Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 14 August 2023 – Friday, 25 August 2023

Virtual Hearing

Name of Registrant:	**Bethany Hook**
NMC PIN	19C2072E
Part(s) of the register:	Registered Nurse - Mental Health (28 September 2019)
Relevant Location:	Norfolk and Suffolk
Type of case:	Misconduct
Panel members:	Shaun Donnellan (Chair, Lay member) Lorna Taylor (Registrant member) Suzanna Jacoby (Lay member)
Legal Assessor:	Willian Hoskins
Hearings Coordinator:	Dilay Bekteshi
Nursing and Midwifery Council:	Represented by Megan Millar, Case Presenter
Miss Hook:	Not present nor represented
Facts proved:	Charges 1, 2, 3, 5a), 5b), 5c), 5d), 6a), 6b). 8a), 8b) and 8c)
Facts not proved:	Charges 4a), 4b), 5e), 7a) and 7b)
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 Miss Hook was not in attendance and that the Notice of Hearing letter had been sent to Miss Hook's registered email address by secure email on 12 July 2023.

Ms Millar, 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 that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Hook's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Miss Hook

The panel next considered whether it should proceed in the absence of Miss Hook. It had regard to Rule 21 and heard the submissions of Ms Millar who invited the panel to continue in the absence of Miss Hook. Ms Millar submitted that all reasonable efforts have been made to serve Miss Hook with notice of this hearing. She referred the panel to an email sent by Miss Hook to the NMC Case Coordinator on 12 July 2023 stating that she still needs to send her statements. Ms Millar accepted that there had been good engagement by Miss Hook with the NMC. However, Miss Hook's absence is voluntary as she is aware of these proceedings. Despite efforts to contact Miss Hook on day 1 of the hearing, there has been no information to suggest that there is anything else the panel should be aware of as to the reason why Miss Hook has not attended. Ms Millar therefore submitted that it would be fair to proceed notwithstanding Miss Hook's 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 Miss Hook. In reaching this decision, the panel has considered the submissions of Ms Millar 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.

The panel noted that there had been no communication from Miss Hook since 12 July 2023, that this has been confirmed by Ms Millar, and therefore she appeared not to be engaging with the NMC's proceedings at this time. The panel noted that the NMC had made attempts to contact Miss Hook recently in relation to this hearing, by email, and by

telephone on the morning of day 1 of this hearing. Miss Hook had not responded to these communication attempts. Miss Hook had not requested an adjournment. The panel did not consider there was any indication that an adjournment would secure Miss Hook's attendance at a hearing on a future date. The panel noted that eight witnesses were due to give evidence and considered that they would be inconvenienced if there were to be any delay in this hearing proceeding. The panel also considered that all of the witnesses were involved in providing patient care and in giving evidence they may be taken away from their clinical duties. The panel also had regard to the wider public interest in the expeditious disposal of these proceedings.

There is some disadvantage to Miss Hook in proceeding in her absence. The evidence upon which the NMC relies will have been sent to her at her registered address. Miss Hook has responded to some of the allegations which the panel will have careful regard to. The panel was concerned that Miss Hook 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 Miss Hook's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make oral submissions on her own behalf.

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

On day 8 of the hearing, the panel was informed that Miss Hook had contacted a Hearings Coordinator and appeared to believe that a meeting was scheduled on the conclusion of her case on 25 August 2023. On 23 August 2023, Miss Hook stated the following in an email: *"The case should be closed on the 25th august but I have not yet heard about the time and day of the final meeting? Please could you let me know asap."*

A number of emails were sent to Miss Hook which confirmed that the hearing was proceeding and invited her to join by means of the remote link. Although Miss Hook appeared to have received these emails, she maintained that she had not received the remote link which was contained within the emails themselves. The panel decided to adjourn early on day 8 and to inform Miss Hook that the hearing would continue at 09:30 on the following day. She was invited to attend at that time or to submit a written representation. No further response was received from Miss Hook in relation to that invitation and the hearing resumed at 09:30 on day 9.

Original details of charge

That you, a registered nurse:

1) Breached professional boundaries in that you engaged in a personal relationship with Patient A having been Patient A's named nurse;

2) On 23 March 2020 failed to follow the correct procedure in preparing an IM injection of lorazepam, by using tap water instead of sterile water;

3) On 4 November 2020 administered a second weekly dose of insulin to Patient B when this had already been administered on 30 October 2022 and/or was not due;

4) On 20 March 2021:

    a) failed to administer medication to one or more patients as prescribed;
    b) incorrectly recorded on one or more patient's medication chart that medication had been administered;

5) On 8 April 2021:

    a) on one or more occasion left a medication trolley unattended;
    b) on one or more occasion left a medication cupboard open and/or unattended
    c) on one or more occasion left the medication clinic unattended;
    d) left keys in the medication cupboard;
    e) did not inform the nurse in charge that you were unable to administer medication;

6) On 19 June 2022 while the nurse in charge you:
    a) failed to administer one or more dose of Pregablin to Patient C as prescribed;
    b) failed to administer one or more dose of omeprazole to Patient D as prescribed;

7) During a night shift on 8 July 2022, in breach of the Home's falls policy, you failed to:
   a) record in Patient E's care notes and/or progress notes that they had a fall;
   b) inform colleagues at handover of the fall;

8) Between 13 and 14 July 2022, in relation to Patient F you:
   a) changed the rate of the PEG feed from the prescribed 8 hours to 3 hours without any clinical justification;
   b) having been informed that Patient had not passed urine and/or was in pain, failed to change their catheter and/or take appropriate action;
   c) administered two doses of morphine sulphate to Patient F within four hours and/or incorrectly recorded the administration of morphine sulphate to Patient F;

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

Decision and reasons on application to amend charges

The panel heard an application made by Ms Millar, following an enquiry made by the panel, to amend the wording of charges 1, 2, 3, 4, 5, 6, 7 and 8. Ms Millar submitted that the proposed amendments would particularise the location of when the alleged incidents took place, provide clarity and more accurately reflect the evidence. She submitted that there is no unfairness to Miss Hook in making these amendments as it is simply to assist the panel with further details of which are already in the documentation provided to Miss Hook.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules):

> *'**28.**— (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—*
>
> *(a) the charge set out in the notice of hearing; or*
>
> *(b) the facts set out in the charge, on which the allegation is based,*
>
> *unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.*
>
> *(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.'*

The panel, having regard to the merits of the case, was satisfied at this stage of the proceedings that no unfairness or injustice would be occasioned to Miss Hook by the

proposed amendment being allowed. The panel decided to allow the amendment, as applied for, to provide clarity and accurately reflect the location set out in the NMC witness statements.

The amended charges

That you, a registered nurse:

1) Breached professional boundaries in that you engaged in a personal relationship with Patient A on or after 16 July 2021, having been Patient A's named nurse while Patient A was a patient at Hellesdon Hospital;

2) On 23 March 2020, while working at Hellesdon Hospital, failed to follow the correct procedure in preparing an IM injection of lorazepam, by using tap water instead of sterile water;

3) On 4 November 2020, while working at Hellesdon Hospital, administered a second weekly dose of semaglutide to Patient B when this had already been administered on 30 October 2022 and/or was not due;

4) On 20 March 2021, while working at Hellesdon Hospital:

    a) failed to administer medication to one or more patients as prescribed;
    b) incorrectly recorded on one or more patient's medication chart that medication had been administered;

5) On 8 April 2021, while working at Hellesdon Hospital:

    a) on one or more occasion left a medication trolley unattended;
    b) on one or more occasion left a medication cupboard open and/or unattended
    c) on one or more occasion left the medication clinic unattended;

d) left keys in the medication cupboard;
e) did not inform the nurse in charge that you were unable to administer medication;

6) On 19 June 2022 while the nurse in charge at All Hallows Care Home you:
    a) failed to administer one or more dose of Pregablin to Patient C as prescribed;
    b) failed to administer one or more dose of omeprazole to Patient D as prescribed;

7) During a night shift on 8 July 2022 at All Hallows Care Home, in breach of the Home's falls policy, you failed to:
    a) record in Patient E's care notes and/or progress notes that they had a fall;
    b) inform colleagues at handover of the fall;

8) Between 13 and 14 July 2022 at All Hallows Care Home, in relation to Patient F you:
    a) changed the rate of the PEG feed from the prescribed 8 hours to 3 hours without any clinical justification;
    b) having been informed that Patient had not passed urine and/or was in pain, failed to change their catheter and/or take appropriate action;
    c) administered two doses of morphine sulphate to Patient F within four hours and/or incorrectly recorded the administration of morphine sulphate to Patient F;

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

Ms Millar, on behalf of the NMC, made an application for parts of the hearing to be heard in private, on the basis that there would be references to Miss Hook's [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.

Having heard that there will be reference to Miss Hook's [PRIVATE], the panel determined to hold those parts of the hearing in private. The panel was satisfied that this would protect Miss Hook's right to privacy and confidentiality, which outweighed the public interest in those matters being heard in public, and that all remaining matters of the hearing could be heard in public.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Millar under Rule 31 to allow the written statement of Witness 8 into evidence. Witness 8 was not present at this hearing, however the NMC had made sufficient efforts to ensure that this witness was present. Ms Millar referred the panel to the documents [PRIVATE].

Ms Millar referred the panel to the factors set out in *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). She submitted that Witness 8 provides evidence in respect of charges 6 – 8. Witness 8's evidence is the sole evidence in relation to charge 6, but in relation to charges 7 and 8, her evidence is supported by both Witness 5 and Witness 6. Ms Millar submitted that Witness 8's witness statement alongside Witness 5's and Witness 6's statements corroborate each other and that there are no inconsistencies. Ms Millar submitted that even if Witness 8 had attended to give live evidence, it would not be challenged by Miss Hook by virtue of the fact that she has not attended. She further submitted that there is no suggestion that witnesses from All Hallows Care Home (the Care Home) had reasons to fabricate these allegations. Ms Millar suggested that Witness 5 and Witness 6 were measured and helpful witnesses.

Ms Millar submitted that there is other evidence which would support charges 7 and 8. She submitted that Witness 8's evidence is the only evidence in respect of charge 6 concerning two further medication errors which she submitted is not the biggest concern in this case.

Ms Millar submitted that the NMC was unaware of Witness 8's current circumstances until the first day of this hearing and therefore have not communicated this information to Miss Hook. However, Miss Millar submitted that this does not impact the fairness in this case as Miss Hook has not attended and is unable to challenge Witness 8's evidence.

Ms Millar therefore submitted that it would be fair and relevant to admit the hearsay evidence of Witness 8 into evidence and invited the panel to take this view.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is '*fair and relevant*', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He referred the panel to the guidance in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

The panel considered the facts, the submissions and the relevant case law with care.

The panel gave careful regard to the application in relation to the statement of Witness 8. This evidence goes to charges 6 – 8 and there is no suggestion of fabrication or inconsistencies in the evidence of Witness 8. Although the panel noted that Witness 8's evidence is sole and decisive in respect of charge 6, her evidence is not sole and decisive in respect of charges 7 – 8 as there is corroborating evidence. The panel noted that Witness 8 has a cogent and good reason for not attending. She has provided a signed statement and the panel will decide what weight and reliance it can place upon it in due course.

The panel next considered whether Miss Hook would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 8 to that of a written statement and exhibits.

The panel considered that as Miss Hook had been provided with a copy of Witness 8's statement and, as the panel had already determined that Miss Hook 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. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 8 and the opportunity of questioning and probing that testimony. 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 written statement and exhibits of Witness 8 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Second application under Rule 28

Ms Millar, following an enquiry made by the panel, made a further application to amend charge 8a) under Rule 28, to change the rate of the PEG feed to 125 ml per hour to 500 ml per hour, without any clinical justification. She submitted that this amendment can be made without injustice to Miss Hook.

Original charge:

8) Between 13 and 14 July 2022 at All Hallows Care Home, in relation to Patient F you:

a) changed the rate of the PEG feed from the prescribed 8 hours to 3 hours without any clinical justification;

Proposed amendment:

8) Between 13 and 14 July 2022 at All Hallows Care Home, in relation to Patient F you:

a) changed the rate of the PEG feed from the prescribed 125ml per hour to 500ml per hour without any clinical justification;

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

The panel gave careful regard to the merits of the case and whether the required amendment, at this stage, cannot be made without creating injustice or unfairness to either party.

The panel did not consider that allowing the amendments to charge 8a), as applied for, would cause any injustice to Miss Hook. The panel considered that these amendments would not alter the substance of the allegations. The panel therefore determined that the

amendments to the charges would not result in any injustice and decided to allow the application.

Consequently, the re-amended charges now read as follows:

That you, a registered nurse:

1) Breached professional boundaries in that you engaged in a personal relationship with Patient A on or after 16 July 2021, having been Patient A's named nurse while Patient A was a patient at Hellesdon Hospital;

2) On 23 March 2020, while working at Hellesdon Hospital, failed to follow the correct procedure in preparing an IM injection of lorazepam, by using tap water instead of sterile water;

3) On 4 November 2020, while working at Hellesdon Hospital, administered a second weekly dose of semaglutide to Patient B when this had already been administered on 30 October 2022 and/or was not due;

4) On 20 March 2021, while working at Hellesdon Hospital:

    a) failed to administer medication to one or more patients as prescribed;
    b) incorrectly recorded on one or more patient's medication chart that medication had been administered;

5) On 8 April 2021, while working at Hellesdon Hospital:

    a) on one or more occasion left a medication trolley unattended;
    b) on one or more occasion left a medication cupboard open and/or unattended
    c) on one or more occasion left the medication clinic unattended;
    d) left keys in the medication cupboard;

e) did not inform the nurse in charge that you were unable to administer medication;

6) On 19 June 2022 while the nurse in charge at All Hallows Care Home you:
    a) failed to administer one or more dose of Pregablin to Patient C as prescribed;
    b) failed to administer one or more dose of omeprazole to Patient D as prescribed;

7) During a night shift on 8 July 2022 at All Hallows Care Home, in breach of the Home's falls policy, you failed to:
    a) record in Patient E's care notes and/or progress notes that they had a fall;
    b) inform colleagues at handover of the fall;

8) Between 13 and 14 July 2022 at All Hallows Care Home, in relation to Patient F you:
    a) changed the rate of the PEG feed from the prescribed from the prescribed 125ml per hour to 500ml per hour without any clinical justification;
    b) having been informed that Patient had not passed urine and/or was in pain, failed to change their catheter and/or take appropriate action;
    c) administered two doses of morphine sulphate to Patient F within four hours and/or incorrectly recorded the administration of morphine sulphate to Patient F;

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

Background

The NMC received a referral from on Norfolk and Suffolk NHS Foundation Trust (the Trust) on 26 October 2021. The referral was made in relation to Miss Hook whilst she was employed at the Hellesdon Hospital (the Hospital) as a registered nurse.

Miss Hook was working as a registered nurse on an acute adult mental health ward at Hellesdon Hospital (the Hospital). Miss Hook commenced her employment at the Hospital on the 2 September 2019 and this was her first substantive role since her qualification as a nurse in 2019. The referral alleges that Miss Hook embarked on a relationship with a patient which amounted to a breach of professional boundaries and abuse of her position of trust. [PRIVATE]. It was only after Miss Hook had left her employment that the Hospital became aware following a Facebook post that Miss Hook and Patient A had become involved in a personal relationship.

Additional concerns relating to clinical practice have arisen relating to incidents which allegedly took place between March 2020 and April 2021 in the Hospital and between June 2022 and July 2022 in All Hallows Care Home (the Care Home). These relate to Miss Hook's management, administration of medications and record keeping.

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 Millar on behalf of the NMC and by written responses by Miss Hook.

The panel has drawn no adverse inference from the non-attendance of Miss Hook.

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: Ward Manager at the Hospital
- Witness 2: Band 6 Charge Nurse at the Hospital
- Witness 3: Clinical Nurse Specialist at the Hospital
- Witness 4: Band 6 Charge Nurse at the Hospital
- Witness 5: Senior Healthcare Assistant at the Care Home
- Witness 6: Care Practitioner at the Care Home
- Witness 7: Band 6 Charge Nurse at the Hospital

The panel also considered the witness statement and exhibits of Witness 8: Deputy Manager at the Care Home.

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

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

Charge 1

1) Breached professional boundaries in that you engaged in a personal relationship with Patient A on or after 16 July 2021, having been Patient A's named nurse while Patient A was a patient at Hellesdon Hospital;

This charge is found proved.

In reaching its decision, the panel took into account the oral and documentary evidence of Witness 1, Facebook screenshots [PRIVATE], Miss Hook's training record, the Hospital's Safeguarding Policy and Miss Hook's response bundle.

The panel found Witness 1 to be a credible and reliable witness who is an experienced senior mental health nurse. It took into account Witness 1's witness statement which states: *"Beth's role as Patient A's named nurse was to help coordinate care, liaise with the multi-disciplinary team and act as the allocated nurse to oversee Patient A's care while she was on the Ward."* In oral evidence Witness 3 told the panel that as a mental health nurse, developing personal relationships with patients or former patients could be particularly inappropriate as clinicians were privy to deeply personal information that vulnerable patients would often not even share with their families.

Witness 1 accepted that there might be exceptional circumstances, such as where there had been a very long period of time between treatment and the formation of a relationship with a former patient, that did not involve crossing professional boundaries. However, that was not the situation in this case. Miss Hook was Patient A's named nurse when Patient A

was admitted to the ward [PRIVATE] and even on Miss Hook's account the relationship had begun soon after Patient A's discharge.

The panel also considered Patient A's Care Plan and noted that Miss Hook was Patient A's named nurse whilst Patient A was admitted to the Hospital. In addition, it considered the clinical community notes which provide information on the nature of the relationship between Patient A and their girlfriend Beth, a mental health nurse. It noted that the clinical community notes suggest that the relationship may be [PRIVATE] and that the relationship may be ongoing.

The panel further took into account the Facebook posts and noted the images are redacted. Witness 1 in her oral evidence was able to confirm that the images in the Facebook posts were of Patient A and Miss Hook.

The panel noted the training records and that Miss Hook had completed training in adult safeguarding on 13 January 2020. It further took into account the Hospital's Safeguarding Adult at Risk of Abuse Policy which Miss Hook would have had access to at the Hospital. The panel took into account the Policy, in particular:

> ***"Maintaining professional boundaries****:*
>
> *Under certain circumstances social relationships of a therapeutic nature as part of an agreed therapeutic plan of care are encouraged. However, personal relationships with service users are considered to be unprofessional due to an imbalance of power and the potential abuse of a position of trust and authority. Developing professional and therapeutic relationships inevitably means the service user discussing intimate and personal matters. Such discussions may be misinterpreted, with perceptions being distorted due to the vulnerability, or distress, of the service user. Problems may arise from transference and counter-transference, fostering a relationship of personal disempowerment rather than professional support.*

…To arrange a meeting with a service user or an ex-service user, where the staff member has provided direct care to the service user, with the intent of seeking an out-of-work relationship or relationship is not consistent with professional boundary guidance. This is to protect both workers and service users; a personal relationship with a service user or ex-service user may jeopardise current or future therapy and prevent an objective professional view from being taken.

All workers must note that to become personally or sexually involved with a service user precludes objectivity, breaches the boundaries of the professional relationship and is subject to legislative scrutiny in line with duty of care and the Trusts prevention and reporting of crime responsibilities."

The panel also considered Miss Hook's response bundle where she admits her relationship with Patient A and states that the relationship did not start whilst Miss Hook was Patient A's named nurse*. "I would like to emphasis no relationship was created nor intended when patient was on the ward or I was working as a mental health nurse on the ward. Contact was made when patient was discharged and I was working in full time employment at the Priory Hospital. Reflecting back on this I would have spoken to my line management about this but I did not feel trusting or supported in management at Hellesdon Hospital…I did not feel in a safe place to raise my concerns about the feelings I had gained for the patient…Patient was discharged from ward and no relationship/friendship/contact was made until I had left NSFT and patient had been discharged from the ward (around a month after contract was made)."*

The panel therefore concluded that, on the balance of probabilities, it was more likely than not that Miss Hook breached professional boundaries in that she engaged in a personal relationship with Patient A on or after 16 July 2021, having been Patient A's named nurse while Patient A was a patient at the Hospital. Accordingly, the panel found this charge proved.

Charge 2)

2) On 23 March 2020, while working at Hellesdon Hospital, failed to follow the correct procedure in preparing an IM injection of lorazepam, by using tap water instead of sterile water;

This charge is found proved.

In reaching its decision, the panel took into account the oral and documentary evidence of Witness 2. Although there are no contemporaneous documents relating to this charge, the panel was satisfied that Witness 2 was credible in his live evidence which was consistent with his written statement. In oral evidence, Witness 2 described in detail that he was restraining a patient and had asked Miss Hook to prepare the IM injection of lorazepam and that it took Miss Hook some time to do so. Witness 2 said that when he went to check on her, it appeared as though Miss Hook was trying to mix the injection with tap water rather than the sterile water which was stored nearby for that purpose.

The panel also took into account the witness statement of Witness 2, in particular: *"I do not think Miss Hook knew the correct procedure and the administration of IM lorazepam, measuring the dosage and the water injection. I remember her asking me what was wrong with putting in tap water into the injection. Tap water has the risk of contamination because it contains chemicals, such as chlorine, that you cannot predict how they will interact with the lorazepam. This is why there is the special water to be used for the injections…Miss Hook should have known what to do as you are shown to administer IM injections when you go through your induction and preceptorship course when you join the Ward as someone would go through all the different medication procedures and observations."* The panel noted that Witness 2 described the incident clearly in his oral and documentary evidence as well as the risks of contamination.

The panel further noted Miss Hook's response bundle where there is reference to one event concerning lorazepam, but it was not clear whether Miss Hook was referring to this specific '*near miss'* incident.

The panel therefore concluded that, on the balance of probabilities, it was more likely than not that on 23 March 2020, while working at the Hospital, Miss Hook failed to follow the correct procedure in preparing an IM injection of lorazepam, by using tap water instead of sterile water. Accordingly, the panel found this charge proved.

Charge 3)

3) On 4 November 2020, while working at Hellesdon Hospital, administered a second weekly dose of semaglutide to Patient B when this had already been administered on 30 October 2022 and/or was not due;

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 3, the print screens documenting the medication error made by Miss Hook, the management of medication error policy and Miss Hook's response bundle.

The panel took into account Witness 3's witness statement, in particular: *"On 4 November 2020, Beth incorrectly administered a second weekly dose of Semaglutide 0.25mg/0.19ml insulin to a patient, ("Patient B") when this had already been given on 30 Octoebr* [sic] *2020 and therefore was not due. Patient B was prescribed two different doses of insulin, a twice daily dose of fast release insulin Biphasic aspart (novomix) and a weekly dose of slow release insulin.*" The panel noted that the evidence referred to Semaglutide as insulin. On cross examination, Witness 3 accepted that Semaglutide was not in fact insulin, but a drug of a similar nature. The panel considered the exhibited copies of the print screens from the electronic system, which documents that error. The panel also noted that the medication error was then managed in line with the Hospital's management of medication error policy.

Witness 3 described Miss Hook as being defensive that she was "*not in the wrong"* and it took a lot of *"convincing".* The panel noted that Miss Hook in her responses had stated that she felt inadequately supported and over-worked in her role, but this was not accepted by Witness 3, who stated that Miss Hook had received more support than anybody else she had ever seen.

The panel further considered Miss Hook's response bundle where she admits that a medication error was made, but she asserted the fact that she was overworked [PRIVATE]. The panel took into account the following: "*2) error with insulin. This drug error was made. I believe I was not supported or given enough knowledge around insulin, although I had done this before*…[PRIVATE]…"

The panel therefore concluded that, on the balance of probabilities, it was more likely than not that on 4 November 2020, while working at the Hospital, administered a second weekly dose of semaglutide to Patient B when this had already been administered on 30 October 2022 and/or was not due. Accordingly, the panel found this charge proved.

Charge 4)

4) On 20 March 2021, while working at Hellesdon Hospital:

a. failed to administer medication to one or more patients as prescribed;
b. incorrectly recorded on one or more patient's medication chart that medication had been administered;

This charge is found NOT proved.

In reaching its decision, the panel took into account the oral and documentary evidence of Witness 3 and Witness 4, the EPMA completed by Miss Hook and the Datix report.

The panel took into account Witness 3's witness statement, in particular: *"On 20 March 2021, Beth was involved in another medication error that was witnessed by two members of staff. Beth had left out pots of medication. I did not witness the error myself but was informed of it by [the Clinical Team Leader / Ward Manager]. I also read the datix reports from the incident logs on Yare Ward. On 1 April 2021, [the Clinical Team Leader / Ward Manager] decided that Beth was not allowed to administer medication on her own and had to be supervised by another nurse. I was not involved in this decision."*

The panel also considered Witness 4's witness statement, in particular: *"I was in the clinic room for the lunchtime medication round on 20 March 2021, I saw medication cups left out that still contained medication. I checked the medication charts for the patients and identified that it was the morning medication. I checked the medication charts and noticed that Miss Hook had recorded that the morning medication had been administered…I was surprised that the medication had been marked as administered when it had not been and was still in the pots in the clinic room."*

The panel considered the exhibit EMPA completed by Miss Hook. It noted that it was a contemporaneous document but despite making every effort to assist the panel, Witness 4

had some difficulty identifying the error. The panel could not see the correlation between the printout and the evidence of Witness 4 in his witness statement and the charge. The panel asked for further information who produced a DATIX report, however, the abbreviated DATIX report was again lacking detail and did not provide any clarity in respect of charge 4.

Therefore, on the balance of probabilities, the panel found charge 4 not proved.

Charge 5)

5) On 8 April 2021, while working at Hellesdon Hospital:

a) on one or more occasion left a medication trolley unattended;
b) on one or more occasion left a medication cupboard open and/or unattended
c) on one or more occasion left the medication clinic unattended;
d) left keys in the medication cupboard;
e) did not inform the nurse in charge that you were unable to administer medication;

This charge is found proved only in respect of charges 5a), 5b), 5c) and 5d).

Charges 5a) & 5b)

In reaching its decision in respect of charges 5a) and 5b), the panel took into account the witness statement of Witness 7, in particular paragraphs 14 – 19. Witness 7 told the panel that Miss Hook on three occasions, left the medical clinic unattended, despite instructions from Witness 7, who was the nurse in charge, to stay in the clinic. Witness 7 said that whenever he returned to the clinic room, the medication keys were hanging from the cupboard and the medication trolley was open. In oral evidence Witness 7 said that Miss Hook apologised for the incidents but could not explain why she had not followed Witness 7's instructions. The panel was satisfied that Witness 7 was clear in his evidence and was consistent with his written statement.

The panel further took into account the witness statement of Witness 3, in particular: *"On 8 April 2021, another staff nurse…, [Charge Nurse] on Glaven Ward worked a shift with Beth. He raised a concern that Beth had left the medication trolley and medication cupboard open, and that she left the keys in the medication cupboard."* The panel noted that this is hearsay evidence as Witness 3 was told by another nurse that he raised a concern that Miss Hook had left the medication trolley and medication cupboard unattended. However, the panel noted that Witness 3's evidence corroborates Witness 7's evidence.

The panel decided to rely on Witness 7's documentary and oral evidence and found charge 5a) and 5b) proved.

Charges 5c) and 5d)

In reaching its decision, the panel took into account the written statement of Witness 7 in particular paragraphs 14, 15 and 17. Witness 7 in evidence said that whenever he returned to the clinic room, the medication keys were hanging from the cupboard and the medication trolley was open. This is also referred to in the witness statement of Witness 3 and it was again, a concern raised by another member of staff that Miss Hook left the medication trolley and medication cupboard open, and that she had left the keys in the medication cupboard. Therefore, on the balance of probabilities, the panel found charges 5c) and 5d) proved.

Charge 5e)

In reaching its decision, the panel took into account Witness 7's witness statement. It had particular regard to the following paragraph: *"…After the medication round was completed, I went and spoke to [Charge Nurse]. I explained to him what had happened and he then informed me that Miss Hook was not allowed to hold medication keys at all. I told [Charge Nurse] that his should have been notified to the nurses working with her on the shift, as we did not know she could not be left alone with the medication keys…I was concerned that Miss Hook was not taking the responsibility to stay with the medication trolley She also knew she could not administer medication or hold the keys and she did not tell me this at the beginning of the round. After the third occurrence of the trolley being left unattended, I knew I had to report it to my manager…*[sic]*"*

The panel also took into account Witness 3's witness statement, in particular: "*On 1 April 2021, [Clinical Team Leader / Ward Manager] decided that Beth was not allowed to administer medication on her own and had to be supervised by another nurse. I was not involved in this decision…Beth did not inform the Clinical Team Leader on Glaven Ward or the Staff nurse she was working with of the support she was receiving and that she was not allowed to administer medication unsupervised."*

The panel considered the email correspondence with Miss Hook in April 2021 which indicates that Miss Hook was not allowed to administer medication without supervision.

The panel was informed by Witness 3 that Miss Hook had been defensive when she had attempted to provide guidance to her, and Miss Hook never achieved her revisited medicine administration competency, and had been elusive when Witness 3 had attempted to complete this exercise. Therefore, Miss Hook's medicines management competence had not been established by the Trust.

The panel was clear that the evidence indicated that Miss Hook could not administer medication unsupervised on 8 April 2021. It seems obvious that this was a restriction on her practice of which she should have informed the nurse in charge. The panel noted that Witness 7 said that Miss Hook had not informed him, and he got the information from the Charge Nurse who was not a witness in these proceedings. The panel could not find the charge proved in its wording "you were unable to administer medication", as this implied Miss Hook could not administer medication in any circumstances. The panel determined from the evidence provided that Miss Hook was unable to administer medication unsupervised. Therefore, on the balance of probabilities, the panel found charge 5e) not proved.

Charge 6)

6) On 19 June 2022 while the nurse in charge at All Hallows Care Home you:
a) failed to administer one or more dose of Pregablin to Patient C as prescribed;
b) failed to administer one or more dose of omeprazole to Patient D as prescribed;

This charge is found proved.

The panel approached the charges with some caution as they rely substantially on the evidence of Witness 8 who the panel have not had the opportunity to examine closely.

The panel took into account the witness statement of Witness 8 (paragraphs 9-12 (in respect of 6a) and paragraphs 13 – 18 (in respect of charge 6b)) and the MAR charts for Patient C and D. The panel noted that the MAR chart shows that there appears to be one extra tablet when the running balance was totalled at the end of each shift. The total had not been completed by Miss Hook who was on shift and signed for the medication. This supports the panel's decision that one or more dose of each had been missed in both charges 6a) and 6b). The panel also noted that the date in the charge correlates with the shifts attended by Miss Hook.

The panel also took into account the reflective account by Miss Hook requested by Witness 8. It noted that under the heading *'what happened',* it states: *"missed mediation, Pregabalin – 12 tablets were remaining with the medication audit when there should have been 11. Omeprazole – 15 tablets were remaining when there should have been 14 on 19/06/2022."* Under the heading *'what would you change about what you did next time',* it states: *"ensure medication was given and write and count number of medication left.* The panel was confident that it relates to these two charges as the dates tallied and it was clear what medications were involved. It noted that further support was given to the authenticity of the handwritten reflective account by the fact that it was signed by Miss Hook and the team leaders.

Although the panel acknowledged that the evidence was hearsay evidence, it was persuaded by the extensive contemporaneous documentation which supported this charge. Therefore, on the balance of probabilities, the panel found charges 6a) and 6b) proved.

Charge 7)

7) During a night shift on 8 July 2022 at All Hallows Care Home, in breach of the Home's falls policy, you failed to:

a) record in Patient E's care notes and/or progress notes that they had a fall;
b) inform colleagues at handover of the fall;

This charge is found NOT proved.

In reaching its decision, the panel took into account the oral and documentary evidence of Witness 6, the witness statement of Witness 8 and gave careful regard to the Care Home's Falls Policy.

The panel considered the witness statement of Witness 6, in particular: "*I checked the Daily Progress Notes folder and the falls diary but there was no record of the fall."* In oral evidence, Witness 6 explained that Patient E had a fall during the night on 8 July 2022 and that she had checked the daily progress notes folder and the care notes, but there was record of Patient E's fall. Witness 6 explained that the procedure at the Care Home was to document falls in a number of different places and it should have been documented in the falls diary, in the progress notes and also in the patient's care notes.

The panel also considered the witness statement of Witness 8, which states: *"The normal practice following a resident fall is to record what happened in the daily progress notes, complete a falls diary and hand it over to the next shift. If Miss Hook was unsure how to do complete the falls diary, she could have written down the information and asked another*

member of the team to complete the fall diary for her. I exhibit a copy of the Falls policy, marked as LH/10A, which Miss Hook should have followed while at the Home."

The panel then considered the Care Home's Falls policy which states:

> *"**Recording falls***
> *All falls, including trips and slips, should be documented in the falls diary(Care plan document 5d)*
> *An Incident Record Form (Care Plan document 5g) does not need to be completed for falls and slips or trips.*
> *An Accident form should be completed if staff are involved when the resident/tenant falls(i.e. Manual handling)"*

The panel noted that the documents including the care notes and/or progress notes set out in the charge do not feature in the policy. Although it appears to have been local practice, it noted that the charge specifically relates to the Care Home's policy. However, the panel could find nothing in the policy to suggest that a nurse must record in care notes and/or progress notes that a patient had a fall or that a nurse must inform a fall to colleagues at handover. Therefore, on the balance of probabilities, the panel found charges 7a) and 7b) not proved.

Charge 8)

8) Between 13 and 14 July 2022 at All Hallows Care Home, in relation to Patient F you:

a) changed the rate of the PEG feed from the prescribed from the prescribed 125ml per hour to 500ml per hour without any clinical justification;
b) having been informed that Patient had not passed urine and/or was in pain, failed to change their catheter and/or take appropriate action;
c) administered two doses of morphine sulphate to Patient F within four hours and/or incorrectly recorded the administration of morphine sulphate to Patient F;

This charge is found proved in its entirety.

Charge 8a)

In reaching its decision, the panel took into account Witness 6's witness statement, in particular: *"As Ms Hook changed the rate from 125ml to 500ml, it meant that the feed was going through at four times the rate it had been prescribed. This can cause distress and abdominal discomfort, vomiting, aspiration because the feed is going too quick."* Witness 6, in her oral evidence told the panel that when she returned to her shift on 14 July 2022, she heard the PEG feed beeping, and that when she went to check it, the feed had been changed from the prescribed 125ml per hour to 500ml per hour. Witness 6 explained that she had previously demonstrated how to set up the PEG feed to Miss Hook.

The panel also considered Witness 8's witness statement which states that Miss Hook was the only person on duty with the responsibility for the administration of the PEG feed. The panel established with Witness 6 that it would not have been possible for Patient F to tamper with the flow rate of the PEG feed.

The panel also took into account the Incident Record Form for Patient F, completed by Witness 6 and followed up by Witness 8 (the Incident Record). Although the panel found the information inaccurate such as inaccurate calculations and volume information, the

statements and oral evidence of Witness 6 supports the charge. Therefore, on the balance of probabilities, the panel found charge 8a) proved.

Charge 8b)

The panel considered the witness statement of Witness 5, in particular: "*After receiving handover from the day staff at 20:00, I went upstairs to start administering medication to the residents. I saw that there was no urine in his leg bag. I went to Miss Hook and told her that there was no urine in the resident's leg bag and I would keep an eye on the resident. As the resident was nil by mouth, all his medication had to be administered by his PEG feed. As the registered nurse on duty, Miss Hook had to administer his medication. I am not allowed to administer via a PEG feed because I am not trained to do so. Around 23:00, the resident requested pain relief and I witnessed Miss Hook administer controlled drug medication to the resident. I counter signed for the resident's medication. There was still no urine output at this point and the resident was complaining about abdominal pain. I tried to make the resident comfortable. I changed his position and hoped this would help with his urine output but it did not work. Miss Hook took her break between 01:00 and 02:00. When her break finished, at approximately 02:00, I went to Miss Hook and informed her that the resident was still in pain, that he was calling out, had been awake all night and that there was still no urine output. I asked Ms Hook to go and see the resident again. Miss Hook went to see him. When she returned, Miss Hook told me that he was fine and that there was no urine output in the bag but that this was alright. I tried to advise Miss Hook that we should call an ambulance or that we should call the NHS 111 service for advice. Miss Hook just walked away from me. I felt that she was abrupt with me because I kept calling her for to help with the resident."*

Witness 8 in her statement states that Miss Hook was aware of the patient's pain and did not take action to change the catheter or seek support from another clinician and felt that this amounted to neglect.

The panel also considered the Incident Report and daily progress notes for Patient F where Miss Hook recorded that Patient F was experiencing pain in his catheter area on a

number of occasions. It noted that there do not seem to have been any steps taken by Miss Hook to change the catheter or take appropriate action by escalating concerns, despite the entries being made in Patient F's notes.

The panel also took into account Witness 6's written statement which corroborates the evidence of Witness 5. Therefore, on the balance of probabilities, the panel found charge 8b) proved.

Charge 8c)

The panel took into account Witness 6's witness statement, which states: *"During the night shift on 13 / 14 July 2022, Ms Hook administered two doses of morphine oral sulphate solution for Resident F's catheter pain within a four hour window. The resident was prescribed morhine subplate* [sic] *as required but it has to be administered with a four hour gap in between doses. The first dose was administered on 13 July 2022 at 23:40 and the second dose was administered at 02:30. Ms Hook recorded these entries and saw that Ms Hook had recorded different entries. Ms Hook had recorded on the controlled drug book that the first dose on 13 July 2022 was at 23:00 and the second dose on 14 July 2022 was on 03:00. This made it appear as though the doses had been administered within four hours but it did not match up with what was recorded on the MAR chart."*

The panel also took into account the witness statement of Witness 8, which states: "*if the doses were administered as per the MAR chart, at 23:40 and 02:30, this meant that the resident had an overdose between two doses should not be administered within four hours of each other. An overdose can cause the resident to be more sedates* [sic] *and in most serious circumstances could cause death.*" The panel noted that the documentary evidence of Witness 8 corroborates the oral evidence heard from Witness 6.

The panel took into account Patient F's MAR chart, the extract from the Home's Controlled Drugs Register, the Carers' Medication Notes and the Incident Record.

The panel decided that charge 8c) is found proved on the basis that there is evidence of the incorrect recording of the time of the administration of morphine sulphate to Patient F on the Carers' Medication Notes and that the medication administration times do not correlate with those recorded on the Controlled Drugs Register. Therefore, on the balance of probabilities, the panel found charge 8c) 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 Miss Hook'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, Miss Hook's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Ms Millar referred the panel 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 Millar invited the panel to take the view that the facts found proved amount to misconduct. The panel should have regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) in making its decision. She identified the specific, relevant standards where Miss Hook's actions amounted to misconduct.

In respect of impairment, Ms Millar referred the panel to the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin). She submitted that the most serious charge in this case is pertained to Miss Hook's relationship with Patient A [PRIVATE]. She directed the panel to Patient A's clinical notes revealing an ongoing relationship that she submitted has adversely affected Patient A's mental health. She further guided the panel's attention to specific references documented in the clinical notes from 22 March 2022. Ms Millar submitted that *"some kind of harm*" was caused to Patient A's [PRIVATE].

Ms Millar submitted that Miss Hook's relationship with Patient A is liable to bring the nursing profession into disrepute. She submitted that the concern stems from the specific circumstances in which the relationship was formed [PRIVATE].

Ms Millar said that there are in total eleven errors which the panel have found proved. She submitted that it is significant to note that the time frame is a significant period of time, starting on 23 March 2022 to approximately 14 July 2022, a period of over two years. Ms Millar presented the panel with evidence of each proven charge, highlighting the associated risks and the potential harm as a result of Miss Hook's actions. Ms Millar apprised the panel that Miss Hook had stated in her response bundle that she experienced workplace pressures, was under resourced and [PRIVATE]. However, Ms

Millar submitted that Miss Hook has not taken real personal responsibility for her errors or implemented measures to prevent the recurrence of the errors. She submitted that Miss Hook has not shown sufficient insight, raising concerns about the potential for errors to be repeated in the future.

In conclusion, Ms Millar invited the panel to take the view that Miss Hook's conduct amounts to misconduct and that her fitness to practise is currently impaired.

The panel accepted the advice of the legal assessor. The legal assessor reminded the panel that misconduct involved a serious departure from generally accepted professional standards. Those standards were to be found in the Code. The legal assessor also reminded the panel of the principles contained in *Grant* and *Cohen v GMC* [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 appreciated that breaches of the Code do not automatically result in a finding of misconduct.

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

Prioritise people

You put the interests of people using or needing nursing or midwifery services first.

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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:

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

8.2 maintain effective communication with colleagues

10 Keep clear and accurate records relevant to your practice

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 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

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:

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

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

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

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

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

Charge 1)

The panel determined that breaching professional boundaries [PRIVATE] is serious misconduct. It noted that professional boundaries are ethical guidelines that define the appropriate relationship and conduct between a healthcare professional and their patients. Breaching these boundaries can compromise patient care and potentially harm the patient. The panel took into account the Trust's 'Safeguarding Adults at Risk of Abuse' policy, in particular under the heading 'Maintaining professional boundaries' which states: "*…personal relationships with service users are considered to be unprofessional due to an imbalance of power and the potential abuse of a position of trust and authority."* Having undergone safeguarding training, Miss Hook had full awareness of the policy. The details of the policy were also readily accessible to her on the internet: "*…a personal relationship with a service user or ex-service user may jeopardise current or future therapy and prevent an objective professional view from being taken."*

The panel noted Miss Hook's written submissions, namely: *"I would like to emphasise there were never professional boundaries broken/breached whilst I was a nurse on yare ward…I did not feel in a safe place to raise my concerns about the feelings I had gained for the patient…I had left NSFT and patient had been discharged from the ward (around a month after contact was made)."*

The panel considered that breaching professional boundaries could damage confidence in the profession and lead to a loss of trust between patients, their families and nurses. This could lead to patients being reluctant to engage with healthcare professionals in the future.

The panel had regard to the NMC's guidance on 'serious concerns which are more difficult to put right', where relationships with patients in breach of guidance on clear sexual boundaries are highlighted.

The panel determined that Miss Hook engaged in a personal relationship with Patient A, [PRIVATE], and the panel considered this to be an abuse of power by Miss Hook. The panel decided that Miss Hook's neglect in recognising and upholding her professional

responsibilities to ensure the welfare and well-being of Patient A, signifies a profound breach of professional duty on her part. The panel therefore found that Miss Hook's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 2)

The panel noted that although no patient harm occurred as a result of this incident due to Witness 4's intervention, without which there was a possibility that the patient could have had potential complications with dilution of the drug using tap water, for example, infection, respiratory problems or over sedation. It further noted that Miss Hook was shown how to administer IM injections when she went through her induction and preceptorship course. Albeit a single incident, it noted that this was a fundamental error which could have placed the patient at significant risk of harm. The panel therefore found that Miss Hook's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charge 3)

The panel noted that Miss Hook wrongly identified a drug and demonstrated a lack of recognition of different drugs contained in distinctively different injection devices. This medication error had the potential to inflict serious harm upon the patient. The administration of a second dose of Semaglutide, in addition to insulin, placed the patient at risk of experiencing severe shock, which can lead to significant physical complications and, in severe cases, death. The panel therefore found that Miss Hook's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charges 5a) 5b) 5c) and 5d)

The panel noted that it is a fundamental part of a nurse's role to keep medication secure in a clinical setting. In this case, it was brought to the panel's attention that Miss Hook had left the medication cupboard and medication trolley unattended three times during her shift. It is important to note though, that the panel also received evidence indicating that

the main door of the medication room was locked, which made it highly unlikely for unsupervised patients to access the medication. The panel therefore determined that charges 5a), 5b), 5c) and 5d) do not meet the threshold for misconduct.

Charges 6a) 6b)

The panel noted that the incidents were errors in the documentation and omission of medication administration relating to two patients that occurred within the span of a single shift. The panel recognised that medication errors can occur and do not invariably amount to misconduct. The panel therefore determined that charges 6a) and 6b) do not meet the threshold for misconduct.

Charge 8a)

The panel noted that Miss Hook has not provided a response for this allegation. Her actions wherein she changed the rate of the PEG feed to a rate four times faster than the prescribed rate without clinical justification, had the potential to cause the patient discomfort, distress and more severe complications due to aspiration (inhalation of stomach contents). The panel therefore found that Miss Hook's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charge 8b)

The panel found that Miss Hook, following the administration of two doses of morphine sulphate for pain, had failed to change the patient catheter or take appropriate action by not referring the patient to a suitably qualified professional. Additionally, Miss Hook ignored the advice of her colleague, a health care assistant, when she asked Miss Hook to refer the patient to NHS 111 or call an ambulance due to the patient's pain and distress, as he was crying out and awake all night. The panel found Miss Hook's actions to be unacceptable in her role as a registered nurse, as she failed to treat this vulnerable patient with care and compassion. The panel therefore found that Miss Hook's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charge 8c)

The panel noted that Miss Hook had administered two doses of morphine sulphate to Patient F and failed to accurately document when these were given, providing times on two documents which did not correlate. The doses documented as being less than every four hours as prescribed constituted an overdose of the opiate drug and could have potentially put Patient F at risk of respiratory depression or even death. The panel determined that the impact of Miss Hook's actions in failing to follow the prescription and policy for controlled drugs administration and documentation could have put Patient F at risk of serious harm. The panel therefore found that Miss Hook's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Hook'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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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) *…*

The panel considered that limbs a, b and c of Dame Janet Smith's test set out in the Fifth Report from Shipman were engaged by Miss Hook's past actions.

Having regard to the test for remediation set out in the case of *Cohen*, the panel determined that in respect of charge 1, it noted the severity of the misconduct, making it challenging to rectify and address adequately. However, when considering the charges related to medication administration and clinical errors, the panel determined that it is remediable with the provision of appropriate interventions, training and support. In considering whether it has been remedied, the panel assessed Miss Hook's practice since these incidents arose as well as her level of insight.

In respect of charge 1, the panel took into account the Trust's 'Safeguarding Adults at Risk of Abuse' policy, in particular under the heading 'Maintaining professional boundaries' which states: "*…personal relationships with service users are considered to be unprofessional due to an imbalance of power and the potential abuse of a position of trust and authority."* The panel further noted that Witness 1 in oral evidence stated that there are management supervision sessions, training opportunities, and even a psychologist available within the team to provide support should a nurse develop feelings for a patient.

However, it noted that Miss Hook did not make use of any of these available avenues for help.

The panel took into account Miss Hook's response bundle in respect of charge 1, which states: *"I would like to emphasise no relationship was created nor intended when patient was on the ward I was working as a mental health nurse on the ward. Contact was made when patient was discharged and I was working in full time employment at the Priory Hospital. Reflecting back on this I would have spoken to my line management about this but I did not feel trusting or supported in management at Hellesdon Hospital...I agree with this statement and take full responsibility of my boundaries being breached. I was working at Hellesdon Hospital at the time of meeting patient. I would like to emphasise there were never any professional boundaries broken/breached whilst I was a nurse on yare ward. I had also handed in my resignation before patient was admitted to yare ward as management were unsupportive/unprofessional and I did not feel in safe place to raise my concerns about the feelings I had gained for the patient…"*

The panel determined that Miss Hook lacks meaningful insight as she appears to downplay the seriousness of her actions and sought to justify them by stating that Patient A was not under her care when their relationship formed. The panel unequivocally views this as an abuse of power, when considering Miss Hook's role as a mental health nurse, and who was privy to highly sensitive and confidential information of a personal nature in relation to Patient A. The panel noted that it is crucial for healthcare professionals to recognise and address any developing feelings they may have towards a patient and to have open communication with management to ensure they maintain appropriate professional boundaries.

While Miss Hook admitted to breaching professional boundaries, she provides no information regarding the current status of her relationship with Patient A or any indication that she has addressed the concerns raised. Although Miss Hook stated that the relationship began after she left the Trust, there is NMC guidance and resources in place which the panel had found no evidence of her utilising. Furthermore, there is no evidence

of reflection on Miss Hook's part, any understanding of the perceived abuse of power or any acknowledgement of how her involvement with Patient A could impact Patient A's [PRIVATE]. Lastly, there is no evidence demonstrating improved insight, strengthened practice or recognition of the need to maintain appropriate professional boundaries with patients. The panel determined that there remains a significant risk of repetition with regard to the breach of professional boundaries identified in this case.

In respect of charges concerning medication administration and clinical errors, the panel considered Miss Hook's response bundle which states *"…I would like to say I am receiving great support from my current agency. No complaints, medication errors has been made and the nurses I have been working with have made me feel confident and competent therefore my practice has improved because of this but also because I have learnt from my mistakes and am much more experience as a nurse now. These errors were made when I was newly qualified, and I didn't feel I received the right guidance and support although I do take full responsibility of the medication errors which have been documented. I believe my practice has improved due to experience, the right support and* [PRIVATE].*"*

Miss Hook has provided no information as to any attempts at remediating her practice, any current relevant training she has undertaken, or any current references from previous or current employers. Aside from the limited levels of insight demonstrated in her response bundle from June 2022, the panel also has no information as to Miss Hook's current level of insight into her misconduct. The panel also had no evidence before it to suggest that since Miss Hook left the Trust and agency work in the Care Home, she had worked in a safe and effective capacity as a nurse, and that she had been able to successfully perform tasks in those areas where her skills were said to be lacking.

There is no evidence presented to it to suggest that Miss Hook had taken steps to strengthen her practice or address the issues since the incidents occurred. The panel therefore determined that there remained a high risk of repetition and that a finding of impairment was necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and wellbeing of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession. The panel considered that confidence in the profession would be undermined if a finding of impairment was not made in this case. The panel therefore determined that a finding of impairment was also necessary on public interest grounds, in order to maintain confidence in the nursing profession, and in order to declare and uphold proper standards of conduct and performance.

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

Submissions on sanction

Ms Millar submitted that the appropriate sanction in this case is a striking-off order, referring the panel to the relevant NMC guidance. She highlighted the aggravating factors which are as follows: breach of professional boundaries; multiple basic and fundamental errors; and limited meaningful insight demonstrated by Miss Hook. Ms Millar further highlighted the mitigating factors: Miss Hook has provided some insight in respect of medication management and record keeping errors; she was a recently qualified nurse at the time the issues arose and that her lack of experience could have been a contributing factor to the medication administration and clinical errors in this case; and that Miss Hook had made some admissions and accepted that she had a relationship with Patient A.

Ms Millar submitted that taking no further action or imposing a caution order would be wholly inappropriate given the identified risk to the public acknowledged by the panel. Furthermore, Ms Millar submitted that a conditions of practice order would not be suitable for this case, particularly due to the breach of professional boundaries involved. She emphasised that this is not a situation where implementing conditions can effectively address the evident attitudinal concerns. Moreover, even in the context of medication errors, Miss Hook has not demonstrated a willingness to strengthen her practice.

Ms Millar submitted that Miss Hook's misconduct is not an isolated incident and that there is clear evidence of attitudinal issues. Additionally, she submitted that there is no evidence regarding the current status of her relationship with Patient A. While there are indications of some level of insight, there is a lack of insight specifically related to Miss Hook's breach of professional boundaries. Regarding the medication errors, Ms Millar told the panel that Miss Hook asserts having a positive relationship with her current employer and no further medication administration or clinical errors, but she has not provided any supporting evidence.

Ms Millar submitted that a striking off order is the appropriate course of action in this case. She submitted that a relationship with a vulnerable patient, which violates professional guidance, combined with the serious medication errors, significantly deviates from the standards expected of a registered nurse. Ms Millar submitted that considering the overall misconduct in this case, Miss Hook's behaviour is fundamentally incompatible with remaining on the register.

In response to panel questions, Ms Millar informed the panel that Miss Hook is subject to an interim conditions of practice order since 31 August 2022 and that the NMC are unaware of her current employment status.

Decision and reasons on sanction

Having found Miss Hook'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:

- Breach of professional boundaries with a vulnerable patient, having been the patient's named nurse, in a mental health setting.
- Abuse of power when in a position of trust.
- Underlying attitudinal concerns by blaming colleagues and her employer and challenging those who tried to provide guidance.
- Lack of meaningful insight presented by Miss Hook to demonstrate the full extent of her breach of professional boundaries.
- Protracted period of time when the breach of boundaries and potentially serious medication administration and clinical errors occurred.
- Conduct which put patients at risk of suffering serious harm.
- Actual harm through additional distress to Patient F.

The panel also took into account the following mitigating features:

- Miss Hook made some admissions in her response bundle.
- At the time when medication administration and clinical errors arose, Miss Hook was a recently qualified nurse with relatively limited experience. The panel also heard evidence highlighting a substantial turnover of staff, including senior staff around the beginning of the COVID pandemic.
- [PRIVATE]

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness and nature of the case. Furthermore, having found that there is a real risk of repetition of the misconduct and Miss Hook's fitness to practise is currently impaired on public interest grounds, the panel determined that an order that does not restrict her practice would place patients and the public at a risk of serious harm. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Hook's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Hook'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 Miss Hook's registration would be a sufficient and appropriate response. The panel determined that whilst some of the charges found proved are clinical in nature, and could potentially be addressed through retraining, the breach of professional boundaries is obviously much more difficult to remediate. Indeed, so far as the panel is aware, the breach of professional boundaries is continuing. Miss Hook's lack of insight and attitudinal concerns mean that there are no practical or workable conditions that could be formulated. It also determined that formulating appropriate conditions to address the breach of professional boundaries in this case would be unfeasible. As identified previously, Miss Hook has not meaningfully reflected on her misconduct or addressed her failings. The panel therefore found that a conditions of practice order would not adequately protect the public or satisfy the public interest in this case.

The panel then went on to consider whether a suspension order would be an appropriate 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 the misconduct did not arise during an isolated incident. The evidence before the panel suggests that Miss Hook has had a personal relationship with Patient A over a significant period of time. The medication and clinical errors also occurred on multiple occasions over a significant period. The panel also found that although wide-ranging, attitudinal concerns were a common thread and inextricably intertwined with the charges found proved which largely relate to Miss Hook's behaviour towards others, primarily patients and colleagues. The panel determined that in refusing to put concerns right, contravening policy and procedure and her treatment of patients and colleagues, there is clear evidence that Miss Hook has a deep-seated attitudinal problem. The panel also noted that Miss Hook has not provided any assurance that she will not continue to breach professional boundaries, and there is no indication that she will now adhere to the policy and guidance pertaining to safeguarding. The panel therefore decided that there is no convincing evidence to suggest that Miss Hook has learned from her actions or that she will not repeat this conduct in the future.

The panel acknowledged that, although a suspension order would protect the public for a period of time, it would not be sufficient enough to mark the seriousness of the case, nor would it be in the public interest.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Hook's actions is fundamentally incompatible with Miss Hook remaining on the register. The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in considering 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?*

Miss Hook'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 case demonstrate that Miss Hook'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.

Given its findings in respect of Miss Hook having a deep-seated attitudinal issue and her failure to demonstrate the requisite insight into the breach of professional boundaries while working as a mental health nurse, the panel determined that there is a real risk of repetition of the misconduct and a consequent risk of serious harm to patients. The panel determined that a striking off order is therefore the only sanction sufficient to protect patients and the public. Having regard to the effect of Miss Hook'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.

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.

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

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Hook's own interests until the striking-off order 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 Millar. She invited the panel to impose an interim suspension order for eighteen months on the basis that it is necessary for the protection of the public and otherwise in the public interest. This would be to ensure that an interim suspension order remains in place in the event that Miss Hook lodges an appeal and remains in place until any such appeal has been determined.

Decision and reasons on interim order

The panel was satisfied that an interim suspension 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. To do otherwise would be incompatible with its earlier findings.

The period of this order is for eighteen months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.

This will be confirmed to Miss Hook in writing.