Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday 15 – Friday 16 September 2022

Virtual Meeting

Name of registrant:	**Helen Mcgovern**
NMC PIN:	89I1360E
Part(s) of the register:	Registered Nurse – Adult Nursing (December 1992)
Relevant Location:	Bristol
Type of case:	Misconduct
Panel members:	Michael Murphy (Chair, registrant member) Jude Bayly (Registrant member) Ian Dawes (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Alice Byron
Facts proved:	Charges 1, 2, 3 (in its entirety), 4, 5 and 6
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

Mrs Mcgovern was not in attendance at this meeting, and the panel noted that the Notice of Meeting had been sent to Mrs Mcgovern's registered address by first class post and recorded delivery on 8 August 2022, which set out that this substantive meeting would be heard on or after 12 September 2022. The panel noted that Mrs Mcgovern did not return the case management form.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, first possible date, and venue of the meeting.

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

The panel had regard to the Royal Mail 'Track and trace' printout which did not confirm the status of the delivery of the notice of meeting. However, the panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Details of charge

That you, a registered nurse, on the 3rd October 2018:

1) Failed to check Patient A's red book and/or records prior to administering a dose of immunisation vaccine to a patient.
2) Administered a duplicate dose of vaccination to Patient A in error.

3) Failed to make an accurate record of the error in Charge 2) in that you:

a) Deleted the entry you made at 16:06:49 on Patient A's record, recording the consultation and the administration of the vaccination.
b) Recorded 'entered in error' as the reason for the deletion of the record at 16:06:49.
c) Added an incorrect entry at 16:41:38 recording that 'patient already up to date with immunisations, nothing else until 1 year. Red Book completed as forgot last appointment'.

4) Failed to report your error in Charge 2) to your clinical lead.

5) Failed to complete a significant event audit form to record your error in Charge 2).

6) Your actions at Charges 3a) and/or 3b) and/or 3c) and/or 4) and/or 5) were dishonest in that you were knowingly trying to conceal the error in Charge 2) from your employers.

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

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 had regard to the written statements of the following witness on behalf of the NMC:

- Witness 1: Business Manager at Pioneer Medical Group at the time the charges arose

The panel also had regard to Mrs Mcgovern's regulatory concerns response form, dated 26 April 2019, but noted that Mrs Mcgovern has not provided any response to the specific charges brought against her.

Background

The charges arose whilst Mrs Mcgovern was working as a practice nurse at Bradgate Surgery (the Surgery), employed by Pioneer Medical Group (PMG). It is alleged that, on 3 October 2018, Mrs McGovern administered a duplicate dose of a 16-week immunisation to an infant, when the child had already received the immunisation the previous month. It is alleged that Mrs Mcgovern only realised her error when she asked for the child's "red book", where the immunisation was already noted. A colleague was present at the appointment with Mrs Mcgovern. It is alleged that, realising her error, Mrs Mcgovern told a colleague that she would "sort it". No harm was caused to the infant as a result of this error.

It is alleged that, following the administration of the duplicate immunisation, Mrs Mcgovern sought to conceal her actions in that she deleted the entry relating to the immunisation on the patient record and made an alternative, false record, which stated *'Pt already up to date with imms, nothing else until 1 year. Red Book completed as forgot last appt'.* This was discovered by the colleague who was present at the appointment on the following day, 4 October 2018. The colleague checked the patient records, noted the consultation template which she had entered the day before had been deleted and another put in its place by Mrs Mcgovern. The colleague subsequently informed Witness 1 about these events.

It is further alleged that Mrs Mcgovern did not report the medication error, when the expected practice would have been to self-report the incident to the appropriate lead and complete the relevant documentation.

Mrs Mcgovern was suspended from the Surgery during the investigation of this incident and dismissed on 17 October 2018.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC which included Mrs Mcgovern's responses at the local investigation, alongside her responses to the regulatory concerns and reflective piece.

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

Charge 1

That you, a registered nurse, on the 3rd October 2018:

1) Failed to check Patient A's red book and/or records prior to administering a dose of immunisation vaccine to a patient.

This charge is found proved.

In reaching this decision, the panel took into account the signed statement of the whistle-blower, meeting notes of the interview conducted with the whistle-blower on 8 October 2018 and internal notes of a follow up telephone call with the whistle-blower on 12 October 2018.

The panel considered the evidence within these notes to be clear and consistent and set out that Mrs Mcgovern checked the computer prior to administering the immunisation, and the red book was not requested until after the immunisation was completed. The panel noted that the telephone note, dated 12 October 2018, sets out that the whistle-blower "categorically stated" this to be the case.

The panel had regard to Mrs Mcgovern's regulatory response form, dated 26 April 2019. It noted that, in response to the NMC regulatory concern one, being failure in medication administration and management, Mrs Mcgovern had selected that she thought the concern is correct and fair at the time. It also considered Mrs Mcgovern's response to the internal

investigation, reflections, and self-referral to the NMC, in which she seemingly accepts her actions as detailed in the charges.

The panel bore in mind, that Mrs Mcgovern has not provided a response to the specific charges before the panel today, however, it determined that the evidence before it was clear and consistent that, on the balance of probabilities, Mrs Mcgovern failed to check Patient A's red book and/or records prior to administering a dose of immunisation vaccine to a patient.

The panel therefore found this charge proved.

Charge 2

That you, a registered nurse, on the 3rd October 2018:

2) Administered a duplicate dose of vaccination to Patient A in error.

This charge is found proved.

In reaching this decision, the panel took into account the signed statement of the whistle-blower, meeting notes of the interview conducted with the whistle-blower on 8 October 2018 and a screenshot of the patient's consultations.

The panel considered the documentary evidence before it and considered this to be clear and consistent with the account set out in the witness statement of Witness 1, which states:

> *"The second error occurred on 3 October 2018 where a whistle-blower was present when Helen was administering a child vaccination and they reluctantly reported Helen's mistake to me"*

The panel had regard to Mrs Mcgovern's regulatory response form, dated 26 April 2019. It noted that, in response to the NMC regulatory concern one, being failure in medication administration and management, Mrs Mcgovern had selected that she thought the concern

is correct and fair at the time. It also considered Mrs Mcgovern's response to the internal investigation, reflections, and self-referral to the NMC, in which she seemingly accepts her actions as detailed in the charges. In the referral document, dated 20 October 2018, Mrs Mcgovern states:

> *'On the afternoon of Oct 3rd during a baby clinic I incorrectly administered some vaccinations'*

The panel bore in mind, that Mrs Mcgovern has not provided a response to the specific charges before the panel today, however, it determined that the evidence before it was clear and consistent that, on the balance of probabilities, Mrs Mcgovern administered a duplicate dose of vaccination to Patient A in error.

The panel therefore found this charge proved.

Charge 3

That you, a registered nurse, on the 3rd October 2018:

3) Failed to make an accurate record of the error in Charge 2) in that you:
   a) Deleted the entry you made at 16:06:49 on Patient A's record, recording the consultation and the administration of the vaccination.
   b) Recorded 'entered in error' as the reason for the deletion of the record at 16:06:49.
   c) Added an incorrect entry at 16:41:38 recording that 'patient already up to date with immunisations, nothing else until 1 year. Red Book completed as forgot last appointment'.

This charge is found proved.

In reaching this decision, the panel took into account the EMIS audit report, internal notes from a meeting with Mrs Mcgovern after the audit trail had been discovered, internal notes of an investigation interview conducted with Mrs Mcgovern on 10 October 2018 and a screenshot of the patient's consultations.

The panel found this documentary evidence to be clear, cogent, and verifiable. The panel noted that the documentary evidence before it supports the account of the allegations provided in Witness 1's NMC witness statement, being:

> *"I produce […] the EMIS audit report which shows the patient consultation on 3 October 2018 and Helen's error. At 16:06:49, Helen adds the consultation and an immunisation in to the patient's records. At 16:39:20, Helen deletes the immunisation and inputs "reason for deletion: entered in error". Helen then adds an observation at 16:41: 38 as "patient already up to date with immunisations, nothing else until 1 year. Red Book completed as forgot last appointment'. Had the whistle-blower not reported this error to me, I would not have known that the mistake had been made. At the time, PMG decided to do an audit trail on EMIS to see whether any other entries had been deleted. However, on EMIS, it is not possible to search by deleted entries. As far as I am aware, this was an isolated incident. When Helen was asked whether she had carried out other deletions and falsification of records previously, she told us that this was a single incident. I believed her and I have no other reason to suspect otherwise.*
>
> *I produce […] the internal notes from a meeting with Helen immediately after the audit trail had been discovered. When I discussed this error with Helen, she was aware of the mistake but did not know why she had made that decision. When confronted with the error, Helen fully admitted that she had made an error and self-reported to the NMC."*

The panel had regard to Mrs Mcgovern's regulatory response form, dated 26 April 2019. It noted that, in response to the NMC regulatory concern two, being failure in record keeping – falsification of patient notes, Mrs Mcgovern had selected that she thought the concern is correct and fair at the time. It also considered Mrs Mcgovern's response to the internal investigation, reflections, and self-referral to the NMC, in which she seemingly accepts her actions as detailed in the charges. In her reflective piece, dated 26 April 2019, Mrs Mcgovern states:

"I later changed the patient's notes in the hope that the error would never be discovered, as I didn't want to let my employers down."

The panel bore in mind, that Mrs Mcgovern has not provided a response to the specific charges before the panel today, however, it determined that the evidence before it was clear and consistent that, on the balance of probabilities, Mrs Mcgovern failed to make an accurate record of the error in Charge 2), as specified in charge 3.

The panel therefore found this charge proved.

Charges 4 and 5

That you, a registered nurse, on the 3rd October 2018:

4) Failed to report your error in Charge 2) to your clinical lead.

5) Failed to complete a significant event audit form to record your error in Charge 2).

This charge is found proved.

In reaching this decision, the panel took into account the meeting notes from an interview conducted with the whistle-blower on 8 October 2018, and the notes of an investigation interview conducted with Mrs Mcgovern on 10 October 2018.

The panel noted that this evidence was consistent in that Mrs Mcgovern told the whistle-blower that she was going to "sort it" which the whistle-blower took to mean that Mrs Mcgovern would report her error, and that Mrs McGovern did not subsequently report her error.

The panel also had regard to Mrs Mcgovern's reflections and self-referral to the NMC, in which she seemingly accepts her actions as detailed in the charges. In her reflective piece, Mrs Mcgovern states:

"Immediately after making the drug error I know I should've:

1) *Notified manager*
2) *" patient*
3) *" child health*
4) *Filled out appropriate documentation*

I didn't notify anyone and hoped the situation would go away!"

The panel bore in mind the evidence provided by Witness 1; that Mrs Mcgovern had been involved in a similar medication administration error a few months before this incident, following which she adhered to the correct reporting procedure. This was supported by the account of Mrs Mcgovern, who set out in her reflective piece the steps which she should have taken when the drug error occurred. In light of this, the panel was satisfied that Mrs Mcgovern was aware of the of the correct reporting procedure at the Surgery.

The panel bore in mind, that Mrs Mcgovern has not provided a response to the specific charges before the panel today, however, it determined that the evidence before it was clear and consistent that, on the balance of probabilities, Mrs Mcgovern failed to report her error in Charge 2) to her clinical lead and failed to complete a significant event audit form to record your error in Charge 2).

The panel therefore found these charges proved.

Charge 6)

That you, a registered nurse, on the 3rd October 2018:

6) Your actions at Charges 3a) and/or 3b) and/or 3c) and/or 4) and/or 5) were dishonest in that you were knowingly trying to conceal the error in Charge 2) from your employers.

This charge is found proved.

In reaching this decision, the panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of *Ivey v Genting Casinos UK Ltd t/a Crockfords* [2017] UKSC 67:

‘When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual’s knowledge or belief as to the facts…. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.’

In ascertaining Mrs Mcgovern’s subjective knowledge and belief of the facts, the panel had regard to Mrs Mcgovern’s regulatory response form, dated 26 April 2019. It noted that, in response to the NMC regulatory concern three, being dishonesty, Mrs Mcgovern had selected that she thought the concern was correct and fair at the time. It also considered Mrs Mcgovern’s response to the internal investigation, reflections, and self-referral to the NMC, in which she seemingly accepts that she was dishonest. In her reflective piece, Mrs Mcgovern states:

“I later changed the patients notes in the hope that the error would never be discovered, as I didn’t want to let my employers down.

[…]

I know what I did was very wrong and very silly and I cannot justify why I made the split second decision to change the records”

The panel applied the standards of ordinary, decent people. It concluded that, by changing the patients records and failing to report the immunisation errors, an ordinary, decent person would find Mrs Mcgovern’s actions to be dishonest as they were carried out to cover up her own error.

The panel therefore finds this charge 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 and, if so, whether Mrs Mcgovern'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 Mcgovern's fitness to practise is currently impaired as a result of that misconduct.

The panel accepted the advice of the legal assessor.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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.'

The NMC 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.

The NMC identified the specific, relevant standards where Mrs Mcgovern's actions amounted to misconduct and stated it considered the misconduct to be serious as the

following provisions of the NMC's guidance on seriousness were engaged by the facts found proved:

- Serious concerns which are more difficult to put right; in that Mrs Mcgovern "breached her duty of candour to be open and honest when things went wrong, including covering up and falsifying records";
- Serious concerns which could result in harm to patients if not put right; in that by not checking the records before giving the child the immunisation and not escalating the error to the clinical lead, direct harm could have been caused to the patient; and
- Serious concerns based on the need to promote public confidence in nurses, midwives and nursing associates; in that Mrs Mcgovern failed to take action to report her error in order to protect herself, but at the cost and disrepute of the profession.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Mrs Mcgovern's fitness to practise impaired on the grounds that:

1) Mrs Mcgovern has in the past acted and/ or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or
2) Mrs Mcgovern has in the past brought and/or is liable in the future to bring the nursing profession into disrepute; and/or
3) Mrs Mcgovern has in the past committed a breach of one of the fundamental tenets of the nursing profession and/or is liable to do so in the future; and
4) Mrs Mcgovern in the past acted dishonestly and/or is liable to act dishonestly in the future.

The NMC submitted that Mrs Mcgovern has displayed some insight through the provision of a reflective piece which recognises how she should have acted differently and apologised for any distress caused. The NMC did not consider, however that Mrs Mcgovern acknowledged the risk of harm of the impact of the alleged dishonesty. It further stated that Mrs Mcgovern has not engaged with the NMC since 2019, has not undertaken any relevant training in respect of the issues of concern, and has not worked as a nurse since she was dismissed from PMG on 19 October 2018. (The panel noted that two of these dates were inaccurate: there is an email from Mrs Mcgovern to the NMC dated December 2020, and the date of her dismissal was 17 October 2018).

The NMC submitted that it considers that there is a continuing risk to the public due to Mrs Mcgovern's lack of full insight and failure to undertake relevant or any training and not being able to demonstrate strengthened practice through work in a relevant area.

The NMC considers that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. It states that Mrs Mcgovern's conduct engages the public interest because of the breach of duty of candour and the risk of harm to the public

The panel had sight of Mrs Mcgovern's reflective statement in which she acknowledges her actions were wrong, details that she was encountering difficult personal circumstances at the time of the incident, and outlines what she would do differently in the same situation in the future.

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 and *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (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 was of the view that Mrs Mcgovern's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Mcgovern's actions amounted to a breach of the Code. Specifically:

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

To achieve this, you must:

16.1- raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 - act with honesty and integrity at all times […]

20.3 - be aware at all times of how your behaviour can affect and influence the behaviour of other people

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel considered each charge individually, and the charges collectively, to determine whether Mrs Mcgovern's actions were misconduct.

The panel considered that charge 1 was misconduct. It determined that checking patient records prior to the administration of medications is a rudimentary nursing skill which Mrs

Mcgovern had a duty to carry out to ensure the basic safety of patients and to minimise the chance of serious errors. The panel concluded that other practitioners would regard this failure as deplorable and tantamount to serious misconduct.

The panel concluded that Mrs Mcgovern's actions at charge 2 in isolation would not amount to misconduct, as a medication error would not be regarded as deplorable by Mrs Mcgovern's colleagues and fellow practitioners.

In respect of charge 3, the panel determined that falsifying patient records constitutes serious misconduct which would be regarded as deplorable by other nurses.

In respect of charges 4 and 5, the panel considered in the circumstances where a nurse may simply forget to carry out the necessary reporting procedure, this may not constitute misconduct. However, it had regard to the facts of the incident and concluded that Mrs Mcgovern had wilfully breached her duty of candour, which had the potential for serious patient harm. In these circumstances, the panel considered that Mrs Mcgovern's actions in these charges amounted to misconduct.

In respect of charge 6, the panel determined that dishonesty with the intention to knowingly cover an error is serious misconduct.

The panel considered the charges as a whole, and that they all formed part of a singular incident. The panel concluded that a young infant was placed at a serious risk of harm, and had the child become unwell as a cause of Mrs Mcgovern administering an unnecessary immunisation, there would have been no evidence before medical practitioners of what the cause of this harm was. In the circumstances, the panel concluded that the charges collectively 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 Mcgovern'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.

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/their fitness to practise is impaired in the sense that S/He/They:*
>
> *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, although no harm was caused to Mrs Mcgovern's young patient, the child was put at risk of harm, and their parents put at risk of emotional harm as a result of Mrs Mcgovern's misconduct. Mrs Mcgovern's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. 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 the reflective piece provided by Mrs Mcgovern. The panel concluded that Mrs Mcgovern demonstrated limited insight in this reflection, in that she accepted that her actions were *"very wrong and very silly" and* outlined how she should act differently in the future*.* The panel also noted that Mrs Mcgovern made a self-referral to the NMC, in which she was honest about her wrongdoing, which was consistent with her responses at her internal investigation interview. However, the panel considered that Mrs Mcgovern's reflections failed to acknowledge the impact which her actions could have had on her patient, who was vulnerable by virtue of their young age, and to the patient's caregiver/s.

The panel was satisfied that the misconduct relating to clinical errors in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Mcgovern has taken steps to strengthen her practice. However, the panel noted that Mrs Mcgovern has not substantially engaged with the NMC since December 2020 and has not provided any information relating to any training which she may have undertaken to strengthen her practice. The panel also bore in mind that dishonesty is an attitudinal concern which is inherently more difficult to remediate.

However, the panel is of the view that there is a risk of repetition based on Mrs Mcgovern's failure to engage with her regulator and demonstrate any steps which she has taken to address the regulatory concerns and strengthen her practise. 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 Mcgovern's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Mcgovern'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 Mcgovern off the register. The effect of this order is that the NMC register will show that Mrs Mcgovern 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.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 8 August 2022, the NMC had advised Mrs Mcgovern that it would seek the imposition of a striking off order if it found Mrs Mcgovern's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mrs Mcgovern'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:

- Dishonesty;
- Breach of duty of candour in failure to follow the correct reporting procedure for drugs errors;
- Mrs Mcgovern potentially compromised the integrity of a colleague and the Surgery;
- Potential of serious harm to a vulnerable infant

The panel also took into account the following mitigating features:

- Mrs Mcgovern self-reported to the NMC;
- Immediate admissions to the concerns at the local investigation;
- Difficulty in personal and professional circumstances

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection and public interest issues identified, an order that does not restrict Mrs Mcgovern'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 Mcgovern'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 Mcgovern's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel concluded that, although the clinical concerns identified in this case were something which may be addressed through retraining, dishonesty cannot be addressed by such a sanction. The panel further bore in mind that Mrs Mcgovern has not substantially engaged with the NMC since December 2020 and therefore could not be satisfied that she would comply with any conditions of practice formulated by the panel Furthermore, the panel concluded that the placing of conditions on Mr Mcgovern'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 repetition of behaviour since the incident;*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel concluded that the concerns in this matter are serious and include a breach of the duty of candour, dishonesty, falsification of records and actions which prioritised Mrs Mcgovern's own interests over the safety of her patients. The panel concluded that such actions are a serious breach of the fundamental tenets of the profession and are fundamentally incompatible with Mrs Mcgovern remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Mrs Mcgovern'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 Mcgovern'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 matters it identified, in particular the effect of Mrs Mcgovern'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 Mcgovern 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 Mcgovern's own

interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that an interim order of suspension should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.

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 to cover the period of any potential appeal of this order.

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

That concludes this determination.