Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 14 November 2022 – Friday 18 November 2022,
Wednesday 23 November – Thursday 24 November 2022

Day 1 to 5: 2 Stratford Place, Montfichet Road, London, E20 1EJ

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Day 6 to 7: Virtual Hearing

Name of registrant:	**Joanna Rachel Wood**
NMC PIN:	89C0662E
Part(s) of the register:	RN1: Adult Nurse, Level 1 – June 1992
Relevant Location:	West Sussex
Type of case:	Misconduct
Panel members:	Deborah James (Chair, Lay member) Jocelyn Griffith (Lay member) Sally Underwood (Registrant member)
Legal Assessor:	John Bromley-Davenport KC (Day 1-5) Graeme Henderson (Day 6 - 7)
Hearings Coordinator:	Daisy Sims
Nursing and Midwifery Council:	Represented by Madeleine Deasy, Case Presenter
Mrs Wood:	Not present and unrepresented
Facts proved:	All charges
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Wood was not in attendance and that the Notice of Hearing letter had been sent to Mrs Wood's registered email address by secure email on 13 October 2022.

Ms Deasy, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Wood'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 Mrs Wood 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 Mrs Wood

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

Ms Deasy submitted that there had been little to no engagement by Mrs Wood with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

Ms Deasy informed the panel that Mrs Wood is not represented and invited the panel to also consider the unfairness to Mrs Wood in proceeding in her absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Wood. In reaching this decision, the panel has considered the submissions of Ms Deasy, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Wood;
- Mrs Wood has not engaged with the NMC recently and has not responded to any of the letters sent to her about this hearing;
- Mrs Wood has not provided the NMC with details of how she may be contacted other than her registered email address;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness has attended today to give live evidence; four additional witnesses are due to attend in the coming days;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Wood in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Wood's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Wood. The panel will draw no adverse inference from Mrs Wood's absence in its findings of fact.

Details of charge

That you, a registered nurse:

1. On an unknown date in 2019, in relation to Patient A, when they reported feeling including a sharp pain in their head and tingling sensations in their face and arm,
    a. Did not adequately assess Patient A and/or **PROVED**

b. Did not advise Patient A to attend hospital given their reported symptoms. **PROVED**

2. On 22 November 2019 and/or 24 November 2019, in relation to Child A, who reported to you with a burn injury which had blistered and/or was across a joint;
    a. Did not adequately assess Child A and/or **PROVED**
    b. Did not advise Child A to attend hospital given the severity of the injury. **PROVED**

3. On an unknown date after 22 November 2019, falsely amended the medical records you had created in respect of the treatment you offered Child A in that you
    a. Made the entry appear to read that there was no blistering when you treated Child A on 22 November 2019, when that was not true **PROVED**
    b. Made the entry appear to read that, on 22 November 2019, you advised that Child A attend the Minor Injury Unit ("MIU") when this was not true. **PROVED**

4. Your conduct at Charge 3a) above was dishonesty as it was intended to conceal that you had given incorrect advice to Child A namely that the injury was less serious and/or three was no need for him to attend hospital. **PROVED**

5. Your conduct at Charge 3b) above was dishonest as it was intended to make it appear that you advised Child A ought to be seen at hospital when you did not. **PROVED**

6. On an unknown date after 24 November 2019, falsely amended the medical records you had created in respect of the treatment you offered Child A in that you made the entry appear to read that, on 24 November 2019, you advised that Child A attend "QVH" or A & E, when this was not true. **PROVED**

7. Your conduct at Charge 6 above was dishonest as it was intended to appear that you advised Child A ought to be seen at hospital when you did not. **PROVED**

8. On 08 October 2019, in relation to Child B, who reported to you with a head injury including potential loss of consciousness, confusion and pupil abnormalities, did not advise Child B to attend a doctor and/or hospital given the symptoms they exhibited. **PROVED**

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

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

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

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 rule on whether or not to go into private session in connection with Mrs Wood's personal matters as and when such issues are raised.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Deasy under Rule 31 to allow hearsay evidence contained within the written statement of Witness 1 into evidence. Ms Deasy informed the panel that there are references to conversations with several other healthcare professionals. Ms Deasy submitted that it is fair and relevant for the panel to

admit this hearsay evidence both for completeness and because it relates to the advice and treatment received by Patient A after her telephone conversation with Mrs Wood. Ms Deasy informed the panel that it is not suggested that this hearsay evidence is the sole and decisive evidence for any of the charges.

In the preparation of this hearing, the NMC had indicated to Mrs Wood in the Case Management Form (CMF), dated 14 July 2022, that it was the NMC's intention for Witness 1 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 1, Mrs Wood made no objections. On this basis Ms Deasy advanced the argument that there was no lack of fairness to Mrs Wood in allowing Witness 1's hearsay testimony into evidence.

The panel gave the application in regard to Witness 1 serious consideration. The panel noted that Witness 1's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and was signed by her.

The panel considered whether Mrs Wood would be disadvantaged by allowing the hearsay testimony into evidence.

The panel considered that as Mrs Wood had been provided with a copy of Witness 1's statement and, as the panel had already determined that Mrs Wood had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence contained within the written statement of Witness 1 but would give what weight it deemed appropriate once it had heard and evaluated all the evidence before it.

Background

The NMC received a referral from Ardingly College ("the School") on 10 March 2020 where Mrs Wood was employed as the Lead Nurse. The referral was made in relation to three incidents that occurred at the School in 2019.

The first incident occurred in or around October 2019 when a member of staff (Patient A) was taken ill with a description of a sharp pain in her head which quickly subsided but left her with a tingling sensation in her face and arm. Patient A telephoned Mrs Wood at the on-site medical centre for advice. Mrs Wood told Patient A to take paracetamol and to see how she was over the weekend. Patient A was concerned by this advice and contacted her GP, who advised calling an ambulance. A first responder arrived, and, after assessing Patient A directed that she be taken by ambulance to hospital where she would be able to have a scan and further tests for a suspected stroke or transient ischaemic attack (TIA).

The second incident occurred on Friday 22 November 2019 when Child A was brought to the medical centre with a burn after pouring hot soup over his hand in the School canteen. Child A was initially treated by the kitchen staff who ran his hand under cold water for five minutes before taking him to Matron (Witness 2). Matron is a qualified First Aider, and she ran his hand under cold water for a further 20 minutes prior to taking him to the medical centre to be assessed by Mrs Wood.

It is alleged that Mrs Wood left the Matron and Child A in the kitchen area with his hand under cold water for a further 15 minutes. Mrs Wood determined that an application of 'cooling gel' and bandages would suffice to treat the burn, together with painkillers.

Mrs Wood told the Matron to inform Child A's parents not to touch the dressing until the evening when the parents could change the dressing if required with the additional dressings provided. On collecting Child A from the School, the parent (Witness 4) spoke

with Mrs Wood who offered to change the dressing and review the burn over the weekend at the medical centre if she was more comfortable with this.

Child A attended the medical centre, with his father, on Saturday 23 November 2019 and was seen by another school nurse who redressed the burn. On Sunday 24 November 2019 Child A and Witness 4 attended the medical centre and again the dressing was changed, this time by Mrs Wood. At that time, it was agreed that Child A would be further reviewed at the medical centre on Monday 25 November 2019.

On Monday 25 November 2019 Child A was seen by another registered nurse (Witness 3) who cleaned and redressed the burn and advised that Child A attend A&E immediately. Child A attended A&E, with his parent (Witness 4), where his burns were treated, and he was referred to a specialist burns unit for further treatment.

It is further alleged that sometime after 22 November 2019 Mrs Wood retrospectively changed the medical records of Child A within the logbook entries that document each patient visit at the medical centre. It is alleged that Mrs Wood amended this documentation to suggest that blistering had not occurred immediately and to suggest that she had advised that hospital attendance may be required.

The third incident occurred on 8 October 2019 when Child B was referred to the medical centre with a head injury sustained whilst playing a football match away from the School. Child B attended the medical centre accompanied by his father and siblings. It was reported to Mrs Wood that Child B had possibly suffered a loss of consciousness and was unable to recall events around the time of the incident. Further it was reported that on the coach journey back to the School it had been noticed that he had been confused and repeating his words. Mrs Wood assessed Child B. Another School Nurse (Witness 5) was present but took no part in the assessment. Mrs Wood recorded that one of Child B's pupils was reacting more slowly to light. The NICE Guidelines on Head Injury: assessment and early management, state that a child should be referred to hospital with suspected concussion when displaying these symptoms. It is alleged that Witness 5 suggested that

Child B should attend A&E, however, Mrs Wood stated that it was not necessary and advised that he should go home.

Following Mrs Wood's assessment, Witness 5 raised her concerns directly to Mrs Wood. Mrs Wood responded that Child B's mother was a doctor and would be able to look after Child B. It is alleged that Mrs Wood did not check whether Child B's mother would be present at the home that night.

Decision and reasons on facts

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 Deasy on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mrs Wood.

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

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

- Witness 1: Patient A
- Witness 2: School Matron
- Witness 3: School Nurse (currently Lead Nurse)
- Witness 4: Parent of Child A

- Witness 5: School Nurse

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC and also had regard to the contents of the registrant's response bundle as prepared by the NMC.

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

Charge 1a:

1. *On an unknown date in 2019, in relation to Patient A, when they reported feeling including a sharp pain in their head and tingling sensations in their face and arm,*
    a. *Did not adequately assess Patient A and/or*

This charge is found proved.

In reaching this decision, the panel took into account the written statement and oral evidence provided by Witness 1.

The panel noted Witness 1's (Patient A) written statement, specifically:

'*I explained to Jo that I had a sudden pain in my head and I'd been left with a tingling sensation in my face and arm'.*

[…]

'This was a very quick conversation, I was on the phone for a matter of seconds.'

The panel also took into account Mrs Wood's recollection of the events that she detailed in her reflections:

> *'Witness 1 [sic] informed me that she had a headache and I advised her to take paracetamol or ibuprofen and rest to see if it would improve. At the time I assessed Witness 1 [sic] with the limited information I had and believed this to be a sufficient care advice.'*

The panel noted that the advice given by Mrs Wood would have been appropriate if the only information given by Witness 1 was that she had a headache and there had been no mention of any other symptoms. The panel also noted that Witness 1 stated that her telephone conversation with Mrs Wood was very short. Witness 1 was adamant that her reason for contacting the medical centre was due to the unusual symptoms that remained following the sudden stabbing pain in her head. She did not have a headache as this subsided '*as soon as it came'* but was concerned about the *'very odd sensation on my left side – specifically my arm and face'.*

The panel noted the hearsay evidence of the other medical professionals involved in this incident. It determined that this information is reliable due to the events that subsequently occurred. The panel concluded that Witness 1 had relayed the same symptoms to her GP, to the first responder, to the ambulance crew and to the hospital.

Therefore, the panel found that, it is more likely than not that Witness 1 had reported to Mrs Wood feeling a sharp pain in her head and an ongoing tingling sensation in her face and arms. Mrs Wood appears to have disregarded the full symptoms experienced by Patient A. Accordingly, the panel was satisfied that Mrs Wood had not adequately assessed Witness 1.

Charge 1b:

1. On an unknown date in 2019, in relation to Patient A, when they reported feeling including a sharp pain in their head and tingling sensations in their face and arm:

    b. Did not advise Patient A to attend hospital given their reported symptoms.

This charge is found proved.

In reaching this decision, the panel took into account that it has already determined that Witness 1 had reported all of her symptoms to Mrs Wood. The panel noted that when Witness 1 reported the same symptoms to her GP and other medical professionals, this had been swiftly escalated, and Witness 1 taken to hospital.

The panel did note that Mrs Wood informed Witness 1 that she could attend the medical centre over the weekend if she wished, however it determined that this does not equate to advising Patient A to attend a hospital.

The panel also took into account that Mrs Wood does not dispute that she did not advise Patient A to attend a hospital.

Therefore, the panel determined that it is more likely than not that Mrs Wood did not advise Patient A to attend hospital given her reported symptoms.

Charge 2a & b:

2. On 22 November 2019 and/or 24 November 2019, in relation to Child A, who reported to you with a burn injury which had blistered and/or was across a joint;

    a. Did not adequately assess Child A and/or

b. Did not advise Child A to attend hospital given the severity of the injury.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements and oral evidence provided by Witnesses 2, 3 and 4.

The panel noted the evidence provided by Witness 2 who was with Child A immediately after the incident occurred. Witness 2 stated that a blister had formed and burst on one of Child A's fingers before she brought him to the medical centre. She also described that the rest of the affected area was bright red. Witness 2 told the panel that Mrs Wood put Child A's hand under a tap in the kitchen at the medical centre and then left the room for 15 minutes. Witness 2 said that Mrs Wood arrived back at the kitchen with '*cooling gel'* and bandages which she used to wrap Child A's hand.

Witness 2 stated that Mrs Wood asked her to inform Child A's mother (Witness 4) of the incident and to tell her to change the bandage before Child A went to bed.

Witness 2 said that Mrs Wood did not advise that Child A attend hospital at that point. The panel noted the original logbook entry which states '*R/V here Saturday'* which the panel interpreted as stating that Child A can be reviewed at the medical centre on Saturday.

Witness 4 described to the panel collecting her son following the incident who was unusually quiet, appeared to be in great pain and was pacing the room. Child A had said to Witness 4 that the burn was '*too painful to cry'*. Witness 4 said that she had then attended the medical centre to speak directly to Mrs Wood who had invited her to bring Child A back to the medical centre over the weekend where the staff would redress the burn, if she felt more comfortable than doing it herself.

The panel noted that Child A was seen by another school nurse on Saturday 23 November 2019 when the burn was redressed.

The panel had sight of the original logbook entries of this incident. These entries had been photographed by Witness 3 at the request of Human Resources (HR) in preparation for the internal investigation. Witness 3 informed the panel that this logbook was used to record patient notes when anyone attended the medical centre. She explained to the panel that it was standard procedure to leave a single line space between entries in the logbook to distinguish between patients. The panel accepted Witness 3's oral evidence that the logbook entries from 22 November 2019 were in Mrs Wood's handwriting. The panel noted that the original logbook entry stated that blistering was present on Child A's hand. The panel also noted that Mrs Wood had not recorded the position or the size of the burn.

The panel took into account the oral evidence of Witness 2 who stated that in her own assessment, as a first aider, the burn was serious given that it had blistered almost immediately, at least one of the burns was over a joint and the fingers were bright red.

Witness 3 told the panel that if blistering is present, the severity of a burn could not be adequately assessed at the medical centre as it masked the extent of the burn. Further Witness 3 told the panel that any burn over a finger joint is particularly serious.

Witness 4 told the panel that on the late afternoon of Sunday 24 November 2019 the dressing had become dislodged and she was shocked to see the extent of the blistering and discoloration on Child A's fingers. She took Child A back to the medical centre where he was seen by Mrs Wood. Witness 4 told the panel that she had raised the issue of whether any further medical intervention was required, but Mrs Wood reassured her that it was healing well. The panel saw the original logbook entries made by Mrs Wood where she writes '*no need to lance blisters'.*

Witness 3 told the panel that when she assessed Child A's burn on Monday 25 November 2019 she was alarmed at the severity of the burn as the blistering was significant and the skin was discoloured. In her experience as an A&E nurse, she said that the blisters

needed '*aspirating and deroofing*'. Therefore she had advised that Child A needed to attend A&E immediately. She also told the panel that whilst she accepted that the blisters may have worsened over the weekend, in her opinion Child A should have been referred to A&E on Friday 22 November 2019.

The panel accepted the evidence before it as to the extent of the burns to Child A's fingers and to the standard procedures which should be followed in these circumstances. The panel therefore determined that Mrs Wood had failed to adequately assess Child A and did not advise attendance at hospital both on 22 November 2019 and 24 November 2019.

Charge 3a:

3. On an unknown date after 22 November 2019, falsely amended the medical records you had created in respect of the treatment you offered Child A in that you;

    a. made the entry appear to read that there was no blistering when you treated Child A on 22 November 2019, when that was not true

This charge is found proved.

In reaching this decision, the panel took into account the written statement, oral evidence and logbook entries provided by Witness 3.

Witness 3 told the panel that she had photographed the logbooks at the request of HR to assist with the internal investigation. She was then asked to photograph the logbooks a second time at which stage she noted that amendments had been made. She declined to take the photographs, which were subsequently obtained by HR.

The panel carefully analysed all of the photographs of the logbook entries provided to it. It determined that there have been clear amendments made to various entries relating to Child A on 22 November 2019 and 24 November 2019. These amendments are in the same handwriting as the original logbook entries. Witness 3 confirmed to the panel that this is the handwriting of Mrs Wood.

The panel noted that Mrs Wood stated within the HR investigation that she would sometimes go back and check her previous logbook entries and amend if required but would initial any such changes for audit purposes. The panel acknowledged that there is nothing inherently wrong or dishonest in going back and amending documentation provided that it is made abundantly clear in the documentation that the new information has been entered after the original information and does not jeopardise what was previously entered. However, the panel noted that no initialling, dates, or notes had been made as to the changes in the relevant logbook entries.

The panel noted the oral evidence of Witness 3 who stated that the original logbook entry stated '*darkened skin and blistering'* and Witness 3 stated this is what she recalled the entry looking like when she took the original photographs of the logbook. The panel noted the clear alteration to the '*and'* symbol. The panel took into account Witness 3's interpretation of the amended logbook entry as now reading to a 0 with a line through it, which she interpreted as reading *'darkened skin and no blistering'*. Witness 3 informed the panel that she would interpret a 0 with a line through it is as meaning *'no'*.

The panel therefore determined that it is more likely than not that Mrs Wood falsely amended this record sometime after 22 November 2019 and the effect of this amendment was to fundamentally alter the meaning of the entry and suggest that no blistering had occurred when Mrs Wood treated Child A on 22 November 2019.

Charge 3b:

3. On an unknown date after 22 November 2019, falsely amended the medical records you had created in respect of the treatment you offered Child A in that you;

    b. Made the entry appear to read that, on 22 November 2019, you advised that Child A attend the Minor Injury Unit ("MIU") when this was not true.

This charge is found proved.

In reaching this decision, the panel took into account the written statement, oral evidence and logbook entries provided by Witness 3.

The panel determined that the original logbook entry does not mention a Minor Injury Unit. It noted that in the amended logbook entry '*MIU*' had appeared to have been squeezed in between the lines of the existing entry.

The panel therefore determined that it is more likely than not that Mrs Wood falsely amended the medical record to read that, on 22 November 2019, she had advised Child A to attend the Minor Injury Unit ("MIU") when she had not.

Charge 4:

4. Your conduct at Charge 3a) above was dishonest as it was intended to conceal that you had given incorrect advice to Child A namely that the injury was less serious and/or there was no need for him to attend hospital.

This charge is found proved.

The panel have already found, in Charge 3a, that Mrs Wood had falsely amended the records.

Further, the panel took into account that Mrs Wood was under investigation by HR at the School in relation to the incidents involving Patient A and Child B at the time of Child A's incident.

The panel concluded that it is more likely than not that Mrs Wood's intention was to conceal further wrongdoing by amending the logbook entry of Child A to make it appear that there was no blistering present when she treated him on Friday 22 November 2022.

The panel could see no alternative explanation for her actions and determined that an ordinary, honest member of the public would consider that this amendment was done dishonestly as it was intended to conceal the incorrect advice given.

Therefore, the panel determined that it is more likely than not that Mrs Wood was dishonest in her conduct as it was intended to conceal that she had given incorrect advice to Child A.

Charge 5:

5. Your conduct at Charge 3b) above was dishonest as it was intended to make it appear that you advised Child A ought to be seen at hospital when you did not.

This charge is found proved.

The panel determined that it's previous findings at Charge 4 also relate to this charge.

It determined that it is more likely than not that Mrs Wood was dishonest in her conduct as it was intended to make it appear that she advised Child A ought to be seen at hospital when she did not.

Charge 6:

6. On an unknown date after 24 November 2019, falsely amended the medical records you had created in respect of the treatment you offered Child A in that you made the entry appear to read that, on 24 November 2019, you advised that Child A attend “QVH” or A & E, when this was not true.

This charge is found proved.

The panel determined that it’s previous findings at Charge 3, 4 and 5 also relate to this charge.

The panel carefully considered the photographs of the logbook entries provided to it. It noted the oral evidence of Witness 3 who informed the panel that it was standard practice to leave a line gap between entries in the logbook to avoid confusion between the entries.

The panel found that an additional entry has clearly been added in the same handwriting as that on the original. Further this entry appears to have been written in the gaps that would normally have been left to avoid confusion between entries. The panel therefore determined that this entry had been amended after the original photo had been taken to make it appear that Mrs Wood had advised Child A’s mother to attend ‘*QVH or A & E’.*

Therefore, the panel determined that it is more likely than not that Mrs Wood falsely amended the medical records that she had created in respect of the treatment she had offered to Child A in that she made the entry appear to read that, on 24 November 2019, she advised that Child A attend “QVH” of A & E, when this was not true.

Charge 7:

7. Your conduct at Charge 6 above was dishonest as it was intended to appear that you advised Child A ought to be seen at hospital when you did not.

This charge is found proved.

The panel determined that, given its findings at charge 6, and for all of the reasons given in charges 4 and 5, Mrs Wood was dishonest in amending the documentation as the alteration was made with the intention of making it appear that she had advised Child A ought to be seen at hospital when she had not done so.

Charge 8:

8. On 08 October 2019, in relation to Child B, who reported to you with a head injury including potential loss of consciousness, confusion and pupil abnormalities, did not advise Child B to attend a doctor and/or hospital given the symptoms they exhibited.

This charge is found proved.

In reaching this decision, the panel took into account Mrs Wood's logbook entry for Child B on Tuesday 8 October 2019, Witness 5's written statement and oral evidence, and the NICE Guidelines on Head Injury: assessment and early management.

The panel noted that Mrs Wood had entered in the logbook that Child B presented with '*some confusion to time, place and subdued on journey […] pupils equal and react to light, right slightly less brisk'.*

The panel also noted the NICE Guidelines on Head Injury: assessment and early management, specifically section 1.1.4 which lists the symptoms that would lead to a referral to a hospital emergency department. The panel noted that this list includes '*any loss of consciousness as a result of the injury',* '*any focal neurological deficit since the injury'* and *'amnesia for events before or after the injury', 'persistent headache since the injury'.* The panel determined that, according to Mrs Wood's entry in the logbook, it is

evident that Child B presented with the above symptoms and therefore he should have been referred to a hospital emergency department immediately.

Witness 5, in her oral evidence, told the panel that she had subsequently discussed the incident with Mrs Wood because she had disagreed with the advice given and that '*Jo said I was right and said that she should have sent him to be reviewed by a doctor in A&E.'*

The panel found that there is no dispute that Mrs Wood did not advise Child B to attend a hospital after the incident in question.

The panel therefore determined that Mrs Wood did not advise Child B to attend a doctor and/or hospital given the symptoms they exhibited.

Fitness to practise

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

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

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

Submissions on misconduct and impairment

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 Deasy invited the panel to take the view that the facts found proved amount to misconduct. Ms Deasy referred the panel to The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) specifically section 20 of the Code named '*Promote professionalism and trust'.* She submitted the specific, relevant standards where Mrs Wood's actions amount to misconduct, namely section 20.2:

> *'**20.2** Act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'*

Ms Deasy addressed the panel on the dishonesty charges, namely charges 3 – 7, that have been found proved. She submitted that dishonesty is incompatible with upholding the Code. She submitted that the charges of dishonesty related to Mrs Wood amending records to fundamentally change their meaning. She referred the panel to its previous finding that an ordinary member of the public would find that Mrs Wood's actions were dishonest and were intended to conceal. She further stated that Mrs Wood has provided evidence of some training in record keeping, however she submitted that this training does not mitigate the dishonesty charges against her and also it had been written for the internal disciplinary hearing which was some time ago.

Ms Deasy then addressed the panel on the poor clinical practice charges, namely 1,2 and 8. She reminded the panel that no serious harm was caused to any patients by Mrs Wood,

however she submitted that there was a serious risk of harm posed by Mrs Wood's actions.

Ms Deasy submitted that there has been a lack of insight and reflection from Mrs Wood. She said that there has been no evidence provided to demonstrate that Mrs Wood has learnt from her actions and therefore submitted that there is a risk of repetition and a continued risk of harm to patients. Ms Deasy acknowledged that there has been a substantial period of time since these allegations occurred and that Mrs Wood is subject to an interim suspension order and so has been unable to show a development in her clinical practice through working as a registered nurse. She also acknowledged that Mrs Wood had provided some insight into her actions, however this was made at the time the allegations occurred and was not made specifically in relation to the charges before the panel today. Ms Deasy therefore submitted that there is a lack of insight and lack of evidence of strengthening practice from Mrs Wood and so there remains a risk of repetition and a risk of harm to patients.

Ms Deasy 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.

Ms Deasy submitted that Mrs Wood's actions amount to misconduct and invited the panel to find that Mrs Wood's fitness to practice is currently impaired given that the charges relate both to dishonesty and serious poor clinical practice.

In light of the above, Ms Deasy invited the panel to find that Mrs Wood's fitness to practice is impaired on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

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* (No 2) [2000]

1 A.C. 311, *CHRE v NMC and Grant* [2011] *EWHC 927 (Admin) and R (Cohen) v GMC* [2009] *EWHC 1048 (Admin).*

Decision and reasons on misconduct

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

The panel considered whether Mrs Wood's actions did fall significantly short of the standards expected of a registered nurse and identified that Mrs Wood's actions amounted to breaches of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
> ***1.2** make sure you deliver the fundamentals of care effectively*
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***6 Always practices in line with the best available evidence***
> ***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*
>
> ***10 Keep clear and accurate records relevant to your practice***
> ***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*
> ***10.3** complete records accurately and without any falsification …*
>
> ***13 Recognise and work within the limits of your competence***

13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*
13.2 *make a timely referral to another practitioner when any action, care or treatment is required*

20 Uphold the reputation of your profession at all times
20.1 *keep to and uphold the standards and values set out in the Code*
20.2 *act with honesty and integrity at all times …'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges found proved were sufficiently serious to amount to misconduct.

In reaching this conclusion, the panel first considered whether each individual proven charge amounted to misconduct and were each serious departures from acceptable standards. It was satisfied in this regard. It considered that the clinical charges, individually, put the patients involved at serious risk of harm. Furthermore, charges 3 – 7 also relate to dishonesty which reinforces the seriousness of the misconduct.

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

Decision and reasons on impairment

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

In this regard the panel considered the test of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 76, she said:

'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 finds that patients were put at risk and could have been subject to physical harm as a result of Mrs Wood's misconduct. In light of her numerous breaches of the Code, the panel considered that Mrs Wood did not adhere to the standards expected of her as a nurse. Her failure to do so brought the profession into disrepute and also breached the fundamental tenets of the profession. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that Mrs Wood has not provided evidence of any insight to this panel. It noted her reflections from the internal investigation at the School, however it determined that this does not amount to full or satisfactory insight into her actions.

The panel was satisfied that the misconduct in relation to poor clinical practice in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Wood has taken steps to strengthen her practice. The panel determined that Mrs Wood has not provided evidence of her improving her practice nor has she accepted that there is an issue with her clinical practice. Therefore, the panel determined that there is a risk of repetition of these actions and so there is a continued risk of harm to patients. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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.

In addition, 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 Mrs Wood's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

The panel accepted the advice of the legal assessor, he referred to the case of Lusinga v NMC [2017] 1458 (Admin). The panel are required to take a nuanced approach to dishonesty.

Submissions on sanction

Ms Deasy informed the panel that in the Notice of Hearing, dated 13 October 2022, the NMC had advised Mrs Wood that it would seek the imposition of a strike-off order should Mrs Wood's fitness to practise be found to be currently impaired.

Ms Deasy submitted that the following aggravating features are present:

- A pattern of misconduct in Mrs Wood's clinical failings over the course of the treatment of three patients in a matter of weeks which included repeated mistakes in identifying the seriousness of their symptoms and how those symptoms should appropriately have been escalated;
- A pattern of misconduct in Mrs Wood's dishonesty in that multiple records were falsified to cover up her failings on three different occasions;
- A lack of insight into her failings and a lack of remediation;
- A lack of evidence of strengthened practice or any further information provided to the panel;
- Mrs Wood put patients at risk of suffering harm

Ms Deasy also submitted that the following mitigating features are present:

- Mrs Wood's contextual factors referred to in her statement, provided for the School's internal investigation, where she set out that her working environment was highly stressful, she worked extremely long hours [PRIVATE];
- [PRIVATE];
- Mrs Wood was well liked and respected by her colleagues as evidenced through the live witnesses.

Ms Deasy informed the panel that Mrs Wood has been subject to an interim suspension order. She stated that due to this Mrs Wood has had a limited chance to address her failings in a clinical manner. However, Ms Deasy submitted that Mrs Wood could have addressed the concerns outside of clinical practice through providing the panel with reflections, evidence of remorse, and the impact of her actions on her colleagues and patients. Therefore, Ms Deasy submitted that Mrs Wood's current interim suspension order does not impact the steps she could have taken to strengthen her practice or provide the panel with insight into her actions.

Ms Deasy referred the panel to the case of Parkinson v NMC [2010] EWHC 1898 (Admin). She stated that this case made clear the effect of dishonesty on a registrant's position on the register.

Ms Deasy submitted that taking into account the findings of Parkinson together with the previous findings of the panel, a striking off order is the appropriate and proportionate action in this case.

Decision and reasons on sanction

Having found Mrs Wood'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:

- Mrs Wood's complete lack of insight into the dishonesty concerns;
- Mrs Wood's limited insight into the clinical concerns;
- The pattern of clinical failings involving three patients over a period of weeks;
- Mrs Wood's conduct which put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- Mrs Wood's contextual factors around her excessive working hours [PRIVATE];
- [PRIVATE].

The panel considered the level of Mrs Wood's dishonesty in accordance with the SG. It considered her dishonesty to be at the upper end of the scale but not at the top end. Mrs Wood deliberately altered patient notes. Although the dishonesty was in a clinical setting it did not involve any risk to patient harm. This involved a deliberate breach of her duty of candour and involved covering up when things went wrong.

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 Mrs Wood's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Wood's

misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Wood's registration would be a sufficient and appropriate response. Whilst the panel was of the view that the clinical concerns could have been addressed through a conditions of practice order, the panel determined that given Mrs Wood's lack of insight into her dishonest actions, there are no practical or workable conditions that could be formulated. Furthermore, the panel concluded that the placing of conditions on Mrs Wood'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 SG states that suspension order may be appropriate where some of the following factors are apparent:

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The clinical concerns in this case occurred over a period of weeks and involved three patients. However, the panel accepted that the dishonesty related to a single patient. Nevertheless, Mrs Wood has provided no explanation for her actions. Neither has she demonstrated any insight or remorse. Therefore, the panel concluded that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Mrs Wood's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Wood's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mrs Wood in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Deasy. She submitted that an interim suspension order is the necessary and proportionate interim order in this case. She submitted that given that the panel has determined that a striking-off order is appropriate and proportionate, it follows that an interim suspension order should be imposed to cover the 28-day appeal period in order to properly protect the public as well as being in the public interest. She submitted that this order should be imposed for 18 months in order to satisfy the public protection for the appeal period and to cover the time needed for an appeal to conclude.

Decision and reasons on interim order

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

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

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

That concludes this determination.