Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday 4 April – Wednesday 5 April 2023

Virtual Meeting

Name of registrant:	**Stephanie Sparrow**
NMC PIN:	15E0073E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (5 October 2015)
Relevant Location:	West Sussex
Type of case:	Misconduct
Panel members:	Birju Kotecha (Chair, lay member) Susan Field (Registrant member) Rachel Barber (Lay member)
Legal Assessor:	Graeme Sampson
Hearings Coordinator:	Jennifer Morrison
Facts proved by way of admission:	All charges
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel noted that the Notice of Meeting had been sent to Mrs Sparrow's registered email address on 15 February 2023.

The panel considered that the Notice of Meeting provided details of the allegations and indicated that the meeting would be held on or after 23 March 2023. The Notice of Meeting also invited Mrs Sparrow to submit any comments in response to the allegations by 16 March 2023.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mrs Sparrow 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').

Details of charge (as amended)

[In relation to case number 081302]

That you, a registered nurse:

1) On 13 June 2018:
   a) administered Oxycodone to Patient A approximately 2 hours earlier than prescribed, resulting in an overdose of the medication;
   b) failed to follow the correct procedure for administering a controlled drug in that you:
      i) did not store the controlled drugs away in the controlled drugs cupboard;
      ii) did not enter details of the controlled drugs into the controlled drugs book;
      iii) did not sign to say that the patient has received and taken the controlled drug;

2) On 10 September 2018:
   a) on one or more occasion administered co-dydramol and paracetamol at the same time to Patient B;

b) on one or more occasion were behind schedule with giving intravenous fluids to patients;
c) on one or more occasion failed to record medication as being administered at the time it was administered;
d) on one or more occasion failed to update fluid charts and/or drug charts to record when fluids were given to a patient;
e) gave a patient a controlled modified release medication 3 hours earlier than prescribed;

3) On 20 September 2018 having completed a further medication administration assessment:
   a) administered insulin to a patient without checking their blood sugar level;
   b) used the packet of a medication sachet to stir the contents of the medication instead of using a spoon;

4) On 13 December 2018:
   a) failed to complete properly or at all fluid charts and cannulas onto the Hospital's electronic system;
   b) on one or more occasion failed to give intravenous fluids to patients at the required time;
   c) failed to update the fluid chart and/or cannula chart for Patient C;
   d) failed to set the fluid chart for Patient C at the correct infusion rate;

5) On 11 December 2018 carried out a risk assessment on a patient and incorrectly noted that the patient, who had been admitted with a fractured neck of femur, was fully mobile when they were not;

6) On 4 January 2019:
   a) set an intravenous pump at the wrong rate;
   b) failed to update fluid charts properly or at all;
   c) failed to conduct patient observations properly or at all;

7) On 7 October 2020 you dispensed a desiccant tablet into the medication pot of Patient D rather than a Nicorandil which was the medication prescribed to Patient D;

8) On an unknown date in November 2020 in relation to Patient E, you set the infusion rate incorrectly for Acetylcysteine.

9) On 5 March 2019 gave Patient F 20mg(10mls) of Oramorph instead of the prescribed 10mg(5mls);

10) On 10 April 2019 failed to take Patient G's observations during the course of your 12 hour shift when they were supposed to have been taken every four hours;

11) On 13 December 2019:
    a) failed to complete one or more patient fluid chart properly or at all;
    b) failed to complete one or patient fluid pump chart properly or at all;

[In relation to case number 086605]

12) Between January 2021 and November 2021 while working as a Band 5 nurse:
    a) on an unknown date gave Patient AA incorrect information concerning the frequency of their cervical smear test;
    b) on an unknown date failed to check Patient AA's medical history before providing information about cervical smear testing;
    c) on an unknown date failed to escalate Patient AA's query to a qualified colleague as you had not completed the relevant training in cervical smear testing;
    d) on 24 May 2021 failed to take Patient BB's blood tests as part of their diabetes review;
    e) on 28 June 2021 failed to take Patient CC's blood tests as part of their diabetes review;
    f) on an unknown date in June 2021 changed Patient DD's prescription for Depixol, an anti-psychotic medication, from 100mg/ml to 20mg/ml when it was not clinically justified to do so;
    g) on 14 September 2021 administered the incorrect flu vaccine to Patient EE;
    h) on 28 September 2021 failed to follow the correct procedure when removing Patient FF's suture;
    i) on 16 August 2021 you failed to undertake health care reviews in relation to:

i) Client A
ii) Client B
iii) Client C

j) on 16 August 2021 you completed care records to indicate that the health care review(s) referred to in charge 12(i) above had been carried out when they had not.

13) Your actions at Charge 12(j) were dishonest as you knew that you had not completed the health reviews and sought to mislead others into believing that you had;

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

Decision and reasons on amending the charges

The panel, of its own volition, determined to amend the wording of charges 12(j) and 13. Charge 12(j) was amended to refer to charge 12(i) rather than to charge '1(i)', and charge 13 was amended to refer to charge 12(j) instead of charge 12(i).

The panel accepted the advice of the legal assessor and had regard to Rule 28. It was of the view that the amendments were necessary to correct what are clearly typographical errors in the drafting of the charges. The panel was satisfied that the amendments were in the interests of accuracy and, in the light of the admissions made by Mrs Sparrow, would cause her no prejudice.

Decision and reasons on facts

The panel noted that Mrs Sparrow returned a form to the Nursing and Midwifery Council (NMC) entitled 'Your response to the charges (amended)' in relation to case reference 081302. This form was signed and dated 28 November 2022. In response to the question 'Do you admit the facts alleged in the charge above?' Mrs Sparrow ticked a box labelled 'Yes' next to each charge.

Mrs Sparrow returned a second form to the NMC entitled 'Your response to the charges (amended)' in relation to case reference 086605. This form was also signed and dated 28

November 2022. In response to the question ‘Do you admit the facts alleged in the charge above?’ Mrs Sparrow ticked a box labelled ‘Yes’ next to each charge.

The panel was satisfied that Mrs Sparrow has made full and unequivocal admissions to all charges.

The panel therefore finds all charges proved in their entirety, by way of Mrs Sparrow’s admissions.

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 Sparrow’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 Sparrow’s fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In reaching its decision on misconduct, 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 panel also had regard to the terms of the NMC Code: Professional standards of practice and behaviour for nurses and midwives [2015] ('the Code').

The NMC submitted that Mrs Sparrow's conduct was a serious departure from the Code and the standards expected of a registered professional. It invited the panel to find that the facts found proved amount to serious misconduct.

In reaching its decision on impairment, the panel has borne in mind the NMC's overarching objective to protect the public as well as wider public interest considerations. This includes the need to declare and uphold proper standards of conduct and performance and maintain public confidence in the profession and in the NMC as a regulator. In this regard, the panel has considered the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

The NMC invited the panel to find that Mrs Sparrow's fitness to practise is impaired. It submitted that her actions were a serious departure from the standards expected of a registered professional and were likely to cause harm to patients in the future if not addressed. The NMC submitted that Mrs Sparrow has brought the profession into disrepute by the nature of her conduct and has acted dishonestly.

With regard to future risk, the NMC submitted that whilst Mrs Sparrow's clinical failures are capable of being addressed, her dishonest behaviour is more difficult to remediate, particularly because it involved falsifying a vulnerable patient's care records and breaching her employer's trust. The NMC submitted that Mrs Sparrow has shown some insight as a result of her admissions to the charges and because she no longer wishes to practise; therefore, it considers that Mrs Sparrow is no longer a risk to the public. However, the NMC submitted that a finding of impairment in the public interest was required to declare and uphold proper standards of conduct and performance.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

The panel endorsed the NMC's submission that Mrs Sparrow's actions breached the following paragraphs of the Code:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

6 Always practise in line with the best available evidence

To achieve this, you must:

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

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

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

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

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

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

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly…

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel found that Mrs Sparrow's actions did fall seriously short of the standards of conduct and performance expected of a registered nurse. The panel concluded that breaches were widespread, extensive, and related to fundamental areas of nursing practice ranging from medicine administration, patient monitoring, accuracy of record-keeping, and ensuring basic patient needs were met. It noted that despite significant efforts to provide Mrs Sparrow with support in various clinical settings, she continued to make repeated errors of the same kind over a number of years in what appears to be a clear pattern of behaviour. In addition, the panel found that the instance of dishonesty was serious in character in that it involved the completion of a care record for a vulnerable patient. This act of dishonesty carried a risk of patient harm given these records are relied upon by other healthcare professionals in ensuring continuity of care.

Accordingly, the panel finds that Mrs Sparrow's actions amount to serious professional misconduct.

Decision and reasons on impairment

The panel went on to decide if as a result of the misconduct, Mrs Sparrow'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 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 all four limbs of the 'test' in *Grant* are engaged. Mrs Sparrow placed patients in her care at risk of significant harm as a result of her misconduct. Mrs Sparrow's misconduct has plainly breached fundamental tenets of the nursing profession and has therefore brought its reputation into disrepute. Mrs Sparrow's actions in falsifying the care records of a vulnerable patient were clearly dishonest by the standards of an ordinary, decent person.

The panel next considered future risk. It was satisfied that in principle, Mrs Sparrow's clinical errors were remediable. However, the panel has considered the significant support that was put in place by multiple employers over a number of years to assist Mrs Sparrow in improving her practice without any apparent impact. Employer support included access to all relevant training, assessments, supervision and supernumerary practice. At the outset of her time at the Trust, she was also on a preceptorship programme.

The panel noted from the evidence that when confronted with numerous drug errors during a local investigatory meeting, Mrs Sparrow demonstrated a lack of understanding of and insight into the seriousness of those errors. In the statement of Witness 1, it was stated that when questioned about the errors, Mrs Sparrow's reflections were of a poor standard and did not provide confidence that learning had taken place. The evidence also indicated that when issues with her practice arose, Mrs Sparrow appeared to resign and move to another role where further concerns arose, rather than take responsibility for her errors and take steps to mitigate their impact. The panel considered that Mrs Sparrow does not appear to have the ability or capacity to remediate, which indicates a real risk of repetition.

The panel further noted that Mrs Sparrow herself appears to acknowledge that there were patterns to her behaviour that she was not capable of remediating. During a telephone call with her case officer, Mrs Sparrow is noted to have said:

'[Mrs Sparrow] said she would not be contesting the regulatory concerns and would not be returning to nursing. She said she had reflected and that there were patterns and she had not learned from her mistakes...'

'I said this mustn't have been an easy decision to come to. She said it wasn't but that she doesn't want to hurt anyone. She said her mother had always said she was slap dash […] and she needed to accept this is a personality thing and she has always been this way. She said she had other good qualities that she could put to good use in a different industry. Sha [sic] said thankfully noone [sic] had come to harm but there was a risk of harm…'

The panel noted that dishonesty is often said to be more difficult to remediate. The panel considered that Mrs Sparrow's act of dishonesty was very serious. It was a pre-meditated, deliberate falsification of a vulnerable patient's care record. Care records are important documents, and Mrs Sparrow made a demonstrably untrue entry in her patient's record. This entry would have been relied upon by others who were caring for the patient. The panel noted that Mrs Sparrow faced only one charge of dishonesty in relation to a single event, but this did not detract from its seriousness and the panel required considerable evidence of remediation and insight. However, the panel has not seen a single piece of such evidence for this. Accordingly, the panel concluded that Mrs Sparrow is liable to repeat her dishonest behaviour.

The panel rejected paragraph 41 of the NMC's submissions that because Mrs Sparrow has advised she no longer wishes to practise as a nurse, there is no longer a risk to the public. Mrs Sparrow could change her mind and return to nursing at any time, a risk made more real considering Mrs Sparrow had previously moved from one role to another after concerns about her ability to practise safely were raised. The panel has found that in the absence of any evidence of insight, remorse or remediation by Mrs Sparrow, there is a real risk of repetition and of consequential patient harm. Accordingly, the panel has determined that Mrs Sparrow's fitness to practise is impaired on public protection grounds.

The panel has borne in mind 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 the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding proper standards of conduct and performance for members of those professions.

The panel considered that public confidence in the profession would be undermined if a finding of impairment were not made in the circumstances. Therefore, it finds that Mrs Sparrow's fitness to practise is impaired in the public interest.

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 Sparrow off the register. The effect of this order is that the NMC register will show that Mrs Sparrow 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 NMC's published guidance on sanction ('the SG').

The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Notice of Meeting, the NMC had advised Mrs Sparrow that it would seek the imposition of a 12-month suspension order if it found her fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mrs Sparrow'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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel considered the following aggravating features:

- Serious, numerous and repeated incidents relating to basic nursing practice over a three-year period

- Dishonesty in falsifying a care record relating to a vulnerable patient
- Risk of serious patient harm

The panel also considered the following mitigating features:

- Mrs Sparrow has made full admissions to the charges.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and its finding of current impairment. 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 as well as the public protection concerns identified, an order that does not restrict Mrs Sparrow'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 found that Mrs Sparrow's misconduct was not at the lower end of the spectrum and decided that a caution order would be inappropriate in view of the seriousness of the case. The panel determined 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 Sparrow's registration would be a proportionate response. Whilst the clinical errors, in principle, could be addressed through a conditions of practice order, the panel determined that as Mrs Sparrow has not demonstrated any improvement in her practice whilst being supported through numerous clinical action plans and learning and development programmes, that are akin to conditions of practice, a conditions of practice order would be neither workable nor achievable. Furthermore, conditions of practice would not address Mrs Sparrow's dishonest conduct. Accordingly, the panel concluded that a conditions of practice order would not protect the public or meet the public interest.

The panel then went on to consider whether a suspension order would be a proportionate sanction. The SG states that a 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 or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel found that none of these factors are engaged in this case. The evidence suggests deep-seated personality and attitudinal problems that extend to Mrs Sparrow's professional capacity to practise safely, as demonstrated by the repetition of basic clinical failures over a number of years. These failures have occurred in various settings after support has been provided and there has been no evidence that Mrs Sparrow has remediated or strengthened her practice.

The panel also found that the act of dishonesty was serious and there had been no accompanying insight. When taken with the numerous and serious clinical failures, the panel determined that a suspension order would not be appropriate.

In this particular case, the panel determined that a suspension order would not be an 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 Sparrow's actions were significant departures from the standards expected of a registered nurse. The range of errors over a considerable number of years and the complete lack of insight into her failings raise fundamental questions about Mrs Sparrow's professionalism, capability, and willingness to improve and therefore calls into question her fitness to remain on the register. The panel was of the view that allowing Mrs Sparrow to continue practising as a registered nurse would not protect the public and would seriously undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after considering all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the risk of Mrs Sparrow's actions to patient safety, and her bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel concluded that removal from the register is required 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 Sparrow 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 is in Mrs Sparrow's own interests until the striking-off sanction takes effect.

The panel accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that should a restrictive sanction be imposed, an 18-month interim suspension order was necessary to protect the public and is 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 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 in order to protect the public and uphold the public interest whilst any appeal that may be lodged is determined.

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

That concludes this determination.