
>
> 3. On 7 August 2018; in respect of one or more unknown patients you:
>   a) Incorrectly calculated a MEWS score at 0 when it should have been recorded at 1.
>   b) Did not offer a patient ~~Verapmil~~ **Verapamil** during the teatime medication slot.
>
> ….
>
> 8. On 27 August 2018, ~~in respect of one or more unknown patients:~~
>   a) Failed to administer medication and/or failed to record in the medication chart that medication was administered for patients in Beds 7 to **9**. ~~10 (includes Patient A below~~).
>   b) Failed to administer any medication including Warfarin **and/or failed to record in the medication chart that medication including Warfarin was administered** to Patient A **in bed 10**.
>
> …

14. ~~Between 30 July 2018 and 9 October 2018, did not to complete mandatory training and/or a reflective statement within the allocated timescales~~

After 30 July 2018 you,

a) **Did not return in a timely manner a reflective piece originally requested to be returned by 30 July 2017.**

b) **Did not complete within two weeks mandatory training including fast track IV training.**

The panel heard submissions from Ms Bayley. She submitted that she agreed with the amendments made to charges 3b, 8a, 8b and 14.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Ms Saran made a further application, later in the proceedings, that Charge 12 be amended to read ‘on or around the 9 September 2018’. This application was opposed by Ms Bayley. The panel decided that it would be unfair to amend this charge in the light of the defence, namely that Miss Bradwell was not on shift that day.

Decision and reasons on service of Notice of the resumed Hearing

The panel resumed hearing this case on 17 October 2022.

The panel was informed at the start of this hearing that Miss Bradwell was not in attendance and that the Notice of Hearing letter had been sent to her registered email address held on the NMC register on 5 September 2022.

Ms Saran submitted that it had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

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

In the light of all of the information available, the panel was satisfied that Miss Bradwell has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Bradwell

The panel next considered whether it should proceed in the absence of Miss Bradwell. It had regard to Rule 21 and heard the submissions of Ms Saran who invited the panel to continue in the absence of Miss Bradwell. She submitted that Miss Bradwell had voluntarily absented herself.

Ms Saran referred the panel to correspondence from the NMC case officer dated 17 October 2022 who had spoken with Miss Bradwell's representative at the RCN who had said that:

> *"He's been instructed by the registrant to inform us that she does not want to engage any further and she consents to the hearing proceeding in her absence.*

They will therefore not be representing her going forward.”

The panel accepted the advice of the legal assessor.

The panel decided to proceed in the absence of Miss Bradwell. In reaching this decision, the panel considered the submissions of Ms Saran, and the advice of the legal assessor. It 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 Bradwell;
- Mrs Bradwell has informed the NMC through her representative that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- The charges relate to events that occurred in 2018;
- There is a strong public interest in the expeditious disposal of the case.

The panel carefully determined that, in light of the evidence any additional information before it, it was fair to proceed in Miss Bradwell’s absence. In doing so, the panel had careful regard to all the information before it including the email of 17 October 2022 and previous emails from the Case Officer to Miss Bradwell at 9:37 am asking Miss Bradwell to confirm attendance or whether she wished for her hearing to be adjourned.

The panel noted an email in which Miss Bradwell said that [PRIVATE], however the panel had no further information on this matter. The panel further considered this matter. It saw an email from the NMC Case Officer to Ms Saran indicating that Miss Bradwell’s representative had called the NMC Case Officer and said that the RCN had been

instructed by Miss Bradwell that she no longer wished to participate in the proceedings and that the RCN is no longer representing her.

In light of the evidence and the duty on the panel for the expeditious disposal if that can be achieved fairly and with justice, the panel considered that Miss Bradwell had been given a chance to respond during the proceeding, months leading up to the hearing as well as today, 17 October 2022.

The panel decided that Miss Bradwell had waived her right to attend and voluntarily absented herself.

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

Background

The concerns in Miss Bradwell's case took place on the Acute Coronary Care Unit (ACCU) of Wythenshawe Hospital between 30 July 2018 and 9 October 2018, when Miss Bradwell had returned to practice from maternity leave. It is alleged that errors in Miss Bradwell's practice at the Trust relate to medication administration, taking/recording observations, record keeping, dishonesty in attempting to cover up an error and falsifying records. It also relates to omitting to reflect on concerns and not completing mandatory training as required.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Bayley who informed the panel that Miss Bradwell made admissions to charges 2a, 3a, 6a, 7a, 7c, and 9b.

The panel therefore finds charges 2a, 3a, 6a, 7a, 7c, and 9b proved by way of Miss Bradwell's admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Saran.

The panel drew no adverse inference from the non-attendance of Miss Bradwell at this resumed hearing nor from the absence of responses from her to the NMC regarding some of the charges. Where a response was received from Miss Bradwell, this was considered very carefully.

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.

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

- Colleague A: Sister on the Acute Coronary Care Unit (ACCU) at the Trust and Registrant's mentor;
- Colleague B: Ward Manager;
- Ms 1: Sister on the ACCU at the Trust;
- Ms 2: Practice Based Educator at the Trust; and
- Ms 3: Sister on the ACCU at the Trust at the time of the events.

Miss Saran submitted that it was open to the panel to draw an adverse inference from the failure of Miss Bradwell to give evidence and drew the panel's attention to *Kuzmin v GMC* [2019] EWHC 2129.The panel accepted the advice of the legal assessor that it was not open to it to draw such an adverse inference because, in accordance with the judgment

in the above case, Miss Bradwell would have to have been given notice and a proper warning that such an inference could be drawn and, as Miss Saran conceded, there was no evidence that such notice or warning had been given.

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

Charge 1

1. On 30 July 2018, did not carry out observations on an unknown patient every four hours as required.

This charge is found proved.

In reaching this decision, the panel considered the evidence of Colleague A and Colleague B.

The panel noted that Colleague A in her witness statement dated 21 August 2019 stated:

> *"The Registrant was responsible for caring for this particular patient. As the nurse in charge of the ACCU on that day, I checked before the end of the day to make sure that all observations had been done for all patients and that medications had been given as prescribed. These checks were part of my usual routine as the nurse in charge. The observations which should have been carried out … include blood pressure, temperature, heart rate, respiratory rate, oxygen levels, whether or not the patient had been to the bathroom, and whether or not the patient had any pain or nausea. These observations should be carried out every four hours, and all of these matters should be checked by the nurse when carrying out the observations...At around 19:00, I checked whether this patient's observations had been carried out earlier in the afternoon at around teatime. The observations had not been carried out and when I asked the Registrant if she had done the observations at teatime, she confirmed that she had not. On this particular*

> *occasion, the observations had last been done for this patient by the Registrant over 4 hours previously. The Registrant should have looked at when the observations were last carried out and then conducted further observations after 4 hours."*

The panel noted that Colleague A's written evidence was consistent with her oral evidence. The panel accepted Colleague A's oral evidence in which she made clear that she checked, on the evening in question, whether the checks had been carried out and that Miss Bradwell had admitted that she had not done the checks at teatime. When reminded by Colleague A, who was also her mentor, that the observations needed to be carried out, Miss Bradwell "*did not say much"* but *"instead just went and carried them out".*

The panel also noted the evidence of Colleague B in which his log of concerns noted that *"Observations were due at 19:00 – had to be reminded to complete them."*

The panel accepted the oral evidence and documentary evidence from the witnesses who gave evidence in respect of this charge. The panel found them to be objective and professional and therefore in a position to give accurate information. The panel found that their oral evidence was consistent and supported their documentary evidence.

The panel considered the fact that on 30 July 2018 Miss Bradwell was on a mandatory training day. However, it was clear to the panel from all the evidence before it that staff would be able to carry out observations although they were completing their mandatory study.

The panel noted that Miss Bradwell was on a long day, which was a 12-hour shift, and had access to her mandatory training in the office. Therefore, it was clear to the panel that Miss Bradwell would have been able to intermittently carry out necessary patient observations on the ward.

The panel accepted the evidence of Colleagues A and B. The panel determined that on 30 July 2018, Miss Bradwell did not carry out observations on an unknown patient every four hours as required.

The panel therefore found charge 1 proved.

Charge 2b

2. On 6 August 2018, whilst subject to supervised practice, you:
   b) Attempted to administer the wrong medication (Clexane) to an unknown patient.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A and Colleague B and Miss Bradwell's documentary evidence.

The panel first noted a letter dated 10 September 2018 outlining the concerns raised in an informal meeting on 28 August 2018. It also noted that Colleague B states the same in his witness statement, that '*You did not know the difference between clexane and cicahep-when to give bed one clexane when prescribed cali-hep.*'. The panel accepted this evidence.

The panel noted the information it had received from Colleague A, in particular, on her witness statement dated 21 August 2019 in which Colleague A said that:

> *"I understand that [Ms 4] noticed that the Registrant was about to give the incorrect drug to this patient and stopped her before it occurred."*

The panel accepted the oral and documentary evidence from Colleague A and Colleague B and noted that although some of the evidence can be classed as hearsay, it was

recorded in full and provided to the panel as documentary evidence. The panel therefore placed some weight on this evidence. The panel was also mindful that Colleague B's oral evidence supported his written statement in which he states that *"you admitted that you made the errors and were visibly upset by the whole ordeal. You were unable to explain why these things kept occurring.''*

The panel noted that Miss Bradwell had denied that she left the treatment room to give this medication to a patient. However, the panel noted inconsistencies in this evidence which was framed in the context of a conversation with a witness who gave clear evidence that she was on holiday at the time. Therefore, the panel found that there was clear evidence to support that on 6 August 2018, whilst subject to supervised practice, Miss Bradwell attempted to administer the wrong medication (Clexane) to an unknown patient.

The panel therefore found charge 2b, on the balance of probabilities, proved.

Charge 3b

3. On 7 August 2018, whilst subject to supervised practice, you:
   b) Did not offer a patient Verapamil during the teatime medication slot.

This charge is found proved.

In reaching this decision, the panel considered all the evidence before it, including Miss Bradwell's documentary explanation.

The panel noted Colleague A's witness statement dated 21 August 2019 in which she stated the following:

> *"…The second issue which had arisen related to the Registrant not giving Verapamil to a patient during the teatime medication slot. Verapamil is prescribed for blood pressure and arrhythmia problems… If a prescribed dose of Verapamil is*

missed, this could send the patient into ventricular tachycardia. I understand that the Registrant had missed administering the dose to this patient but that my colleague [Ms 4] had noticed it during the day shift. She told me during handover that the Registrant had not given the medication and had not checked with the patient if they wanted to have a mediation at bedtime, but had assumed that because it was given at night time the day before that this is when it was due. I recall that [Ms 4] had to put a downward arrow on the medication chart to indicate for the medication to be administered at bedtime. When I spoke to the patient about this at the start of the night shift, the patient told me that he had not been asked at teatime about receiving the medication. I confirmed that the Registrant did not tell me about this at handover and did not say anything to me about the medication. … I also recall that this patient had been admitted to the ACCU having missed a dose of Verapamil previously."

The panel noted that although the evidence in relation to this charge is hearsay evidence, the panel had before it, substantial documentary evidence in respect of this.

The panel noted that Verapamil is a vital drug which could have adverse consequences if not administered as prescribed. The panel noted that the Verapamil was given in the morning and therefore missing the teatime administration was an omission. This also clearly demonstrated to the panel that Miss Bradwell was the nurse responsible for caring for this patient as she had signed the morning dose in the medication chart.

The panel noted that Miss Bradwell in her written response suggests that she was not responsible as she was still under indirect supervision, however, she says that she is not dismissing the allegation. The panel also noted that Miss Bradwell had administered the medication earlier in the day for this patient and therefore she had allocated patient care responsibility.

The panel determined that Miss Bradwell had allocated patient care and had omitted to administer a significant drug to the patient. It bore in mind the nature of the drug and noted

the significant harm it could have on a patient if not administered as prescribed. Given all the evidence before it, the panel was satisfied that there is sufficient evidence before it to find that on 7 August 2018, whilst subject to supervised practice, Miss Bradwell did not offer a patient Verapamil during the teatime medication slot.

The panel accepted the evidence of Colleague A.

The panel therefore found charge 3b proved.

Charge 4a

4. On 13 August 2018, in respect of one or more unknown patients you:

   a) Did not carry out observations and/or record observations at 17:00 until prompted to do so by Colleague A.

This charge is found proved.

In reaching this decision, the panel considered the evidence of Colleague A and Colleague B and Miss Bradwell's documentary explanation.

The panel noted that Colleague A in her witness statement dated 21 August 2019 stated:

> *"When I conducted my usual checks of patients towards the end of the shift at 19:00, I identified that this patient had not had observations carried out at the appropriate time… When I told her to carry out the observations, she said 'ok'…"*

The panel noted that Miss Bradwell accepts this in her response. She states *"…however there had been this one incident of not doing obs."* The panel found that Miss Bradwell's acceptance is consistent with Colleague A's evidence.

The panel also noted the Informal Conduct Meeting letter dated 10 September 2018 in which it was recorded that on 13 August 2018 "*Observations were last done at 13:00. At 19:00 had to be reminded you had not done teatime observations that should have been completed by 17:00".* The panel bore in mind that this was corroborated by Colleague A's oral evidence which the panel was able to cross examine.

The panel noted that in Miss Bradwell's response to the allegations, she states that at this point she was under the impression of being supervised. The panel heard clear, consistent oral evidence from two witnesses that Miss Bradwell had a named supervisor she was working with on the day, however, this was indirect supervision, and that Miss Bradwell had been allocated patient care. The panel further reminded itself of the evidence it had heard from Colleague B that supernumerary status did not equate to direct supervision and did not absolve her from her obligation to undertake patient care. The panel was satisfied that Miss Bradwell was allocated patients and had to provide patient care.

The panel also saw a letter entitled 'Return to work following Maternity and Annual leave' dated 30 July 2018 from Colleague B to Miss Bradwell laying out the conditions of her return to work. The panel noted that point 3 stated: *"Manage 3 patients competently and complete nursing tasks ensuring effective time management…".*

The panel accepted the evidence of Colleagues A and B and rejected the response of Miss Bradwell. The panel found that on 13 August 2018, in respect of one or more unknown patients, Miss Bradwell did not carry out observations and/or record observations at 17:00 until prompted to do so by Colleague A.

The panel therefore found charge 4a proved.

Charge 4b

4. On 13 August 2018, in respect of one or more unknown patients you:

b) Did not record the amount of fluids consumed on the fluid balance chart between 07:00 and 20:00.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A and Colleague B and Miss Bradwell's documentary evidence.

The panel noted that Colleague A in her witness statement dated 21 August 2019 stated:

> *"There was also an issue regarding a separate patient and their fluid balance chart. … exhibit…'. On the chart, in the columns for 13 August 2018, this shows the drinks that the patient had apparently received. The Registrant had been on duty from 07:00 to 20:00 on this day and was responsible for caring for this patient, but the fluid balance chart was blank except for infusions. I recall that this patient would have been a transplant patient. In such circumstances, the fluid balance would impact on how much Furosemide (sic) would be prescribed and administered to the patient. If drinks are not recorded on the fluid balance chart, the urine output would appear higher than it actually is and the patient would then be given a lower dose of Furosemide (sic). This could send them into pulmonary oedema. I spoke to the patient and they informed me about the drinks they had received and consumed throughout the day. … the fluid balance chart did not include drinks consumed by the patient. I confirm that I was on duty with the Registrant on this day and noticed the concerns during the evening checks. I cannot recall any details of any discussions with the Registrant about this incident."*

The panel had sight of Colleague B's witness statement dated 14 August 2019 in which he said:

"Having reviewed Colleague A's log of concerns… I recognise that the Registrant also made some mistakes in relation to fluid balance during her shift on 13 August 2018. Colleague A notes that the Registrant had not completed the patient's fluid balance chart or documented the patient's input accurately."

The panel accepted the evidence of the witnesses. The panel found them to be professional and consistent witnesses. It found the above evidence to be confirmed by Colleague B's log of concerns.

The panel also had sight of a contemporaneous document summarising various incidents, including this one, documented by Colleague A which she collated and sent to her manager on 22 August 2018. The panel therefore found that there were numerous consistent, strong and sufficient evidence before it in respect of this charge.

The panel was of the view that completing fluid charts is a very basic nursing skill and therefore is an act that Miss Bradwell ought to have recorded. The panel therefore determined that there was sufficient evidence before it to find that on 13 August 2018, in respect of one or more unknown patients, Miss Bradwell did not record the amount of fluids consumed on the fluid balance chart between 07:00 and 20:00.

The panel therefore found charge 4b proved.

Charge 5a

5. On 14 August 2018, in respect of one or more unknown patients you:
    a) Did not give any medications until you were reminded to do so at 19:00 by Colleague A.

This charge is found proved.

In reaching this decision, the panel considered the evidence of Colleague A and Colleague B and Miss Bradwell's documentary explanation.

The panel saw a letter to Miss Bradwell entitled 'Informal Conduct meeting' dated 10 September 2018 in which Colleague B states what the concerns are and what Miss Bradwell's duties are, in particular*, "14/08/2018 Sister in charge checked your Kardex at 19:00, tea time medications had not been given, Sister in charge had to remind that you needed to give them between 17:00 and 19:00".*

The panel reminded itself of the evidence it had heard that once Miss Bradwell had been reminded of these duties by others, she would do it.

The panel noted that Miss Bradwell states in her response form that:

> *"It was my understanding at the time that I had not passed all the competencies as set out and still required assessment from the practice educator which meant that I was not to give out medications without supervision while I am in Supernumerary. I had not had a conversation/ meeting or discussion with anyone to inform otherwise. Competencies had been set out to be reviewed in 4 weeks, this incident was within that time frame."*

The panel rejected Miss Bradwell's explanation and determined that although Miss Bradwell was under supervision, Colleague B's letter on 30 July 2018 made it clear what her duties were, which included medication administration. Further, the panel was of the view that being under supervision and being supernumerary does not absolve Miss Bradwell from her normal nursing duties.

The panel was of the view that administering medication is a fundamental task required of a nurse. Further, the panel bore in mind Miss Bradwell's length of experience as a qualified nurse.

The panel accepted the evidence of Colleagues A and B.

The panel therefore determined that on 14 August 2018, in respect of one or more unknown patients Miss Bradwell did not give any medications until reminded to do so at 19:00 by Colleague A.

The panel therefore found charge 5a proved.

Charge 5b

5. On 14 August 2018, in respect of one or more unknown patients you:
    b) Did not give Colleague A 30 minutes notice that a patient's intravenous infusion of Dopamine was running out and needed to be changed.

This charge is found proved.

In reaching this decision, the panel accepted the evidence of Colleague A and Colleague B.

The panel noted that Miss Bradwell had not passed intravenous medication competency. It had regards to Colleague A's witness statement dated 21 August 2019 stated:

> *"The Registrant was allocated to care for patients in beds 4 and 5 who were both on infusions for their medication. In the morning, I told the Registrant to give me half an hour of notice before the infusions ran out so that I could make up the medication infusion for her. Later that day, I recall that the Registrant came to tell me that her patient's Dopamine infusion was running out in 2 minutes. The machines would 'ping' at 10 minutes and 2 minutes to inform the nurse that the medication is about to run out. I recall that this patient was waiting for a transplant and had a severe heart failure. … when the Registrant came to inform me that there was only two minutes left on the Dopamine infusion, I had to leave my patient*

who I was caring for at the time to make up the infusion. I recall I also missed the doctor's review of my patient during the ward round because of this. I recall that I made up the infusion of Dopamine and set it up for the patient who the Registrant was caring for."

The panel noted that Colleague A's statement was corroborated and supported by the contemporaneous log of concerns by Colleague A sent to her manager dated 22 August 2018.

The panel was of the view that despite the fact that Miss Bradwell had not passed her intravenous medication competency, she had a duty to alert the nurse responsible in a timely manner when the intravenous infusion needed to be replaced. This had been clearly articulated to Miss Bradwell by Colleague A at the beginning of the shift to give her 30 minutes to be able to prepare the infusion as prescribed.

Given all the evidence in relation to this charge, the panel determined that on 14 August 2018, in respect of one or more unknown patients Miss Bradwell did not give Colleague A 30 minute's notice that a patient's intravenous infusion of Dopamine was running out and needed to be changed.

The panel therefore found charge 5b proved.

Charge 6b

6. During a medication assessment on 4 August 2018 you:
   b) Failed to check the allergy status for an unknown patient before administering medication.

This charge is found proved.

In reaching this decision, the panel accepted the evidence of Ms 2.

The panel had sight of Ms 2's witness statement dated 1 August 2019 in which she said:

> *"When I watched the Registrant administer medication to this patient, she forgot to check the patient's allergy status…*

The panel also had sight of Miss Bradwell's Medication Assessment Supervisor Record dated 14 August 2018 in which the following was noted by Ms 2:

> *"She also failed to check his allergy status prior to giving the medications, when challenged about this she advised it was because she knew the patient details from the day before. I advised that even though she knows the patient at each medication round she still needs to check their identity and allergy status. … When I asked the Registrant about not checking the patient's allergy status, she said that she knew the patient's details from the previous day. I advised her that she should still check for allergies each time."*

The panel noted the charge and determined that checking a patient's allergy status is a critical aspect of basic nursing skills. Further the panel bore in mind that allergy status has the capacity to change and therefore assessing an allergy status before administering medication is critical.

Given the evidence in relation to this charge, the panel determined that during a medication assessment on 4 August 2018 Miss Bradwell failed to check the allergy status for an unknown patient before administering medication.

The panel therefore found charge 6b proved.

Charge 6c

6. During a medication assessment on 4 August 2018 you:

c) Failed to change your gloves when drawing up Heparin medication for an unknown patient.

This charge is found proved.

In reaching this decision, the panel considered the evidence of Ms 2.

The panel had sight of Ms 2's witness statement dated 1 August 2019 in which she said:

> *"When I watched the Registrant drawing up the Heparin medication, I noticed that she did not change her gloves. I spoke to the Registrant about the importance of good hand hygiene and changing her gloves. Unfortunately, she did not seem to know or understand why she needed to change them. I was concerned about this because failing to change gloves means that the patients are being put at risk of infections.'*

The panel also had sight of Miss Bradwell's Medication Assessment Supervisor Record dated 14 August 2018 in which the following was noted by Ms 2:

> *"When drawing up the heparin I did have to speak with Alison about her hand hygiene/ changing gloves between cleaning the tray and starting to draw up the medications. She advised that she didn't really see why she needed to and asked about evidence as to why this is necessary."*

The panel noted that the above Medication Assessment Supervisor Record dated 14 August 2018 was contemporaneous and was signed by Miss Bradwell.

The panel accepted the evidence of Ms 2.

The panel determined that during a medication assessment on 4 August 2018, Miss Bradwell failed to change her gloves when drawing up Heparin medication for an unknown patient.

The panel therefore found charge 6c proved.

Charge 6d

6. During a medication assessment on 4 August 208 you:
    d) Retrospectively recorded that you administered laxatives to a patient on 13 August 2018

This charge is found proved.

In reaching this decision, the panel accepted the evidence of Ms 2.

The panel had sight of Ms 2's witness statement dated 1 August 2019 in which she said:

> *"When checking Patient Two's drug chart, the Registrant noticed that the laxatives from the previous day (13 August 2018) had not been signed for. As patient two had been in her care on the previous day, the Registrant said she was sure that she had administered them and asked whether she should retrospectively sign for them. I told the Registrant that she should not really be retrospectively signing for the medication and that she should instead sign after it had been administered or at the latest, by the end of her shift. The Registrant decided to sign for the medication in any event."*

The panel also had sight of Miss Bradwell's Medication Assessment Supervisor Record dated 14 August 2018 in which the following was noted by Ms 2:

"Whilst in the room she noticed that the medication – senna and lactulose hadn't been signed for on the previous day. Alison advised that she had been looking after the patient the previous day and had forgotten to sign for the medications. Alison asked about signing the Kardex retrospectively which I advised shouldn't really be done, however Alison advised that she was 100% sure that she had given them and decided to sign for them."

The panel further had sight of an email dated 17 August 2018 sent from Ms 2 to Colleague B which included the following:

"I did have to speak to her about retrospective signing for medications. As you will see in the contact sheet she had been looking after a patient on the day prior to my assessment and had failed to sign for the laxatives but could recollect giving them. I did advise that really we shouldn't be signing for drugs given the day previous but because she was 100% sure that she had given them she signed the kardex."

Given the evidence in relation to this charge, the panel determined that during a medication assessment on 4 August 2018, Miss Bradwell retrospectively recorded that she administered laxatives to a patient on 13 August 2018.

The panel therefore found charge 6d proved.

Charge 7b

7. On or around 21/22 August 2018, in respect of one or more unknown patients you:
    b) As a result of your miscalculation, did not complete observations every 30 minutes in accordance with the MEWS policy.

This charge is found proved.

In reaching this decision, the panel took into account the observation chart for the patient. Ms 1, Colleague A, Colleague B and Miss Bradwell's evidence.

The panel first had sight of the observation chart for a patient involved in the incident on 21 August 2018 as charged.

The panel then had sight of a document summarising various incidents by Miss Bradwell noted by Colleague A and sent her to manager on 22 August 2018. The panel noted that this document records:

> *"22nd August 2018: Mews score was documented 0, however patient was actually scoring a 3. Blood pressure 80 systolic and saturations 95%. Was then altered after was spoken to by sister [Ms 1]. -As was scored 0 at 8am observations were not completed again until 10am instead of as per policy within half an hour. -Incomplete observations documented all day 10:30 observations no temperature documented but scored 0 in the box. 12:00 observations no temperature documented, box left blank of the observations chart."*

The panel noted that Ms 1 in her witness statement dated 20 August 2019 stated:

> *"… Therefore, I looked into the patient's MEWS further and realised that the patient actually had a MEWS of three. This meant that the Registrant should have been checking the patient's observations every thirty minutes, but had not been doing so. The patient's condition should also have been reported to me as the nurse in charge and escalated to doctors as per the MEWS protocol. This did not happen as the Registrant had miscalculated the MEWS at 0, which requires no intervention (unless clinically concerned). Although I cannot recall any further details of the incident I believe that I highlighted the Registrant's mistake to her and reported the incident to Colleague B..."*

The panel noted that Colleague A in her witness statement dated 21 August 2019 stated:

"On 21 August 2018, a further set of incidents arose regarding the registrant. This included a MEWS score being calculated incorrectly, observations not being completed …."

The panel noted that Colleague B in her witness statement dated 14 August 2019 stated:

"As the patient had a MEWS of three, observations should have been completed again within 15 minutes. After 15 minutes, if it was that case that the observations had not improved, the Registrant should have escalated the matter to the medical staff within half an hour. Due to the miscalculations, the Registrant did not complete further observations within this timeframe."

The panel took account of Miss Bradwell's response in which she said the following:

"It is my understanding now that with a MEWS score of 3, hourly ob.'s is required, and the primary nurse is to be informed. Sister [Ms 1] was present with me at the time and she was aware of the patients MEWS score at 8am. At 9am was the ward rounds with the Doctors so I made the false assumption that as my named nurse was on the ward round that she would complete the hourly ob.'s for the patient. I now know that this is not how the unit operates and that to cover myself I should have repeated the observations at 9am."

However, the panel did not accept her explanation. The panel was of the view that she was not absolved from her duties and rejected her explanation that she assumed it was no longer her responsibility.

The panel determined that there was sufficient evidence before it to find that on or around 21/22 August 2018, in respect of one or more unknown patients Miss Bradwell, as a result of her miscalculation, did not complete observations every 30 minutes in accordance with the MEWS policy.

The panel therefore found charge 7b proved.

Charge 8a

8. On 27 August 2018:
    a) Failed to administer medication and/or failed to record in the medication chart that medication was administered for patients in Beds 7 to 9.

This charge is found proved.

In reaching this decision, the panel considered all the evidence before it, in particular, the oral and written evidence of Ms 3 and Colleague B.

The panel noted a contemporaneous email dated 27 August 2018 from Ms 3 who was on the night shift on 27 August. Her email to Colleague B stated that she had concerns regarding missed or not signed medication for patient in beds 7-10. The panel noted that Ms 3 had identified that the nurse assigned to those patients was Miss Bradwell. The panel was told that the night staff had been unable to contact Miss Bradwell to ascertain if the medication had or had not been given as they did not have a contact number for her.

The panel noted that following that email, Colleague B had met with Miss Bradwell on the morning of 28 August 2018 to highlight the missing medications recorded or administered. This was recorded in a letter to the Miss Bradwell from Colleague B on 28 August 2018 identifying that there were 6 medication errors in one day. On 28 August 2018, Miss Bradwell had had a further assessment with the practice educator, Ms 2, who had recorded on the supervision contact sheet that "*…She advised that she had been working independently the day prior and made some errors in relation to medications- omitted one medication and failed to sign for several others…*"

The panel also noted that Colleague B said in his witness statement dated 14 August 2019:

> *"I explained to the Registrant that if the patient had had two doses of Warfarin, he will need to be taken off the transplant list and have bloods taken to ensure that he was within clotting range. When I explained this to the Registrant she suddenly retracted and said that he had not given the Warfarin. Following this I asked the Registrant if she was certain about giving the other medications which had not been signed for. She said that she had given them. I went on to tell the Registrant that these too had been administered by the night staff. Upon hearing this, the Registrant again retracted and confirmed that she had not given the other medications."*

The panel also noted the contents of the email sent from Colleague B to Ms 2 dated 28 August 2018 at 07:54:

> *"Alison Bradwell appears to have missed various medications on her patients again yesterday. It was noticed on the night shift that there were a total of 6 missed signatures on 3 patients form the whole shift. Some were morning medications, some lunch and some teatime so it isn't as though 1 while medication round was missed. I went through each medication in turn and she told me that she had administered them. However one patent was adamant that he hadn't had his warfarin and as the night shift did not have a contact number for Alison, they did give it. She thinks that she didn't give that one now...*
>
> *She did have to take 4 patients yesterday but none were especially complex and the work load was not overwhelming…"*

The panel then had sight of Miss Bradwell's response. She said the following:

"On this day there were 3 members of staff on shift. I believed I was still under supervision and supernumerary as I did for all these incidents. Out of the 10 beds I was allocated 5 patients. More than one of these patients was acutely unwell and a further one of them was on a balloon pump. The unit was categorized as on HIGH that day which resulted in 1 of the staff members being off the ward most of the day. The balloon pump patient should of received one to one care as per policy due to the nature of the heightened observations and this took the majority of my time during the day...

Due to the extremely busy nature of the ward that day I can only admit that I did not sign for some medications."

The panel did not accept Miss Bradwell's response in which she appeared to focus more on her perceived lack of support, rather than her errors.

The panel accepted the evidence of Ms 3 and Colleague B.

Given all the evidence before it, the panel determined that on 27 August 2018, Miss Bradwell failed to administer medication and/or failed to record in the medication chart that medication was administered for patients in Beds 7 to 9.

The panel therefore found charge 8a proved.

Charge 8b

8. On 27 August 2018:
    b) Failed to administer any medication including Warfarin and/or failed to record in the medication chart that medication including Warfarin was administered to Patient A in bed 10.

This charge is found proved.

At the outset of the hearing Ms Bayley on behalf of the Registrant admitted that Miss Bradwell failed to record any medication and failed to administer or record Warfarin. She denied that the Registrant had failed to administer any medication other than Warfarin.

However, our attention was drawn by Ms Saran to a part of the transcript dated 23 February 2022 (Day 2) which reads:

> *"MS BAILEY (sic): Yes. Thank you. Charge 8(b) it is admitted that Mrs Bradwell failed to administer the warfarin, and it is admitted that she failed to record in the medication chart that medication was administered to Patient A in bed ten, so it is admitted she failed to administer morphine but not that she failed to administer any medication, and it is admitted that she failed to record the administration of that medication."*

However, the panel also noted another passage from the same transcript which reads:

> "CHAIR: *Charge 8(b) is an admission that there was a failure to administer warfarin and a failure to record on the medication chart but not admissions about other medications; is that right?*
>
> *"MS BAILEY (sic): That is right, madam. Thank you."*

The panel noted that this later passage conflicts with the earlier passage which mentions Morphine. The panel also noted that Morphine is not referred to in the charge and there was no evidence at all that the Registrant had failed to administer Morphine in any of the other written or oral evidence that the panel had before it.

Therefore, the panel concluded that the earlier admission in regard to Morphine, must have been a slip of the tongue or a transcription error.

In the light of this, the panel concluded that the admission of ‘failure to administer’ only related to Warfarin and not to any other medication.

Ms Saran accepted that apart from the partial admission, there was no oral or documentary evidence to demonstrate that this charge related to Morphine.

The panel accepted the evidence of Colleague B and Ms 3. Ms 3 stated:

> *‘I was working on the night shift on 27 August 2018. When I came into work, I noticed that the patients in beds seven to 10 (that the Registrant had been looking after during the day shift) did not have all their day time medications signed for on their medication charts. Therefore, it was unclear as to whether their medications had been given or not, if the Registrant had given the medication and had forgotten to sign for them. One of the patients … was adamant that he had not had his Warfarin that this was due during the day so I administered it to him myself.’*

Further, Colleague B stated:

> *‘Throughout [27 August 2018], six medications over three different patients had not been signed for by the Registrant as having been administered…I was able to speak to the Registrant about this at around 7:00am as she had come in for her shift. I asked her if she gave the medications which had not been signed for. She was adamant that she had and said that she had just forgotten to sign for them.’*

In these circumstances, the panel found this charge proved, namely on the balance of probabilities and having regard to all documentary and oral evidence, the Registrant had failed to record any medications, and had admitted that she failed to administer or record Warfarin.

To that extent the panel found the charge proved in relation to failing to record any medications and in failing to administer and record Warfarin.

Charge 9a

7. On or around 28 August 2018, during a conversation with Colleague B:
   a) Incorrectly informed Colleague B that Patient A had received his Warfarin medication.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it including Colleague B's evidence and Miss Bradwell's responses.

The panel noted the Informal Conduct Meeting letter dated 10 September 2018 in which it was recorded that on 13 August 2018 "*Administration of medication on 3 patients on 27/08/2018 in total there were 6 medication errors in 1 day. You initially stated that you had administered the medication for each of them but had not signed the prescription chart. In one incident of medication not signed for, Warfarin you initially said that you had given it to the patient on the 17:00 medication round. When explained that he had been given the medication afterwards as the patient had expressed that he "had definitely not had it" you then admitted that you had not administered that particular one."*

The panel noted that Colleague B makes it clear that Miss Bradwell had been adamant that she had forgotten to do it:- *"This incident was reported to me the following morning (28 August 2018) via an email from [Ms 2]. … I was able to speak to the Registrant about this at around 7:00am as she had come in for her shift. I asked her if she gave the medications which had not been signed for. She was adamant that she had and said that she had just forgotten to sign for them."*

The panel bore in mind that Colleague B's oral evidence was consistent with the documentary evidence that Miss Bradwell was '*adamant*' that she had given the Warfarin and had forgotten to sign it.

The panel also had regard to Colleague B's witness statement dated 14 August 2019 in which he states:

> *"… You [Miss Bradwell] initially stated that you had administered the medication for each of them but had not signed the prescription chart. In one incident of medication not signed for, Warfarin you initially said that you had given it to the patient on the 17:00 medication round…*

The panel also noted the email sent from Colleague B to Ms 2 dated 28 August 2018 at 07:54:

> *"Alison Bradwell appears to have missed various medications on her patients again yesterday. It was noticed on the night shift that there were a total of 6 missed signatures on 3 patients form the whole shift. Some were morning medications, some lunch and some teatime so it isn't as though 1 while medication round was missed. I went through each medication in turn and she told me that she had administered them. However one patient was adamant that he hadn't had his warfarin and as the night shift did not have a contact number for Alison, they did give it. She thinks that she didn't give that one now.*

The panel noted that Miss Bradwell stated the following in relation to this charge:

> ***"**My confusion regarding the warfarin is that when I was asked if I had given the warfarin it was because I was unaware that the warfarin is prescribed on a separate chart. I did administer all that patient's medication on the Kardex that day but did not know that warfarin is prescribed separately on its own chart and separate to all other medications. I am now familiar with the process of having the warfarin prescribed by the doctor following the results of the morning bloods and that this is prescribed daily."*

The panel accepted the oral evidence of Colleague B, which was consistent with the documentary evidence. The panel rejected Miss Bradwell's explanation as she had wide experience of drugs used for cardiac patients such as Warfarin, including the associated blood tests which are necessary to prescribe the correct dose, and there is clear evidence that Warfarin would have been included on the patient's main medication chart as well as on the specific Warfarin chart.

The panel therefore determined that on or around 28 August 2018, during a conversation with Colleague B, Miss Bradwell incorrectly informed Colleague B that Patient A had received his Warfarin medication.

The panel therefore found charge 9a proved.

Charge 10

10. Your actions as set out in charge 9 (a)-(b) above were dishonest in that you attempted to cover up your error.

This charge is found proved.

The panel accepted the advice of the legal assessor. He referred them to the case of Ivey v Genting Casinos [2018] AC 391, they also had regard to the NMC guidelines for 'Making Decisions on Dishonesty Charges'. The panel had to consider the actual state of mind of the Registrant and her knowledge of the facts and also whether or not it was dishonest by the standards of ordinary decent people. It also had to have regard of whether or not there was an alternative innocent explanation for her actions or omissions.

In reaching this decision, the panel took into account all the evidence before it, including Colleague B's evidence.

The panel had regard to Colleague B's witness statement dated 14 August 2018 in which he states:

> *"…It also breaches paragraph 12.6.10 of the Medicine Management Policy … The policy states clearly that medication errors should be clearly recorded with the appropriate Code giving details of the omission. Therefore, the Registrant would have been aware that she should clearly record her mistakes…*
>
> *…On 27 August 2018 misrepresented the facts to me about what medications she had administered after she failed to sign for them. As a nurse, the Registrant had a duty of candour where she ought to have put the patients first and come clean about her mistakes as soon as she realised them. Instead, she used the unclear record keeping to cover up the extent of her mistakes. … This put the Registrant's patients at risk of receiving incorrect doses of medication which can have very serious effects on patient health."*

The panel accepted the evidence of Colleague B.

When she met with colleague B on the morning of the 28 August 2019 Miss Bradwell stated that she had forgotten to sign for them but was adamant that she had administered the medication. When it was explained to the Registrant, the catastrophic impact this would have on Patient A's ongoing care, she suddenly retracted and said that she had not given the Warfarin.

Colleague B stated:

> *'I asked her if she gave the medications, which had not been signed for. She was adamant that she had and said that she had just forgotten to sign for them. I explained to the Registrant the potential problem this raised; the Warfarin had been given the patient by the night staff because the patient believed that he had not had the medication. I explained to the Registrant that if the patient had two doses of*

Warfarin, he will need to be taken off the transplant list and have bloods taken to ensure that he was within clotting range. When I explained this to the Registrant, she suddenly retracted and said that he (sic) had not given the Warfarin.

The panel considered that the sudden retraction indicated that the Registrant was aware that she had not given the Warfarin.

Furthermore, the Registrant in her responses states:

'My confusion regarding the warfarin is that when I was asked if I had given the warfarin it was because I was unaware that the warfarin is prescribed on a separate chart. I did administer all that patient's medication on the Kardex that day but did not know that warfarin is prescribed separately on its own chart and separate to all other medications.'

However, the panel rejects this explanation as the Warfarin prescription would have been on the patient's main medication chart. The panel, therefore, decided that this explanation was unlikely.

The panel therefore decided that both limbs of the test in Ivey were engaged, namely 1.) that she had knowledge or belief as to the facts and 2.) that this was dishonest by applying the objective standards of ordinary decent people (the objective test).

The panel concluded that by saying that Miss Bradwell had given Warfarin when she had not was a deliberate dishonest statement to cover up her failure. The panel therefore rejected the overall explanation Miss Bradwell gave in her responses to the Trust that she was confused.

In the light of all the evidence, the panel determined that Miss Bradwell's actions as set out in charge 9 (a)-(b) above were dishonest in that it concluded that she had deliberately attempted to cover up her error by lying.

The panel therefore found charge 10 proved.

Charge 11a

11. During a medication assessment on 28 August 2018,

    a) Were involved in a near miss incident, in that you omitted to give an unknown patient their prescribed medication (Movicol) until prompted.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, in particular, the evidence of Ms 2.

The panel had sight of the staff contact sheet in which it records the incident as described by Ms 2, that Miss Bradwell had missed a prescribed medication of Movicol until prompted. The panel noted that Miss Bradwell has signed this document on 4 September 2018.

The panel further noted that Ms 2 had confirmed that:

> *"She did miss one prescribed medication for a patient (Movicol) until I pointed it out to her at which time she returned to the patient to see if the medication was required."*

The panel accepted the evidence of Ms 2 and found that during a medication assessment on 28 August 2018, Miss Bradwell was involved in a near miss incident, in that she omitted to give an unknown patient their prescribed medication (Movicol) until prompted.

The panel therefore found charge 11a proved.

Charge 11b

11. During a medication assessment on 28 August 2018,

    b) Demonstrated a lack of knowledge of various medicine.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, in particular, the evidence of Ms 2.

The panel had regard to Ms 2's witness statement dated 1 August 2019 in which she stated:

> *'I asked the Registrant about the use of various medications commonly used in cardiac care. She did not know what they were used for and admitted that she had not improved her knowledge on the medications since I had asked her to during the first assessment. This illustrated to me that she was not prepared to take on my advice and get better. Moreover, cardiac medication can have quite a serious effect on patient heart rate and blood pressure which can make patients rather unwell. Not having the knowledge underpinning the effects of the medications could subsequently result in patients' conditions deteriorating. It was a serious concern that the Registrant was not familiar with the medications she was administering to the patients. … I also ran through a theoretical part of the assessment with the Registrant. We discussed NMC standards along with the Hospital's medication policies. We also discussed what she would do if a drug error is made, or if a patient reacted to medication and the method for ordering controlled drugs. I found the Registrant's knowledge rather variable. She knew the main points but needed some prompting as she didn't know all of the answers. The Registrant became upset during the assessments on the day and she said "I'm not into this today, can*

you tell?" … at the end of the assessment I still did not feel confident signing her off as competent."

On 28 August 2018, Miss Bradwell had had a further assessment with the practice educator, Ms 2, who had recorded on the supervision contact sheet the following:

> "*…During the drugs assessment Alison was questioned about a couple of drugs which she was administering, one of which she attempted to guess its use and the other she didn't know. She admitted that she hadn't read up on any medications which I had requested at the last assessment. I advised Alison to ensure that she read drugs leaflets/ BNF before administering medications to patients because it is important that she is aware of what drugs she is giving. … I felt that because Alison did miss a medication within the drugs round, had limited drugs knowledge and was unable to fully answer some of the theoretical components of the assessment that I would need to repeat the medications assessment."*

It was clear to the panel from both the written and oral and documentary evidence before it that Miss Bradwell had admitted at local level that she had not read up on the medication.

The panel also took into account that there is a medication administration policy which was easily available to all clinical staff across the Trust and must be adhered to by those prescribing and administering medication.

The panel accepted the evidence of Ms 2 and concluded that during a medication assessment on 28 August 2018, Miss Bradwell demonstrated a lack of knowledge of various medicines.

The panel therefore found charge 11b proved.

Charge 12

12. On 9 September 2018, in respect of one or more unknown patients you:

a) Incorrectly calculated and recorded a MEWS score as 0 when it should have been recorded as 1 or 2.

b) Did not complete a skin bundle for a patient with grade 2 pressure sores since 13:00 and/or in the alternative did not record that a skin bundle had been performed

This charge is found NOT proved in its entirety.

Firstly, the panel did not accept the submissions made by Ms Saran that the date of the stem of this charge was immaterial and did not accept her submission that the panel could treat this charge as if it read on or around 9 September 2018. The panel noted that the reason for this is that it had refused an earlier application to amend the charge to read 'in or around 9 September 2018'. In addition, the panel decided that it would be unfair to Miss Bradwell to treat this charge as if it were to read 'on or around 9 September 2018'. The panel bore in mind that Miss Bradwell and her then representative were present at the time to make representations in relation to this amendment. Further, the panel remained of the view that it would be unfair to treat the charge as if it had read "on or about 9 September 2018", in light of the defence that the registrant did not work on Sundays and given the duty rota showing that Miss Bradwell was not on duty on that day.

Then, in reaching this decision, the panel accepted all the evidence before it, including that of Colleague B.

The panel accepted the evidence from Colleague B during his cross examination that Miss Bradwell only worked on Monday and Tuesday and therefore the alleged incidents could not have involved her on 9 September 2018 which was a Sunday. The panel bore in mind that Colleague B took the panel to a duty roster which confirmed this and showed that

Miss Bradwell had worked a long day on 10 September 2018 but had not been working on 9 September 2018. For this reason, the panel find both parts of this charge not proved.

The panel further had sight of a letter dated 30 July 2018 from Colleague B to Miss Bradwell confirming that her working days are Monday, Tuesday and/or Wednesday.

The panel also has sight of an email dated 12 September 2018 at 08:25 sent from Colleague B to Ms setting out Miss Bradwell's working days. The panel noted that there is reference within the email to Miss Bradwell working 2 set long days on Mondays to Wednesdays with no mention of working on a Sunday.

The panel accepted the evidence of Colleague B and determined that he was a consistent and professional witness and that his oral and documentary evidence could be relied on.

The panel bore in mind that the burden of proof at the fact-finding stage rests on the NMC. Given the evidence before it, the panel determined that on the balance of probabilities, the NMC has not discharged its burden of proof in respect of both sub charges to charge 12.

The panel found charges 12a and 12b not proved.

Charge 13

13. During a medication assessment on 11 September 2018, demonstrated a lack of knowledge of various medicines.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, in particular, the evidence of Ms 2.

The panel had regard to Ms 2's witness statement dated 1 August 2019 in which she stated:

> *"Unfortunately, the Registrant was still demonstrating limited medication knowledge but she was checking leaflets in the medication boxes…*
>
> *…I still did not feel confident passing the Registrant off as competent."*

The panel also had sight of the Staff Supervision Contact Sheet signed and dated by Ms 2 on 14 September 2018 which stated the following:

> *"Alison did still demonstrate limited drugs knowledge but was now checking the leaflets in drugs boxes. Some of the medications prescribed were cardiac drugs which would have an effect of the patient heart rate and blood pressure."*

The panel also noted the Registrant's Medication Assessment No 3 Supervisor Record dated 11 September 2018, which stated that *"Alison did still demonstrate limited drugs knowledge".*

The panel accepted the oral evidence of Ms 2 and the supporting documentary evidence.

The panel therefore concluded that during a medication assessment on 11 September 2018, Miss Bradwell demonstrated a lack of knowledge of various medicines.

The panel therefore found charge 13 proved.

Charge 14a

14. After 30 July 2018, you
    a) Did not return in a timely manner a reflective piece originally requested to be returned by 30 July 2017.

This charge is found proved.

The panel considered a submission at the admission stage of the hearing by Ms Bayley, Miss Bradwell's then representative, that the panel ought to consider whether or not these allegations amounted to a failure. Having taken advice from the Legal Assessor, the panel rejected this submission and decided to consider the charges as worded and without importing the word 'failure' into charge 14a.

In reaching this decision, the panel accepted all the evidence before it including that of Colleague B and Miss Bradwell's response.

The panel first had sight of an outcome letter from a meeting on 28 August 2018 from Colleague B to Miss Bradwell. The letter records: *"Not sending in a piece of reflective practice to the matron that should have been completed on 03/07/2017."*

The panel noted Miss Bradwell's response in which she stated:

> *"I believe that I did submit this prior to the 03.07.2018 but as I could not locate it and I am still unable to, it was re-submitted in September when [Colleague B] approached me. I received an email back from [another colleague] once it had been submitted and she said that she was happy with the reflection and the action plan I had set myself to complete."*

However, the panel determined that there was no evidence that the registrant had returned the reflective piece in a timely manner after 30 July 2018. The panel saw evidence in a document titled Return to Work dated 30 July 2018 and a record of an informal conduct meeting dated 10 September 2018 showing that the reflective piece originally due on 30 July 2017 had still not been returned by the 10 September 2018.

In all the circumstances, and on the balance of probabilities, the panel was satisfied that Miss Bradwell did not return in a timely manner a reflective piece originally requested to be returned by 30 July 2017.

The panel therefore found charge 14a proved.

Charge 14b

14. After 30 July 2018, you
    b) Did not complete within two weeks mandatory training including fast track IV training.

This charge is found proved.

The panel bore in mind a submission at the admission stage of the hearing by Ms Bayley, Miss Bradwell's then representative, that the panel ought to consider whether or not these allegations amounted to a failure on Miss Bradwell's behalf. Having taken advice from the Legal Assessor, the panel did not accept this submission and considered the charges as worded and did not import the word 'failure' into charge 14b.

The panel reminded itself that there was an admission in relation to charge 14b, but not that it amounted to failure. However, given the partial denial, the panel was of the view that it should examine the evidence presented by the NMC and consider whether or not the NMC have proved this charge on a balance of probabilities.

In reaching this decision, the panel accepted the evidence of Colleague B and noted Miss Bradwell's response.

The panel first had sight of a letter dated 30 July 2018 sent from Colleague B to Miss Bradwell in which it states:

> *"I have provided you with study time over the first 2 weeks (24 hours) to enable you to complete all of your Mandatory training. I would also require you to complete your fast track IV training and glucometer training via the learning hub..."*

The panel also noted the Staff Supervision Contact sheet signed by Ms 2 dated 14 September 2018 in which she records:

> *"…by next week she will aim to:*
> *-Complete all mandatory training and book into practical moving and handling/ Hospital life support sessions;*
> *- Complete her fast track injectable medications training;*
> *- ANTT e-learning;…*
> *-Finish/submit reflection to her manager about the drugs errors/ omissions made.*
>
> *Alison advised that she will aim to get all of this done by next week. I showed her on the learning where to find the injectable medicines course to enable her to complete it."*

The panel bore in mind Miss Bradwell's response to the NMC in which she stated the following:

> ***"****I did have the mandatory training all complete on the first day that you provided, the only reason the iv fast track was not complete was because I was not given access to it until last week. The only other parts of my training that I have not completed are the sessions in which I have to attend. I have completed both reflections, however one will now need to be changed to reflect the points you have raised in this letter. … PS. Could you please send me the injectable medicines policy and any other policy in regards to medication. I am part way through completing the assessment…*
>
> *I completed online mandatory training on the 31.07.2018. I completed all the training apart from Face to Face sessions which required booking them in a time off the unit. I was allocated online mandatory training on the 07.08.2018 but I was told to work on the unit. I attended handover and was given patients. I was still under the understanding that I was supernumerary. The fast track intravenous online training was not available to me within the first month back and so I was unable to*

commence this training until it had been authorised. When I attempted to complete the training at home once it had become available to me, I passed the theoretical part but could not progress to the next session due to issues with the system which still as yet have not been resolved. I reported this to [Colleague B] and he informed me that I would need to contact Sister Bleasdale, in which I did but was not responded to.”

The panel considered Miss Bradwell’s response to this charge which focussed on access to the online training system. The panel further reminded itself of the evidence it had heard from Ms 2 that she had checked the online learning hub and that there was no impediment on the learning hub from 14 August 2018.

The panel accepted Ms 2’s evidence and rejected Miss Bradwell’s response.

Given all the evidence before it, the panel concluded that Miss Bradwell did not complete within two weeks mandatory training including fast track IV training.

The panel therefore found charge 14b proved.

Charge 15a

14. Between 30 July 2018 and 9 October 2018 failed to demonstrate competency in the following areas:
    a) Administration of medication

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, including Miss Bradwell’s job description and the Trust policy.

The panel was of the view that medications administration is clearly within the role of a

band 5 nurse. It noted that in Miss Bradwell's job description it clearly states that she is responsible for administration of medicines and treatments in line with NMC and trust policy. The panel considered that charges 2b, 3b, 5a, 6a, 6b, 6c, 8a, 8b, and 11a, found proved by the panel, all relate to deficiencies in medicines administration.

Having regard to these matters found proved and having regard to the fact Miss Bradwell was an experienced band 5 nurse, the panel decided that Miss Bradwell's failings fell far below an acceptable standard of professional performance judged on a fair sample of their work, which could put patients at risk. For those reasons, the panel found there was lack of competence in relation to administration of medication.

The panel therefore found charge 15a proved.

Charge 15b

15. Between 30 July 2018 and 9 October 2018 failed to demonstrate competency in the following areas:
    b) General knowledge of medicines

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, including Miss Bradwell's job description, the Trust policy and the evidence of Ms 2.

The panel was of the view that general knowledge of medicines is clearly within the role of a band 5 nurse. It noted that in Miss Bradwell's job description clearly states that her main duties and responsibilities includes administration of medicines as per the Trust medicines management policy. The panel considered that charges 2a, 11b and 13, found proved by the panel, all relate to a lack of competence in general knowledge of medicines.

The panel had regard to Ms 2’s witness statement dated 1 August 2019 in which she stated:

> *“By the end of the three assessments, I had still had not signed the Registrant off as competent and I did not feel that she was safe to administer medications by herself. She did not appear to have insight into the potential risks of what she was doing or the consequences of not giving medications/ not having knowledge of medications.”*

Having regard to these matters found proved and having regard to the fact that Miss Bradwell was an experienced band 5 nurse, the panel decided that her lack of general knowledge of medicines fell far below an acceptable standard of professional performance judged on a fair sample of their work, which could put patients at risk. For those reasons, the panel found there was lack of competence in relation to general knowledge of medicines.

The panel therefore found charge 15b proved.

Charge 15c

15. Between 30 July 2018 and 9 October 2018 failed to demonstrate competency in the following areas:
    c) MEWS calculations

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, including Miss Bradwell’s job description, the Trust policy and the evidence of Colleague B.

The panel was of the view that MEWS calculations are clearly within the role of a band 5 nurse. The panel considered that charges 3a, 7a and 7b, found proved by the panel, all relate to MEWS calculations.

The panel had sight of Colleague B's witness statement dated 14 August 2019 in which he said:

> *"The Registrant's observation and MEWS calculation inaccuracies were another serious cause of concern. MEWS calculations and observation taking again are included in standard nursing training along with the Trust's induction for nurses... Moreover, the Registrant had been nursing for a few years so this is something that she should have known from her time in practice."*

Having regard to these matters found proved and having regard to the fact that Miss Bradwell was an experienced band 5 nurse, the panel decided that her lack of competence in MEWS calculations fell far below an acceptable standard of professional performance judged on a fair sample of their work, which could put patients at risk. For those reasons, the panel found that there was lack of competence in relation to MEWS calculations.

The panel therefore found charge 15c proved.

Charge 15d

15. Between 30 July 2018 and 9 October 2018 failed to demonstrate competency in the following areas:
    d) Record keeping

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, including Miss Bradwell's job description, the Trust policy and the evidence of Colleague B.

The panel was of the view that to maintain accurate, contemporaneous patient records is in line with Trust policy and is clearly within the role of a band 5 nurse. The panel considered that the charges 4a, 4b, 6d,7c, 8a and 8b. found proved by the panel, all relate to a lack of accurate record keeping.

The panel had sight of Colleague B's witness statement dated 14 August 2019 in which he said:

> *"…*the Registrant also failed to sign for medications after they had been administered. This is in direct breach of paragraph 12.6.9 of the Medicine Management Policy. … I believe this to be serious because failing to sign of medication causes confusion as to whether or not medications have been administered. It leaves patients at risk of overdose if it appears to other staff that medication has not been given when actually it has but has not been signed for. …"

Having regard to these matters found proved and having regard to the fact that Miss Bradwell was an experienced band 5 nurse, the panel decided that her lack of accurate record keeping fell far below an acceptable standard of professional performance judged on a fair sample of their work, which could put patients at risk. For those reasons, the panel found that there was lack of competence in relation to record keeping.

The panel therefore found charge 15d proved.

Charge 15e

16. Between 30 July 2018 and 9 October 2018 failed to demonstrate competency in the following areas:
    e) Carrying out observations

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it, including Miss Bradwell's job description, the Trust policy and the evidence of Colleague B.

The panel was of the view that Miss Bradwell's job description made clear that the main duties and responsibilities of her band 5 role include: 'to undertake comprehensive healthcare needs assessment of patients and reassessing' as appropriate in line with Trust policy. The panel considered that charges 1, 3a, and 4a, found proved by the panel, all relate to carrying out observations.

The panel had sight of Colleague B's witness statement dated 14 August 2019 in which he said:

> *"The Registrant's observation and MEWS calculation inaccuracies were another serious cause of concern. MEWS calculations and observation taking again are included in standard nursing training along with the Trust's induction for nurses. As such, I understand the Registrant would have been aware of how to complete observations… In relation to observation taking, the Registrant had a duty to ensure that she was completing all of the necessary observations"*

The panel noted that Miss Bradwell's response focussed on alleged failings of others which the panel considered not relevant to this charge.

Having regard to these matters found proved and having regard to the fact that Miss Bradwell was an experienced band 5 nurse, the panel decided that her failure to carry out observations appropriately and accurately fell far below an acceptable standard of professional performance judged on a fair sample of their work, which could put patients at risk. For those reasons, the panel found that Miss Bradwell has failed to demonstrate competency in carrying out observations.

The panel therefore found charge 15e proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct in regard to charges 9 and 10 and whether the facts found proved in regard to charges 1, 2b, 3b, 4a, 4b, 5a, 5b, 6b, 6c, 6d, 7b, 8a, 8b, 11a, 11b, 13,14a, 14b, 15a, 15b, 15c, 15d and 15e amount to a lack of competence, and if so, whether Miss Bradwell's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct and/or lack of competence. Secondly, only if the facts found proved amount to misconduct or lack of competence, the panel must decide whether, in all the circumstances, Miss Bradwell's fitness to practise is currently impaired as a result of misconduct and/or lack of competence.

Submissions on misconduct and lack of competence:

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.'*

Ms Saran first addressed the panel in regard to misconduct in relation to charges 9 and 10. She drew the panel's attention not only to the case of *Roylance v GMC [2000]* but also of *Nandi v GMC [2004] EWHC 2317 (Admin)*. She invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

Ms Saran identified the specific, relevant standards where Miss Bradwell's actions amounted to misconduct. She submitted that Miss Bradwell had provided incorrect information to a colleague regarding administering Warfarin to Patient A but subsequently admitted that Warfarin had not been administered when she was told of the 'grave consequences' to the patient if they had received too much of this medication. She submitted that charge 10 amounted to 'a cover up attempt'.

Ms Saran submitted that by incorrectly informing her colleague that the patient had received this medication, Miss Bradwell was in breach of section 8, 8.2, 8.5 and 8.6 of the Code as she did not work co-operatively, maintain effective communication with colleagues, work with colleagues to preserve the safety of those receiving care or share information to identify and reduce risk to patients.

Ms Saran submitted that by lying to her colleague about the administration of Warfarin, Miss Bradwell was in breach of section 20, 20.1 and 20.2 of the Code as this requires her to uphold the reputation of the profession at all times, keep to and uphold the standards and values set out in the Code, and act with honesty and integrity at all times.

Ms Saran submitted that these breaches amounted to 'serious professional misconduct'.

Ms Saran then addressed the panel on lack of competence. She submitted that the panel has already found charge 15 proved, which states that Miss Bradwell lacked competence in regard to:

- Administration of medication
- General knowledge of medicines
- MEWS calculation
- Record keeping
- Carrying out observation.

As such, Miss Bradwell had fallen short of the competency standards required by a registered nurse and invited the panel to confirm its finding that the charges amount to lack of competence. She then took the panel through charges relating to lack of competence and the areas of the Code that had been breached.

Firstly, Ms Saran submitted that by failing to follow the policy in relation to MEWS calculation and escalation in charges 1, 3a, 4a, 7a, 7b, 15c, and 15e, Miss Bradwell was in breach of 3 and 3.1 of the Code which requires that registered nurses must assess and respond to the physical, social, and psychological needs of people and promote their health and wellbeing during all life stages. She also submitted that Miss Bradwell was in breach of 8, 8.5, and 8.6 of the Code in the she did not work co-operatively with her colleagues to preserve the safety of her patients or share information to identify and reduce risk.

Ms Saran then addressed the panel regarding the charges that related to the administration of medication and fluids and the proper record keeping of these, which are charges 8a, 8b, 4a, 4b, 6d, 7c, and 15 d. Ms Saran submitted that these charges breached 10, 10.1, 10.2, and 10.3 of the Code which sets out that registered nurses must keep accurate and complete records without any falsifications. She submitted that 14 14.1 and 14.3 was breached in that registered nurses must be open and candid with service users during all aspects of their care, act immediately if there is a potential for harm and document any incidents so they can be dealt with quickly. She submitted that 19 and 19.1 of the Code was also breached in that Miss Bradwell had failed to reduce, as far as possible, any potential for harm and to reduce, as far as possible, the likelihood of mistakes, near misses in the course of her practice.

Ms Saran submitted that charges 2b,3b, 5a, 5b, 6b, 6c 8a,8b 11a, 15a, which regard administering the correct medication to patients in a safe way, at the correct time, were in breach of 19, 19.1,19.2, 19.3 and 19.4 of the Code in that Miss Bradwell had failed to reduce as far as possible, any potential for harm and to reduce as far as possible the likelihood of mistakes, near misses in the course of her practice nor did she promote the recommended practice in controlling and preventing infection.

Ms Saran next addressed the panel on charge 14a which detailed Miss Bradwell's failure to complete a reflective piece. Ms Saran submitted that this was in breach of 9.2 of the Code, to gather and reflect on feedback from a variety of sources, using it to improve your practice and performance and 24 and 24.2 which requires registered nurses to respond to any professional complaints and use this an opportunity for reflection and learning.

Ms Saran submitted that the last remaining charges 2a, 6a,11b, 13,15b and 14b, which focus on Miss Bradwell's failure to demonstrate knowledge of drugs and complete mandatory training breaches 6 and 6.1 of the Code, to always practice with the best available evidence and maintain safe and effective practice, as well as 13 and 13.3 (sic), to work within your competence and complete necessary training.

Submissions on impairment

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

Ms Saran invited the panel to consider the four questions as set out by Dame Janet Smith in the Fifth Shipman Inquiry Report to determine whether lack of competence or

misconduct shows that Miss Bradwell's fitness to practise is impaired. She took the panel through each question of this test and set out the ways in which the charges met the criteria as set out by each question. She submitted that all of the limbs of the test are engaged in Miss Bradwell's case by virtue of the charges found proved. She submitted that not only would the panel be justified in finding that Miss Bradwell is currently impaired, and is liable in the future to repeat the same mistakes. She submitted that Miss Bradwell has shown:

- *"no remediation*
- *almost no insight: admissions were made when originally confronted in August 2018, but she moved away from those admissions in this trial (sic), and changed her admissions in this hearing*
- *no remorse*
- *no apology to her colleagues or patients*
- *concerning lack of engagement with the proceedings"*

Ms Saran, in light of this, invited the panel to find that Miss Bradwell is currently impaired and there remains a real risk of repetition.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* and *General Medical Council v Meadow* [2007] QB 462 (Admin). He advised the panel that breaches of the Code are also relevant to lack of competence.

Decision and reasons on misconduct and lack of competence

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

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

The panel considered the charges in the same order and groupings that Ms Saran had discussed them during her submissions.

Charges 9, 10

The panel considered that Miss Bradwell's actions in relation to charges 9 and 10, involving dishonesty, amounted to a breach of the Code, and determined that the following sections were engaged in this case:

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

…

20 Uphold the reputation of your profession at all times
To achieve this, you must:

20.1 keep to and uphold and uphold the standards and values set out in the Code"

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

Charges 1, 3a, 4a, 7a, 7b, 15c, 15e

The panel considered that Miss Bradwell's actions in relation to charges 1, 3a, 4a, 7a, 7b, 15c, and 15e amounted to a breach of the Code, and determined that the following sections were engaged in this case:

6 Always practise in line with the best available evidence
To achieve this, you must:

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

…

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

Charges 8a, 8b, 4a, 4b, 6d, 7c, 15d

The panel considered that Miss Bradwell's actions in relation to charges 8a, 8b, 4a, 4b, 6d, 7c, 15d amounted to a breach of the Code, and determined that the following sections were engaged in this case:

10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

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

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

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

…

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

To achieve this, you must:

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

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

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

…

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

Charges 2b, 3b, 5a, 8a, 8b, 11a, 15a, 5b, 6b, 6c,

The panel considered that Miss Bradwell's actions in relation to charges 2b, 3b, 5a, 8a, 8b, 11a, 15a, 5b, 6b, 6c, amounted to a breach of the Code, and determined that the following sections were engaged in this case:

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

Charge 14a

The panel considered that Miss Bradwell's actions in relation to charge 14a amounted to a breach of the Code, and determined that the following sections were engaged in this case:

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

Charge 2a, 6a, 11b, 13, 14b,15b

The panel considered that Miss Bradwell's actions in relation to charge 2a, 6a, 11b, 13, 14b,15b amounted to a breach of the Code, and determined that the following sections were engaged in this case:

6 Always practise in line with the best available evidence
To achieve this, you must:

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

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

…

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:

13.5 complete the necessary training before carrying out a new role

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct nor lack of competence. However, the panel was of the view that the charges found proved in regard to misconduct were very serious and there was the potential for serious harm to a particularly vulnerable patient. There is no evidence to suggest that the failure found proved in charge 9 occurred on more than one occasion. However, the panel was of the view that the seriousness of this incident was compounded by Miss Bradwell's lack of candour and dishonesty to protect herself rather than the wellbeing of a vulnerable patient. The panel was of the view that Miss Bradwell is an experienced nurse and that an informed member of the public would be shocked to learn that a registered nurse had behaved in this way, especially given the grave consequences to the patient if they were to have received two doses of the same medication.

The panel found that Miss Bradwell's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

The panel next considered whether Miss Bradwell's performance demonstrated a lack of competence. The panel bore in mind, when reaching its decision, that Miss Bradwell should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard. The panel looked at the substantial and ongoing support available to Miss Bradwell at the time. [PRIVATE], had previously worked on a cardiology ward but was on an intensive cardiology ward, however the panel determined that even with the robust ongoing support, the failures concerned basic fundamental skills expected of any registered nurse. Namely:

- Administration of medication;
- General knowledge of medicines;
- MEWS calculations;
- Record keeping;
- Carrying out observations.

As the panel found charge 15 proved in its entirety, and taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Miss Bradwell's practice was below the standard that one would expect of the average registered nurse acting in Miss Bradwell's role.

In all the circumstances, the panel determined that Miss Bradwell's performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct and lack of competence, Miss Bradwell's fitness to practise is currently impaired.

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

Regarding insight, the panel considered Miss Bradwell's responses to the NMC but determined that these demonstrated minimal insight and did not include personal reflection, remorse, or any record of continued training. Neither has she demonstrated evidence of strengthened clinical practice nor given any testimonials from recent practice. The panel noted that Miss Bradwell had admitted some failings in the past, but some of these admissions had been retracted. The panel was also of the view that in some of Miss Bradwell's responses to the NMC she seemed to apportion blame to her colleagues rather than reflect on her own failings.

The panel applied the test in *Cohen v GMC [2008] EWHC 581* as to whether the charges are easily remediable, have been remedied, and are unlikely to be repeated. The panel was of the view that many of the charges are remediable but have not been in any way remedied and that the likelihood of repetition is high.

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

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

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

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

The panel found that patients were put at risk as a result of Miss Bradwell's misconduct and lack of competence. The panel found that she had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was of the view that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious as she lied in order to protect herself and put a vulnerable patient at a serious risk of harm. The panel determined that all limbs of the test are met in this case.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

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

Having regard to all of the above, the panel was satisfied that Miss Bradwell's fitness to practise is currently impaired, in relation to both misconduct and lack of competence, on the grounds of both public protection and the public interest.

Decision and reasons on application to admit documentary evidence at the sanction stage

The panel heard an application made by Ms Saran under Rule 24 (13) (c) to admit two further documents relating to the previous history of the Registrant's practice.
The two documents submitted by Ms Saran were number one, Registrant's Final Written Warning Letter dated 28 June 2017 (document 1) from the Trust setting out findings in relation to similar clinical failings. Ms Saran pointed out that this document had been exhibited to Colleague B's witness statement, and had been seen by the Registrant's representatives, but was not put before the panel at the facts stage of the hearing, in fairness to the Registrant.

The second document (document 2) was an NMC employment reference titled 'HCA Healthcare Reference re Bradwell'. Ms Saran accepted that no notice had been given to the registrant or legal representative that this document would be relied upon at the sanction stage.

The panel accepted the advice of the legal assessor.

The panel considered both documents and decided that it was both relevant and fair to admit document 1. That document showed a history of Miss Bradwell's clinical failings prior to 30 July 2018. These failings were of a similar nature to the charges the panel had to consider. Furthermore, they decided that it was fair to admit this document as it had been exhibited to Miss Bradwell's legal representatives.

So far as document 2 was concerned, the panel did not consider that it was fair to admit this document as no notice had been given Miss Bradwell or her legal advisors that such a document would be relied upon by the NMC at the sanction stage. In any event, the panel concluded that this document was of limited relevance.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Miss Bradwell's registration has been suspended.

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

The panel noted that in the Notice of Hearing, dated 24 January 2022, the NMC had advised Miss Bradwell that it would seek the imposition of a 12-month suspension order if it found Miss Bradwell's fitness to practise currently impaired.

Ms Saran directed the panels' attention to the sanction guidance and submitted that the panel take into account the following aggravating features in its deliberations on sanction:

- Demonstrated wide ranging failings in a variety of basic nursing skills, which exposed patients to a real risk of harm
- The panel's finding of dishonesty is the most serious as it deliberately breaches the professional duty of candour to be open and honest when things go wrong in relation to a patient's care
- Limited insight and failed to engage in the second half of the proceedings
- No steps toward remediation
- A pattern of failings

She further submitted the following mitigating features:

- Miss Bradwell made some admissions from the outset
- There was no actual harm caused
- [PRIVATE]

Ms Saran submitted, however, that there was no evidence in regard to Miss Bradwell's health conditions.

Ms Saran next took the panel through the possible sanctions. She submitted that taking no further action in this case would be inappropriate as there have been numerous competency issues and a finding of dishonesty. She submitted that there is a real risk of repetition in this case and a sanction is necessary to protect the public from harm and to maintain public confidence in the profession. She submitted that for these same reasons a Caution Order is also not appropriate.

Ms Saran then addressed the panel as to whether a conditions of practice of order would be the appropriate sanction. She submitted that it would not meet the public protection required as Miss Bradwell has been given much support and supervision to improve her practice and despite this, she has continued to repeat the same mistakes and failings. She submitted that further conditions of learning, support, and supervision would not reduce

the risk or address the public interest requirements. She submitted that there were no workable conditions that would address Miss Bradwell's dishonesty and limited insight.

Ms Saran concluded that either a suspension or striking off order would be the appropriate sanction in this case given the seriousness of the misconduct, as the panel has found dishonesty. She invited the panel to impose a suspension order of 12 months. She quoted from the guidance and submitted that while some of the criteria for a strike off order were met in this case, the panel may find that strike off would be disproportionate as the misconduct and dishonesty found was a one-off incident.

Decision and reasons on sanction

Having found Miss Bradwell's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Very limited insight
- No evidence of remediation or strengthening practice
- Previous disciplinary finding in relation to similar concerns
- Wide ranging failures in basic nursing care
- Exposed patients to the risk of serious harm
- Deliberate breaches of duty of candour, when things go wrong, especially in regard to vulnerable patients or someone in their care
- Repeated pattern of behaviour- range of failures over a sustained period of time
- Attempted to deflect blame to other clinical colleagues

The panel also took into account the following mitigating features:

- [PRIVATE]
- Some admissions to the charges
- No actual harm was caused to any patient

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Bradwell's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Bradwell's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Bradwell's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular whether there is:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*

- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that, based on the above guidance, there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel noted that despite the robust support Miss Bradwell has received she continued to have wide ranging and serious failings. The panel noted Miss Bradwell had very limited insight and had not expressed remorse and considered that this with the misconduct of dishonesty identified in this case was not something that could be addressed through a conditions of practice order.

Furthermore, the panel concluded that the placing of conditions on Miss Bradwell's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel took careful note of the SG and found that the following elements concerning a suspension order are particularly engaged:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel determined that there were possibly ongoing attitudinal problems, given the repetition of behaviour and the fact that the incidents occurred over a period of time. The panel has determined that the registrant had very limited insight and the

registrant has a high risk of repeating this behaviour. Therefore, the panel then went on to consider a striking-off order.

In considering whether a striking-off order would be appropriate and proportionate, the panel noted that the majority of the charges found proved were related to Miss Bradwell's lack of competence in respect of which the panel had no power to strike-off at this time. Additionally, the panel was of the view that though the misconduct found in charges 9 and 10 was very serious it was a single instance of misconduct and the panel concluded that a striking-off would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Miss Bradwell's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the only appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Miss Bradwell. However this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 12 months, with review, was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Her attendance at any future hearings
- An up-to-date structured reflective piece
- Employment testimonials in a care setting or otherwise, paid or unpaid
- Details of any plans she may have to return to nursing
- Evidence of keeping up to date with nursing practice

This will be confirmed to Miss Bradwell in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Bradwell's own interests until the suspension sanction takes effect.

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

Submissions on interim order

The panel took account of the submissions made by Ms Saran. She submitted that due to the imposition of the substantive order it is necessary to impose an interim suspension order to protect the public during the period of appeal. She submitted that 18 months would be the appropriate length of time in the case of an appeal.

Decision and reasons on interim order

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

The panel concluded to impose an interim suspension order due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and provide sufficient time in case an appeal is made.

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

That concludes this determination.