Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 27 November – Tuesday 5 December 2023

Virtual Hearing

Name of registrant:	**Carol Anne Trow**
NMC PIN:	73J1482E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 21 April 2001 Registered Nurse – Sub Part 2 Adult Nursing – 25 April 1977
Relevant location:	South Gloucestershire
Type of case:	Misconduct
Panel members:	Caroline Rollitt (Chair, Lay member) Melanie Lumbers (Registrant member) Barry Greene (Lay member)
Legal Assessor:	John Donnelly
Hearing Coordinator:	Sherica Dosunmu
Nursing and Midwifery Council:	Represented by Omar Sabbagh, Case Presenter
Ms Trow:	Not present and unrepresented
Facts proved:	All
Facts not proved:	N/A
Fitness to practise:	**Impaired**
Sanction:	**Striking-Off Order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Trow was not in attendance and that the Notice of Hearing letter had been sent to Ms Trow's registered email address on 5 October 2023.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and means of joining the virtual hearing and, amongst other things, information about Ms Trow's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Sabbagh, 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.

In the light of all of the information available, the panel was satisfied that Ms Trow 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 Ms Trow

The panel next considered whether it should proceed in the absence of Ms Trow. It had regard to Rule 21 and heard the submissions of Mr Sabbagh who invited the panel to continue in the absence of Ms Trow.

Mr Sabbagh referred the panel to correspondence from Ms Trow and the NMC, between January to November 2023. He informed the panel that on two separate occasions in January 2023, Ms Trow responded to NMC communication about her fitness to practise hearing and indicated that she has no intention to engage with the NMC any further. He

stated that the NMC has since made various efforts to contact Ms Trow, but she has not responded to any further communication.

Mr Sabbagh submitted that it is clear that Ms Trow had voluntarily absented herself. He submitted that there has been no application for an adjournment and, as a consequence, there was no reason to believe that an adjournment would secure Ms Trow's attendance on some future occasion. He reminded the panel that there are six witnesses lined up to give evidence at this hearing who will be impacted by an adjournment.

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

- No application for an adjournment has been made by Ms Trow;
- Ms Trow has not engaged with the NMC since January 2023, and has not responded to any further communication from the NMC in relation to this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Some of the charges date back to 2018;
- Six witnesses are due to give live evidence;

- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Trow in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she will not be able to challenge the evidence relied upon by the NMC 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 Ms Trow's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

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

During Colleague 2's oral evidence it became apparent that proper exploration of Ms Trow's case involved some matters relating to [PRIVATE]. The panel of its own volition considered whether it would be appropriate to hold parts of the hearing in private pursuant to Rule 19.

Mr Sabbagh indicated that he had no objections to this.

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 Ms Trow's [PRIVATE], the panel determined to hold such parts of the hearing in private.

Decision and reasons on application to read witness statement from Colleague 1 & Colleague 6

On 28 November 2023, the panel heard an application made by Mr Sabbagh to have the witness statements of Colleague 1 and Colleague 6 read, and for these two witnesses not to be called for oral evidence. He submitted that Colleague 1 and Colleague 6 do not provide key evidence central to the allegations. In particular, he highlighted that Colleague 1 provides a very short statement in which she explains that she does not recall much of her interactions with Ms Trow.

Mr Sabbagh submitted that as a result, Colleague 1 and Colleague 6's oral evidence would not take the case any further. He stated that it would assist more efficient case management to have their statements read, but these witnesses are available and can be called for oral evidence if the panel deemed it appropriate to do so.

The panel accepted the advice of the legal assessor.

The panel granted this application on the basis that Ms Trow was sent the witness statements of Colleague 1 and Colleague 6, and she has not put forward any challenge to their evidence. Additionally, the panel decided that it had no ancillary questions to ask Colleague 1 or Colleague 6. In light of this, the panel was satisfied that no injustice or unfairness would be caused by having the witness statements of Colleague 1 and Colleague 6 read during these proceedings.

Details of charge

That you a registered nurse:

1. On 29 October 2018 whilst on a home visit, failed to conduct clinical observations on Patient B, in that you did not;
   (a) Check their temperature. **[PROVED]**
   (b) Check their heart rate. **[PROVED]**
   (c) Check their blood pressure. **[PROVED]**
   (d) Check their rate of respiration. **[PROVED]**
   (e) Check their oxygen saturation level. **[PROVED]**
   (f) Calculate their NEWS score. **[PROVED]**
   (g) Complete their pain score. **[PROVED]**
   (h) [PRIVATE]. **[PROVED]**

2. On 29 October 2018 whilst on a home visit failed to ensure that Patient B;
   (a) Drank some fluid. **[PROVED]**
   (b) [PRIVATE]. **[PROVED]**

3. On or around 3 November 2018 made an incorrect entry in Patient B's notes declaring that Patient B had, *"refused to have her observations taken at the time"*. **[PROVED]**

4. Your actions in charge 3 were dishonest in that;
   (a) You wanted others to believe that Patient B had refused to have their clinical observations taken when you knew that they had not. **[PROVED]**
   (b) You were attempting to conceal your failure to carry out clinical observations on Patient B. **[PROVED]**

5. On 12 December 2018, having assessed Patient C as having a NEWS score of 3 and [PRIVATE], failed to;
   (a) [PRIVATE]. **[PROVED]**

(b) [PRIVATE]. **[PROVED]**

(c) [PRIVATE]. **[PROVED]**

(d) [PRIVATE]. **[PROVED]**

(e) [PRIVATE]. **[PROVED]**

6. On 12 December 2018 failed to escalate Patient C's [PRIVATE] by incorrectly declaring to Colleague 1 that *"all the other observations were within normal parameters"* or words to that effect. **[PROVED]**

7. On 12 July 2019 in relation to Patient D failed to;
   (a) Complete a full capacity assessment of Patient D. **[PROVED]**
   (b) Contact the paramedics to transfer Patient D to hospital following identification of red flag symptoms. **[PROVED]**
   (c) Inform Patient D of the consequences if they did not immediately go to hospital. **[PROVED]**
   (d) Document clearly within Patient D's notes what was said to the GP regarding Patient D's condition. **[PROVED]**

8. In relation to Patient A on 2 January 2020;
   (a) Whilst at Patient A's address, failed to identify that they had a NEWS score 6. **[PROVED]**
   (b) [PRIVATE]. **[PROVED]**
   (c) Having realised that you could not access Patient A's electronic notes at their address, failed to document Patient A's observations using the paper NEWS chart. **[PROVED]**
   (d) Upon leaving Patient A's address, incorrectly declared to Colleague 5 that Patient A was, *'NEWS 0'* or words to that effect. **[PROVED]**
   (e) When Colleague 2 enquired about Patient A, you incorrectly declared that *'there were no concerns with Patient A'* or words to that effect. **[PROVED]**

(f) Having completed Patient A's electronic notes, failed to identify that a failure to obtain Patient A's oxygen saturation levels should result in a NEWS score 3. **[PROVED]**

(g) Having recorded a NEWS score 3 in Patient A's electronic notes, failed to complete [PRIVATE]. **[PROVED]**

9. On 2 January 2020;

(a) Failed to follow Colleague 3's instructions to escalate Patient A. **[PROVED]**

(b) Failed to escalate Patient A to Colleague 2. **[PROVED]**

And in light of the above your fitness to practise is impaired by reason of your misconduct

Background

The NMC received a referral from Sirona Care and Health CIC (Sirona) regarding Ms Trow's fitness to practice on 17 July 2020. At the time of the referral, Ms Trow was working within Sirona's Rapid Response Team (Rapid Response) as a Band 5 Registered Nurse. Ms Trow started working with Rapid Response in February 2018, working different roles within this service.

Rapid Response is a team responsible for visiting patients in the community with an aim on reducing hospital admissions. [PRIVATE].

On 29 October 2018, Ms Trow was called to assess Patient B [PRIVATE]. The referral alleges that during this visit Ms Trow failed to conduct clinical observations on the patient. Ms Trow made an entry on the electronic patient notes system (EMIS) on 29 October 2018. It is alleged that this entry on EMIS did not contain adequate notes of the following:

- Patient B's temperature.
- Patient B's heart rate.
- Patient B's blood pressure.

- Patient B's rate of respiration.
- Patient B's oxygen saturation level.
- Patient B's NEWS score.
- Patient B's pain score.
- [PRIVATE].
- Whether Patient B had been encouraged to drink fluids.
- [PRIVATE].

Ms Trow later amended the original entry on EMIS, on 3 November 2018. It is alleged that she amended this entry to state that Patient B had *'refused to have her observations taken at the time'*.

On 12 December 2018, Ms Trow was sent to assess Patient C [PRIVATE]. Ms Trow later completed handover to the incoming early day shift staff when concerns were raised regarding Ms Trow's clinical assessment and documentation. Ms Trow documented that [PRIVATE] which triggered a National Early Warning Score (NEWS) score of '*3*', however, allegedly indicated that there were no concerns with the patient and '*all the other observations were within normal parameters*.' It is alleged that Ms Trow failed to complete the following:

- [PRIVATE].
- [PRIVATE].
- [PRIVATE].
- [PRIVATE].
- [PRIVATE].
- Escalation to Colleague 1.

It is alleged that Ms Trow's documentation on this occasion did not reflect an appropriate assessment following the patient's symptoms.

On 12 July 2019, Ms Trow went to assess Patient D, who had an extremely elevated NEWS score and '*red flag'* symptoms [PRIVATE]. Ms Trow contacted Colleague 7 (a senior colleague) for advice, who advised her to arrange an immediate transfer to hospital for emergency treatment and that if Patient D did not want to go to hospital for emergency treatment, then a full capacity assessment needed to be completed and documented. Ms Trow instead contacted an out of hours General Practitioner (GP). It is alleged that Ms Trow's documentation for this visit failed to show the following:

- Whether a full capacity assessment of Patient D was completed.
- Whether she contacted the paramedics to transfer Patient D to hospital after identification of '*red flag'* symptoms.
- Whether she informed Patient D of the consequences if they did not immediately go to hospital.
- Clear documentation within Patient D's notes of what was said to the GP regarding Patient D's condition.

Due to these incidents, Ms Trow was placed on a stage one action plan on 30 July 2019.

On 2 January 2020, following a referral received about Patient A having an unwitnessed fall, Ms Trow went with Colleague 5, a Healthcare Assistant (HCA), to assess the patient. [PRIVATE]. Additionally, it is alleged that Ms Trow failed to calculate the correct NEWS score for Patient A at the time, therefore failing to escalate the patient [PRIVATE].

Patient A reportedly did not have internet connection within their home and electronic documentation could not be accessed or completed during the visit. However, Ms Trow had access to paper documentation including a paper copy of the NEWS scoring system, and it is alleged that she failed to document Patient A's observations despite being able to do so with paper documentation.

After the visit, Ms Trow later verbally handed over Patient A to Colleague 3, Senior Nurse, and allegedly declared that '*there were no concerns'* or used words to that effect. Ms Trow

then completed Patient A's notes and recorded Patient A's NEWS score as '*3*'. As a result of the score, Colleague 3 informed Ms Trow that the patient would need to be escalated to Colleague 2, the Community Matron, so that Patient A could be allocated an urgent visit. It is alleged that Ms Trow failed to follow Colleague 3's instruction and went home without escalating to Colleague 2.

Colleague 3 later spoke to Colleague 2 who then allocated Patient A to Colleague 6 (a Paramedic). [PRIVATE].

Following this incident, Ms Trow was transferred to day shifts so that she could be supervised easier and have her action plan monitored.

In February 2020, Ms Trow went on sick leave for a period of time.

A disciplinary hearing subsequently took place in July 2020, and Ms Trow was issued with a final written warning and transferred to Sirona's Urgent Care Centre to work on her action plan. Ms Trow's action plan was never completed as she retired in August 2020.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Sabbagh on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Ms Trow.

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:

- Colleague 2: Band 7 Community Matron at Sirona;
- Colleague 3: Band 6 Senior Nurse at Sirona;
- Colleague 4: Assistant Locality Manager (and Registered Nurse) at Sirona;
- Colleague 5: Band 3 Healthcare Assistant at Sirona;
- Colleague 7: Band 6 Night Sister at Sirona.

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

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

Charge 1

1. On 29 October 2018 whilst on a home visit, failed to conduct clinical observations on Patient B, in that you did not;
   (a) Check their temperature.
   (b) Check their heart rate.
   (c) Check their blood pressure.
   (d) Check their rate of respiration.
   (e) Check their oxygen saturation level.
   (f) Calculate their NEWS score.

(g) Complete their pain score.
(h) [PRIVATE].

This charge is found proved in its entirety.

In reaching this decision, the panel reminded itself that where a charge alleges a failure, the NMC must prove that there was a duty on the registrant to carry out the actions alleged in the charge. It also had regard to the documentary evidence exhibited, which included Patient B's notes dated 29 October 2018 and an email from Colleague 2 to Ms Trow dated 29 October 2018.

The panel noted the following evidence from Colleague 5's witness statement:

> *'Taking observations is very important when completing visits within the community as it is the foundation of the National Early Warning Score (NEWS) system, which all members of staff, including the HCA's, are trained on. Observations measure a patient's vital signs and return a NEWS score depending on the measurement.'*

The panel found that Colleague 5's account was corroborated by all other witnesses from Sirona, who reflected on their knowledge of the procedures in place for home visits and explained in detail the clinical observations expected at the time. On this basis, the panel was satisfied that it was within Ms Trow's responsibilities to conduct the clinical observations set out in charge 1(a)-(h) during her visit to Patient B on 29 October 2018.

The panel had regard to Patient B's contemporaneous notes recorded on 29 October 2018 on EMIS. It found no documented evidence that Ms Trow conducted the clinical observations set out in charge 1(a)-(h). It noted that this was supported by an email sent by Colleague 2 to Ms Trow on 29 October 2018, in which Colleague 2 highlighted concerns that the clinical observations were omitted from Patient B's notes.

Ms Trow later made an amendment to the 29 October 2018 entry. Having seen both the original and amended entry made by Ms Trow during a review, Colleague 2 identified in her evidence that Ms Trow's amendment added to Patient B's notes that the patient refused to have observations taken. The panel noted that the printed audit trail indicated that this amendment was made retrospectively on 3 November 2018. It was of the view that the amendment made on 3 November 2018 was in response to Colleague 2's email sent to Ms Trow, and concluded that the original entry on 29 October 2018, provided compelling evidence that the clinical observations were not completed at the time with no documented reasons for this omission.

Therefore, the panel determined that, on the balance of probabilities, Ms Trow failed to conduct the clinical observations for Patient B set out in charge 1(a)-(h) on 29 October 2018.

Accordingly, the panel found charge 1 proved in its entirety.

Charge 2

2. On 29 October 2018 whilst on a home visit failed to ensure that Patient B;
   (a) Drank some fluid.
   (b) [PRIVATE].

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague 2. It also had regard to the documentary evidence exhibited.

The panel noted the following evidence from Colleague 2's witness statement:

> *'On 29 October 2018, I sent an email to the Registrant (in which number of senior staff, including* [Colleague 1], *were copied) about a concern* [PRIVATE] *in relation to Patient*

B. I attach a copy of the email that I sent as Exhibit PA5. As set out at Exhibit PA 5, I was made aware from reading the patient's EMIS notes (as I had been called earlier that morning by a carer to say that there was [PRIVATE] *on 29 October 2018 at 01:32. A copy of Patient B's notes are attached as Exhibit PA6. The Registrant's documentation in relation to her visit to this patient was insufficient (which appear as an entry at 01:32 on 29 October 2018 at Exhibit PA6) in that there was no record of… whether the patient was encouraged to drink fluids* [PRIVATE]*.'*

The panel considered that Colleague 2's written witness statement was consistent with her oral evidence, in which she maintained the importance of ascertaining [PRIVATE], and that the practise would be to ensure that the patient drank a small amount of water [PRIVATE]. The panel was of the view that Colleague 2 provided a very detailed account of the processes in place at the time, which it regarded as compelling. The panel accepted Colleague 2's evidence and was therefore satisfied that it was Ms Trow's responsibility to ensure that Patient B drank fluid and to monitor [PRIVATE].

The panel had regard to Patient B's contemporaneous notes recorded on 29 October 2018. It found no documented evidence that Ms Trow ensured that Patient B drank fluid or [PRIVATE], with EMIS stating that '*advised that she needs to drink more…*'. This was supported by an email sent by Colleague 2 to Ms Trow in relation to the visit on 29 October 2018, in which she stated:

'…You mention [PRIVATE] *encouraging fluid to be drunk but you have not detailed whether or not you helped her drink* [PRIVATE]. *The safe practise would be to drink a small amount whilst with the patient to see if* [PRIVATE].*'*

The panel therefore determined that, on the balance of probabilities, Ms Trow failed to ensure that Patient B drank fluid or [PRIVATE] on 29 October 2018.

Accordingly, the panel found charge 2 proved in its entirety.

Charge 3

3. On or around 3 November 2018 made an incorrect entry in Patient B's notes declaring that Patient B had, *"refused to have her observations taken at the time"*.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 2. It also had regard to the documentary evidence exhibited.

The panel noted the following evidence from Colleague 2's witness statement:

> *'Having seen the audit trail for the patient's EMIS notes, a copy of which is attached as Exhibit PA7, I can see that the Registrant initially made the entry at 01:42:38 on 29 October 2018, where the following was added…*
>
> *The final entry, as it appears, includes an additional comment under number 6 "refused to have her observations taken at the time" which was not included when the entry was initially added by the Registrant at 01:42:38 on 29 October 2018. This edit adds that the patient declined to have observations taken. This was omitted in the original entry and it is therefore uncertain whether this is accurate and whether the patient was actually asked. The audit trail of the patient's notes does not directly reference this additional comment being subsequently added. However, the audit trail indicates that a further edit was made to the entry at 00:18:09 on 3 November 2018 by the Registrant (in her username), although it does not indicate what edit was made.'*

The panel considered that Colleague 2's written witness statement was consistent with her oral evidence, in which she maintained that Ms Trow's initial 29 October 2018 entry did not include the comment that Patient B refused to have observations taken and this was added after an amendment on 3 November 2018. The panel was of the view that

Colleague 2 provided a very detailed account of her review of Patient B's notes having witnessed the entry before and after the amendment, which it regarded as compelling. Therefore, the panel accepted Colleague 2's evidence that, Ms Trow retrospectively added on 3 November 2018 that Patient B refused to have observations taken.

The panel noted that Ms Trow's amendment took place after an email was sent to her by Colleague 2 on 29 October 2018, which highlighted the clinical observations omitted from the Patient B's notes. It determined that following this scrutiny, Ms Trow's amendment was in response to Colleague 2's email and influenced by a desire to mitigate consequences for her omissions.

The panel concluded that that on the balance of probabilities, the entry made in Patient B's notes on 3 November 2018 declaring that the patient had, *"refused to have her observations taken at the time"*, was an incorrect entry.

Accordingly, the panel found charge 3 proved.

Charge 4

4. Your actions in charge 3 were dishonest in that;
   (a) You wanted others to believe that Patient B had refused to have their clinical observations taken when you knew that they had not.
   (b) You were attempting to conceal your failure to carry out clinical observations on Patient B.

This charge is found proved in its entirety.

In reaching this decision, the panel bore in mind its findings for charge 3, that Ms Trow incorrectly entered the entry on 3 November 2018 in response to scrutiny from Colleague 2. It considered that Ms Trow provided no other response following Colleague 2's email on

29 October 2018, despite being asked to respond to acknowledge safe practise and documentation.

The panel noted that in oral evidence, Colleague 2 indicated that if retrospective entries are made on EMIS, the expectation was that it would be identified as such in the notes. It found that Ms Trow made no such identification following her amendment and therefore would have been aware that this would lead others to think Patient B refused clinical observations on 29 October 2018, when this was incorrect.

Having regard to the evidence and circumstances in context, including its reasoning in charge 3, the panel determined that Ms Trow entered this incorrect entry five days later to conceal her clinical observation omissions.

When considering the propensity and credibility of the evidence in this charge, the panel bore in mind that Ms Trow practised with an unblemished career for a number of years. However, in these circumstances, it determined to place little weight on Ms Trow's previous good character.

The panel concluded that, by the standards of ordinary and decent people, Ms Trow was dishonest when she amended her entry to lead others to believe Patient B refused clinical observations in an attempt to conceal her omissions.

Accordingly, the panel finds charge 4 proved in its entirety.

Charge 5

5. On 12 December 2018, having assessed Patient C as having a NEWS score of 3 and [PRIVATE], failed to;
   (a) [PRIVATE].
   (b) [PRIVATE].
   (c) [PRIVATE].

(d) [PRIVATE].
(e) [PRIVATE].

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague 2, Colleague 3 and Colleague 5. It also had regard to the documentary evidence exhibited, which included Patient C's notes dated 12 December 2018, an email from Colleague 1 dated 12 December 2018 and Sirona's Deteriorating Patient Policy.

The panel noted the following evidence from Colleague 2's witness statement:

> *'On 12 December 2018, I sent an email to* [Colleague 1] *raising concerns about the Registrant's clinical assessment skills and documentation. I attach a copy of this email as Exhibit PA8. As set out at Exhibit PA8, this concern was brought to my attention during the morning handover from the night shift team to the early day shift team on 12 December 2018. During this handover, the Registrant said that she had seen a patient (Patient C) with* [PRIVATE].
>
> [PRIVATE], *which she was expected to do in this circumstance. Moreover, in* [Colleague 1's] *email response to me (Exhibit PA8), she confirmed that the Registrant did not inform her about* [PRIVATE] *when the Registrant escalated to her and in fact said that all other observations were "within normal parameters". The Registrant therefore failed to escalate to her as appropriate due to not raising this symptom with the matron,* [Colleague 1].
>
> *Patient C's notes, as documented by the Registrant during her visit, did not reflect an appropriate assessment following the patient's symptoms which resulted in the NEWS of 3* [PRIVATE]. *A copy of Patient C's notes are attached as Exhibit PA9 and the entry made by the Registrant appears at 03:12.'*

The panel found that Colleague 2's account was corroborated by Colleague 3 and Colleague 5, who both explained that a NEWS score of '*3*' prompts a [PRIVATE]. This was also consistent with Sirona's Deteriorating Patient Policy, which stated the following:

'[PRIVATE]

- [PRIVATE]
- *Triggers on NEWS*
- *NEWS of 3 or more*
- [PRIVATE]
- [PRIVATE]
- *When concerned'*

On this basis, the panel was satisfied that it was Ms Trow's duty to conduct a [PRIVATE] and a review of Patient C's symptoms as set out in charge 5(a)-(e) during her visit on 12 December 2018.

In her oral evidence Colleague 2 went through Patient C's notes recorded on 12 December 2018 and explained how it did not reflect an appropriate assessment for a patient with elevated NEWS score, as the notes did not include the assessments set out in charge 5(a)-(e). The panel had regard to Patient B's contemporaneous notes and found that this was consistent with Colleague 2's evidence. This was further supported by an email sent to Colleague 2 from Colleague 1 on 12 December 2018 in relation to the visit, in which the following is stated:

> *'…He had a NEWS score of 3 and* [PRIVATE] *should have prompted* [PRIVATE] *and a review of systems to ascertain* [PRIVATE] *or even to rule it out'.*

The panel concluded that there was clear, consistent evidence which indicated that Ms Trow ought to have completed the assessments set out in charge 5(a)-(e) but failed to do so during her visit to Patient C on 12 December 2018.

Accordingly, the panel found charge 5 proved in its entirety.

Charge 6

6. On 12 December 2018 failed to escalate Patient C's [PRIVATE] by incorrectly declaring to Colleague 1 that *"all the other observations were within normal parameters"* or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 2. It also had regard to the documentary evidence exhibited, which included an email from Colleague 1 dated 12 December 2018 and Sirona's Deteriorating Patient Policy.

The panel noted the following evidence from Colleague 2's witness statement:

> *'*[PRIVATE]*, which she was expected to do in this circumstance. Moreover, in* [Colleague 1's] *email response to me (Exhibit PA8), she confirmed that the Registrant did not inform her about* [PRIVATE] *when the Registrant escalated to her and in fact said that all other observations were "within normal parameters". The Registrant therefore failed to escalate to her as appropriate due to not raising this symptom with the matron,* [Colleague 1].'

The panel considered that Colleague 2's written witness statement was consistent with her oral evidence, in which she maintained that concerns were raised to her about Ms Trow's handover, as she did not escalate Patient C's [PRIVATE] where she was expected to do so. It also considered that this evidence was consistent with Sirona's Deteriorating Patient Policy, which indicated that this was an action Ms Trow would be expected to take given the patient's [PRIVATE] NEWS scoring 3. The panel accepted Colleague 2's evidence and was therefore satisfied that it was Ms Trow's duty to escalate Patient C's [PRIVATE].

The panel noted that Colleague 2 was also consistent in her evidence that Ms Trow did not provide full information about Patient C's deteriorating condition to Colleague 1, and in fact described all of Patient C's symptoms other than [PRIVATE] as being '*within normal parameters'*. It noted that Colleague 2's evidence was further supported by an email sent to her from Colleague 1 on 12 December 2018, in which Colleague 1 stated that she was told that Patient C was '*fine and there were no worries about him'*.

The panel concluded that there was clear, consistent evidence which indicated that Ms Trow failed to adequately escalate Patient C's [PRIVATE] by incorrectly declaring to Colleague 1 that all the patient's other observations were fine.

Accordingly, the panel found charge 6 proved.

Charge 7

7. On 12 July 2019 in relation to Patient D failed to;
   (a) Complete a full capacity assessment of Patient D.
   (b) Contact the paramedics to transfer Patient D to hospital following identification of red flag symptoms.
   (c) Inform Patient D of the consequences if they did not immediately go to hospital.
   (d) Document clearly within Patient D's notes what was said to the GP regarding Patient D's condition.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague 2 and Colleague 7. It also had regard to the documentary evidence exhibited, which included Patient D's notes dated 12 July 2019 and a record of two telephone calls between Colleague 7 and Ms Trow on 12 July 2019.

The panel noted the following evidence from Colleague 7's witness statement:

‘On 12 July 2019, I was contacted by the Registrant during a visit in regards to a patient (Patient D) with NEWS 8 (“NEWS” being the system used to measure a patient’s vital signs when observations are taken). I attached as Exhibit AW5 a record of the two phone calls that I received from the Registrant at 00:10 and 01:30. The Registrant said that during the first telephone call (00:10) the patient had returned NEWS 8 and has declined to go to hospital. During the second telephone call (01:30), the Registrant said that she escalated to the out of hours GP, as Patient D said that he would be willing to go to [PRIVATE]*, who advised to repeat observations every four hours and that the hospital admission was not needed at that point. I advised the Registrant to immediately contact the paramedics as Patient D* [PRIVATE]*, had returned NEWS 8 and had a red flag* [PRIVATE] *(which requires hospital admission).’*

The panel found that Colleague 7’s account was corroborated by Colleague 3, in which she recounts her knowledge of the telephone conversations between Colleague 7 and Ms Trow:

‘… [Colleague 7] *said to the Registrant that she needed to contact 999 and that, if the patient did not want to go to the hospital, a full capacity assessment needed to be completed and the consequences of not receiving urgent treatment for potential sepsis (ie, if not seen within an hour, increased probability of death* [PRIVATE]*) needed to be explained to the patient. This is also needed to be clearly evidenced in the patient’s notes.*

[…]

The Registrant contacted [Colleague 7] *again to inform her that she had escalated to an out-of-hours GP as the patient would be able to arrange this, however, the GP only advised that observations needed to be made every four hours.* [Colleague 7] *advised the Registrant to call the paramedics immediately as Patient D* [PRIVATE]

had NEWS 8 and a red flag for sepsis. [Colleague 7] *made a note of these two telephone calls in the patient's notes, a copy of which is attached as Exhibit PA12. […]*

An entry appears for […] (an out-of-hours GP) at 05:18 documenting that observations needed to be rechecked every 4 hours but it is not clear from the patient notes what was said by the Registrant to the GP about the patient's condition…'

On this basis, the panel was satisfied that Ms Trow was aware of her responsibility to undertake the actions set out in charge 7(a)-(d).

In her evidence Colleague 2 asserted that having reviewed Ms Trow's notes for Patient D, documented on 12 July 2019, it was apparent that Ms Trow did not take the appropriate actions as set out in charge 7(a)-(d). The panel had regard to Patient D's contemporaneous notes of the telephone conversation between Colleague 7 and Ms Trow and found that this was consistent with Colleague 2's evidence.

The panel therefore determined that, on the balance of probabilities, Ms Trow failed to undertake to actions set out in charge 7(a)-(d) for Patient D on 12 July 2019.

Accordingly, the panel found charge 7 proved in its entirety.

Charge 8

8. In relation to Patient A on 2 January 2020;
   (a) Whilst at Patient A's address, failed to identify that they had a NEWS score 6.
   (b) [PRIVATE].
   (c) Having realised that you could not access Patient A's electronic notes at their address, failed to document Patient A's observations using the paper NEWS chart.

(d) Upon leaving Patient A's address, incorrectly declared to Colleague 5 that Patient A was, *'NEWS 0'* or words to that effect.
(e) When Colleague 2 enquired about Patient A, you incorrectly declared that *'there were no concerns with Patient A'* or words to that effect.
(f) Having completed Patient A's electronic notes, failed to identify that a failure to obtain Patient A's oxygen saturation levels should result in a NEWS score 3.
(g) Having recorded a NEWS score 3 in Patient A's electronic notes, failed to complete a sepsis screening form.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague 2, Colleague 3 and Colleague 5. It also had regard to the documentary evidence exhibited, which included Patient A's notes dated 2 January 2020, a local investigation interview with Ms Trow dated 12 February 2020 and Sirona's Deteriorating Patient Policy.

(a) Whilst at Patient A's address, failed to identify that they had a NEWS score 6.

The panel noted the following evidence from Colleague 5's witness statement:

'There was no signal or internet connection at Patient A's address and it was therefore impossible to complete any electronic documentation whilst at the address. We always leave a paper NEWS chart in a patient's home, so when the day staff return, they can compare the observations in case a patient deteriorates. As the Registrant was the registered nurse leading the visit, she was responsible for ensuring that Patient A's observations were recorded, NEWS calculated and follow-up actions completed as necessary. As we left Patient A's address, I asked the Registrant if Patient A was 'NEWSing' (scoring on NEWS, which would indicate that at least one of her vital signs fell outside of the normal parameters to some extent) and the Registrant said to me that she was NEWS 0 (that all of Patient A's

vital signs fell within the normal parameters). As the Registrant was the registered nurse leading the visit and was responsible for the patient's care (in addition to having removed the oxygen sats probe and packing the obs kit away), I deferred to her better knowledge, skill and judgement as a registered nurse.'

The panel found that Colleague 5's account was corroborated by Colleague 3, whereby Colleague 3 explained that upon return to the office Ms Trow '*did not raise any concerns'* about Patient A.

The panel found that this was also consistent with Patient A's contemporaneous notes documented by Ms Trow on 2 January 2020, in which the patient's NEWS score was not recorded at '*6*'.

Additionally, the panel had regard to a partial admission from Ms Trow in a local investigation interview on 12 February 2020:

'22.Upon return to the office, you discussed the patient with **[Colleague 3].** ***Can you recall the conversation?***
Told [Colleague 3] *I realised when I was writing up the notes it was a score of 3, my sats probe didn't register and that's when* [Colleague 3] *highlighted it was another 3 which made a NEWS score of 6.*
I had forgotten that. I gave her the information I had received at the time of the referral which turned out not to be the full background.'

The panel concluded that there was clear, consistent evidence which indicated that Ms Trow failed to identify that Patient A had a NEWS score '*6'* whilst at their address. The panel has heard evidence that a NEWS score '*6'* was the appropriate score.

Accordingly, the panel found charge 8(a) proved.

(b) [PRIVATE]**.**

The panel noted the following evidence from Colleague 5's witness statement:

> *'*[PRIVATE]*'*

The panel also noted the following evidence from Colleague 2's witness statement:

> *'A NEWS of 3 should be escalated immediately to either a senior clinician or to a GP. The action to take is clearly indicated in the NEWS sheet itself in addition to being set out in the Recognition of the Deteriorating Patient policy (Exhibit PA/3). Not only this, but the Patient's overall condition* [PRIVATE] *which is a basic nursing assessment that is familiar to all nurses (not just Rapid Response nurses) and also to GSW's.*'

The panel found that Colleague 5 and Colleague 2's depiction of Patient A's presentation at the time of Ms Trow's visit was supported by Patient A's contemporaneous notes on 2 January 2020.

The panel considered Ms Trow's subsequent actions in conjunction with the Sirona's [PRIVATE] Policy, in which it sets out that there is a requirement to check if a patient present with signs or symptoms that indicate [PRIVATE]. On this basis, the panel was satisfied that it was Ms Trow's responsibility to identify that Patient A's presentation was indicative of [PRIVATE], during her visit on 2 January 2020.

The panel noted that despite Patient A's presentation during Ms Trow's visit, Colleague 3 explained that upon return to the office Ms Trow '*did not raise any concerns'* about Patient A.

The panel therefore concluded that, on the balance of probabilities, having identified that Patient A was '[PRIVATE], it was more likely than not, that Ms Trow failed to identify that this was indicative of [PRIVATE].

Accordingly, the panel found charge 8(b) proved.

(c) Having realised that you could not access Patient A's electronic notes at their address, failed to document Patient A's observations using the paper NEWS chart.

The panel had regard to a partial admission from Ms Trow in a local investigation interview on 12 February 2020:

'***13. Do you carry paper NEWS charts with you?***
Yes I do carry them with me and no I didn't fill it out on this occasion. I could have completed one back at […] and asked someone to take it out but I didn't'

The panel noted that this was consistent with Colleague 3's evidence that Ms Trow did not record Patient A's NEWS score whilst at Patient A's home:

'On the basis that the Registrant did not report this during our initial conversation (where she said that she had no concerns and that Patient A was suitable for an afternoon visit), it appeared that she did not calculate Patient A's NEWS score until her return to the office.

The proper approach is to follow with the NEWS system to record vital signs and calculate the NEWS whilst still with the patient, which the Registrant did not do.'

The panel noted the following evidence from Colleague 5, in which she explained that the use of paper NEWS chart in the patient's home was also available to Ms Trow:

'There was no signal or internet connection at Patient A's address and it was therefore impossible to complete any electronic documentation whilst at the

address. We always leave a paper NEWS chart in a patient's home, so when the day staff return, they can compare the observations in case a patient deteriorates.'

The panel found that Colleague 5 (a more junior staff member) evidence corroborated Colleague 3's account that the proper approach was to calculate the NEWS whilst still with the patient. On this basis, the panel was satisfied that Ms Trow had an obligation to document Patient A's observations on a paper NEWS chart before leaving their home, despite not having access to the electronic system.

The panel therefore concluded that, on the balance of probabilities, Ms Trow failed to document Patient A's observations using the paper NEWS chart whilst at Patient A's address.

Accordingly, the panel found charge 8(c) proved.

(d) Upon leaving Patient A's address, incorrectly declared to Colleague 5 that Patient A was, *'NEWS 0'* or words to that effect.

The panel noted the following evidence from Colleague 5's witness statement:

'There was no signal or internet connection at Patient A's address and it was therefore impossible to complete any electronic documentation whilst at the address. We always leave a paper NEWS chart in a patient's home, so when the day staff return, they can compare the observations in case a patient deteriorates. As the Registrant was the registered nurse leading the visit, she was responsible for ensuring that Patient A's observations were recorded, NEWS calculated and follow-up actions completed as necessary. As we left Patient A's address, I asked the Registrant if Patient A was 'NEWSing' (scoring on NEWS, which would indicate that at least one of her vital signs fell outside of the normal parameters to some extent) and the Registrant said to me that she was NEWS 0 (that all of Patient A's vital signs fell within the normal parameters). As the Registrant was the registered

nurse leading the visit and was responsible for the patient's care (in addition to having removed the oxygen sats probe and packing the obs kit away), I deferred to her better knowledge, skill and judgement as a registered nurse.'

The panel considered that Colleague 5's written witness statement was consistent with her oral evidence, in which she maintained that when asked if Patient A was scoring on the NEWS chart Ms Trow said that Patient A was NEWS 0. The panel was of the view that Colleague 5 provided a very detailed account, which it regarded as compelling. Further, this was consistent with Colleague 3's evidence, in which she explained that upon return to the office Ms Trow '*did not raise any concerns'* about Patient A when asked.

The panel therefore accepted Colleague 5's evidence that, Ms Trow incorrectly declared to her that Patient A was, '*NEWS 0'*.

Accordingly, the panel found charge 8(d) proved.

(e) When Colleague 2 enquired about Patient A, you incorrectly declared that *'there were no concerns with Patient A'* or words to that effect.

The panel noted the following evidence from Colleague 2's witness statement:

'I asked the Registrant if Patient A was OK and the Registrant told me that she has undergone a mechanical fall as a result of getting her foot caught in the duvet cover and that there were no concerns with Patient A, who the Registrant said the family had described as a "drama queen" or words to that effect. As I was satisfied that there were no concerns with Patient A, there was no prompt for any urgent action.'

The panel considered that Colleague 2's written witness statement was consistent with her oral evidence, in which she recounted that no concerns were raised about Patient A following Ms Trow's return to the office. The panel was of the view that Colleague 2 provided a very detailed account, which it regarded as compelling. Further, this was

consistent with Colleague 3 evidence, in which she also explained that upon return to the office Ms Trow '*did not raise any concerns'* about Patient A.

The panel therefore accepted Colleague 2's evidence that, Ms Trow incorrectly declared that *'there were no concerns with Patient A'*.

Accordingly, the panel found charge 8(e) proved.

(f) Having completed Patient A's electronic notes, failed to identify that a failure to obtain Patient A's oxygen saturation levels should result in a NEWS score 3.

The panel noted the following evidence from Colleague 3's witness statement:

'I do not recall exactly what the Registrant said to me but she did not raise any concerns, although she was unable to get oxygen saturations reading during her vital signs observations due [PRIVATE]*, and said that Patient A was suitable for an afternoon follow-up visit. The Registrant then started to complete and upload Patient A's notes onto the electronic system.*'

Additionally, the panel had regard to a partial admission from Ms Trow in a local investigation interview on 12 February 2020:

'22.Upon return to the office, you discussed the patient with* [Colleague 3]*. Can you recall the conversation?
Told [Colleague 3] *I realised when I was writing up the notes it was a score of 3, my sats probe didn't register and that's when* [Colleague 3] *highlighted it was another 3 which made a NEWS score of 6.*
I had forgotten that. I gave her the information I had received at the time of the referral which turned out not to be the full background.'

The panel found that this was also consistent with Patient A's contemporaneous notes written upon return to the office on 2 January 2020, in which the patient's NEWS score was documented at '*3*' by Ms Trow but not *'6*' (the eventual recorded score).

The panel therefore concluded that, on the balance of probabilities, Ms Trow failed to identify that her failure to obtain Patient A's oxygen saturation levels would result in a NEWS score '*3*'.

Accordingly, the panel found charge 8(f) proved.

(g) Having recorded a NEWS score 3 in Patient A's electronic notes, failed to complete a [PRIVATE]**.**

The panel noted the following evidence from Colleague 2's witness statement:

> *'A NEWS of 3 should be escalated immediately to either a senior clinician or to a GP. The action to take is clearly indicated in the NEWS sheet itself in addition to being set out in the Recognition of the Deteriorating Patient policy (Exhibit PA/3). Not only this, but the Patient's overall condition* [PRIVATE] *which is a basic nursing assessment that is familiar to all nurses (not just Rapid Response nurses) and also to GSW's.*'

The panel also noted the following evidence from Colleague 3's witness statement:

> *'On being informed by Registrant that Patient A had a NEWS 3, I said to her that this needed to be escalated to the matron,* [Colleague 2], *and I asked the Registrant to do this. I do not remember what the Registrant said in response to this but she acknowledged what I said. The Registrant finished her shift and left about 10 minutes (approximately) after this conversation, however, it appeared that she did not speak to* [Colleague 2] *about Patient A as when I subsequently spoke to*

[Colleague 2], *within a few minutes of the Registrant leaving the office, she was not familiar with Patient A's NEWS 3.*

As above, NEWS 3 requires escalation to a matron for advice, which I reminded the Registrant to complete before she left (and was her responsibility to do so as the attending nurse who assessed Patient A), however, she did not do this and it fell to me to escalate to [Colleague 2].*'*

The panel found that Colleague 2's account was corroborated by Colleague 3 and Colleague 5, who both explained that a NEWS score of '*3*' prompts escalation. This was also consistent with Sirona's Deteriorating Patient Policy, which stated the following:

'[PRIVATE]

- *...*
- *...*
- *NEWS of 3 or more*
- *...*
- *...*
- *…'*

On this basis, the panel was satisfied that it was within Ms Trow's responsibility to conduct a sepsis screening on Patient A, due to the patient's NEWS score.

The panel concluded that there was clear, consistent evidence which indicated that Ms Trow failed to do so whilst at Patient A's address.

Accordingly, the panel found charge 8(g) proved.

Charge 9

9. On 2 January 2020;

(a) Failed to follow Colleague 3's instructions to escalate Patient A.

(b) Failed to escalate Patient A to Colleague 2.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague 2, Colleague 3, Colleague 5 and Colleague 6. It also had regard to the documentary evidence exhibited, which included a local investigation interview with Ms Trow dated 12 February 2020.

The panel noted the following evidence from Colleague 3's witness statement:

> *'On being informed by Registrant that Patient A had a NEWS 3, I said to her that this needed to be escalated to the matron,* [Colleague 2], *and I asked the Registrant to do this. I do not remember what the Registrant said in response to this but she acknowledged what I said. The Registrant finished her shift and left about 10 minutes (approximately) after this conversation, however, it appeared that she did not speak to* [Colleague 2] *about Patient A as when I subsequently spoke to* [Colleague 2], *within a few minutes of the Registrant leaving the office, she was not familiar with Patient A's NEWS 3.*
>
> *As above, NEWS 3 requires escalation to a matron for advice, which I reminded the Registrant to complete before she left (and was her responsibility to do so as the attending nurse who assessed Patient A), however, she did not do this and it fell to me to escalate to* [Colleague 2].*'*

The panel found that Colleague 3's account was corroborated by Colleague 2 and Colleague 5, who both confirmed in their evidence that a NEWS score of '*3*' requires escalation. The panel noted that this was also consistent with Sirona's [PRIVATE] Policy. On this basis, the panel was satisfied that it was Ms Trow's responsibility to escalate

Patient A's condition (as instructed by Colleague 3) due to the patient's NEWS scoring, as she was the attending nurse to this patient.

The panel noted the following evidence from Colleague 2:

> *'However, the Registrant did not escalate Patient A immediately on detecting NEWS 3 which is also apparent from Patient A's notes (Exhibit PA/2). Additionally, the Registrant also provided the false impression to me that there were no concerns with Patient A when I questioned her about it at around 07:30 on 2 January 2020, which made me think as a senior clinician that there were no issues with Patient A (NEWS 0) which required immediate attention.'*

The panel found Colleague 2's evidence was consistent with Colleague 3, which indicated that Ms Trow did not escalate Patient A's condition to Colleague 2 as instructed.

The panel took into account Ms Trow's response at the local investigation interview dated 12 February 2020:

> *'**26. Do you recall* [Colleague 3] *asking you to escalate the patient to* [Colleague 2]*?***
> *Yes, I informed* [Colleague 2] *and she said that was fine, I recall* [Colleague 2] *saying she would catch up with* [Colleague 3] *in a minute.'*

However, the panel noted that Ms Trow's response was not consistent with the evidence from Colleague 2, Colleague 3 and Colleague 6. The evidence of Colleague 2, Colleague 3 and Colleague 6 all stated that as soon as Patient A was escalated by Colleague 3 to Colleague 2, Colleague 2 immediately allocated Colleague 6 to conduct an urgent home visit.

The panel therefore determined that, on the balance of probabilities, Ms Trow failed to follow Colleague 3's instruction by failing to escalate Patient A to Collleague 2.

Accordingly, the panel found charge 9 proved in its entirety.

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 Ms Trow'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, Ms Trow's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Sabbagh 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.'* He also referred to the case of *Aremu v Health and Care Professions Council* [2018] EWHC 978 (Admin).

Mr Sabbagh invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code). He identified the specific, relevant standards where he submitted that Ms Trow's actions amounted to misconduct.

Mr Sabbagh submitted that, through repetition of the various failures found proved in this case, Ms Trow has demonstrated a complete disregard for the regulations and policies designed to protect the safety of vulnerable patients.

Mr Sabbagh submitted that the charges proven include various occasions where Ms Trow failed to carry out NEWS checks, systems reviews, [PRIVATE] and other key checks/assessments. He submitted that such checks would have been standard procedure and are crucial to the early identification of potential problems and health concerns for vulnerable patients.

Mr Sabbagh submitted that the charges proven also include various occasions where Ms Trow failed to carry out a [PRIVATE]. He stated that these failures took place in circumstances where the patient would be making a decision that may be adverse to [PRIVATE].

Mr Sabbagh submitted that there were also instances of Ms Trow failing to escalate matters appropriately or at all, contrary to standard procedure and policy. He stated that such failures place patients at risk by having the potential to lead to substantial delay of care, in circumstances where rapid intervention was crucial.

Mr Sabbagh submitted that Ms Trow's actions also included occasions where she failed to take or keep adequate or accurate records. He submitted that failure to take or keep adequate records places patients at real risk of harm, as this disrupts continuity in the care a patient receives and may lead to delays in them receiving the care they need, especially in a context where rapid intervention is essential.

Mr Sabbagh submitted that in relation to charge 4, Ms Trow acted dishonestly by amending the EMIS record to state that Patient B refused to have observations taken, when she knew that this was not true.

Mr Sabbagh submitted that overall, Ms Trow's actions set out in the charges found proved, represents serious departures from the professional standards expected of a registered nurse.

Submissions on impairment

Mr Sabbagh moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. It also included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Nicholas-Pillai v GMC* [2009] EWHC 1048.

Mr Sabbagh highlighted that Ms Trow has disengaged with the NMC regulatory process. He submitted that as a result, there has not been any evidence of Ms Trow's insight, whether she would accept that there are concerns, or steps she has taken to remediate the concerns either through further training or continued practise as a nurse.

Mr Sabbagh referred to an email from Ms Trow, dated 18 January 2023, in which she stated, '*I have been set up by the original complaint'*. He submitted that Ms Trow has sought to minimise her own responsibility and to deflect blame onto others by implying that she has been '*set up'*. He stated that, Colleague 2, also gave evidence that Ms Trow's attitude to feedback and improvement was '*arrogant*'.

Further, Mr Sabbagh outlined that during the local investigation, Ms Trow provided a response to the 2 January 2020 incident in her interview with Colleague 4. He stated that

Ms Trow accepted that she missed the NEWS scoring due to the '*time of the morning and that her* [PRIVATE]. He stated that she also explained that she was aware of what she should have done and that it was a '*blip on this occasion'*. He submitted that Ms Trow appeared more concerned with getting back in time rather than concentrating on the task at hand with the patient. He submitted that, as is suggested by Colleague 4 in her evidence, it would appear that Ms Trow was aware of what to do but failed to do it. He submitted that, any insight demonstrated by Ms Trow's account in that interview is partial and limited at best.

Mr Sabbagh submitted that in respect of each charge, there is a real risk of repetition and therefore Ms Trow's fitness to practice remains impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

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

> *'**1 Treat people as individuals and uphold their dignity***
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***4 Act in the best interests of people at all times***
> *4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

8 Work co-operatively

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

10 Keep clear and accurate records relevant to your practice

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

10.2 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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed…

13 Keep clear and accurate records relevant to your practice

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

14 Keep clear and accurate records relevant to your practice

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

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

19 Keep clear and accurate records relevant to your practice
19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times…
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered the charges collectively and the circumstances of the case as a whole. It took account of all the evidence before it and the time span of the incidents.

The panel noted that the facts found proved in charge 1 - 9 do not relate to an isolated incident, rather that they collectively demonstrate a pattern of behaviour over a prolonged period of time that fails to acknowledge professional and clinical protocols, which led to unsafe practice. It determined that Ms Trow's actions demonstrated repeated failings in fundamental aspects of nursing.

The panel was of the view that as an experienced nurse, the range and nature of Ms Trow's clinical omissions and documentation failures, demonstrated an unacceptably low standard of professional practice. It found that Ms Trow's actions exposed a number of

vulnerable patients to serious risk of harm and had the potential to impact on the follow up care patients received from other professionals; with some patients seen by Ms Trow requiring urgent hospital treatment. This is compounded by Ms Trow's dishonesty in charge 4, in which she recorded inaccurate information in Patient B's notes to conceal her failure to carry out observations. The panel was of the view that honesty and integrity are fundamental to the nursing profession and to dishonestly attempt to conceal clinical omissions as a nurse, creates a harmful environment for patients. It determined that the variety and combination of Ms Trow's actions would be considered deplorable by fellow practitioners and damaging to the trust that the public places in the profession.

The panel therefore concluded that Ms Trow's actions in charge 1 - 9 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, Ms Trow'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 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 determined that all four limbs in the above test were engaged in this case.

Taking into account all of the evidence adduced in this matter, the panel found that patients were put at unwarranted risk harm as a result of Ms Trow's misconduct. The panel determined that Ms Trow's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that

confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel next went on to consider the matter of insight. The panel noted that whilst Ms Trow had made some early admissions at the local level investigation, it was not presented with evidence of insight or remorse. It noted that it had not received any evidence to suggest that Ms Trow has demonstrated an understanding of how her actions had put patients at a risk of harm, how this impacted negatively on the reputation of the nursing profession and how she would handle situations differently in the future. The panel took into account that Ms Trow has disengaged with the NMC regulatory process and therefore it was not presented with any information regarding her current level of insight. It determined that Ms Trow demonstrated a significant lack of insight and remorse.

The panel was satisfied that the misconduct in this case is capable of being addressed, although it noted that the dishonesty element is more difficult to put right. The panel carefully considered the evidence before it in determining whether or not Ms Trow has taken steps to strengthen her practice. However, the panel has not received any information to suggest that Ms Trow has taken any steps to address the specific concerns raised about her practice, such as relevant training or reflection on the consequences of her conduct/dishonesty.

The panel was of the view that due to the lack of insight, remorse and evidence of strengthened practice, there remains a high risk of repetition. The panel considered that Ms Trow's actions set out in the charges found proved demonstrated a pattern of behaviour that fails to acknowledge professional and clinical protocols, which inevitably led to unsafe practice. It took into account the fact that concerns were repeated, even after Ms Trow was placed on a performance related action plan at Sirona. On the basis of all the information before it, the panel decided that there is a risk to the public if Ms Trow was allowed to practise without restriction. The panel therefore determined that a finding of current impairment on public protection grounds is necessary.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

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

Having regard to all of the above, the panel was satisfied that Ms Trow was unable to practise kindly, safely and/or professionally and therefore her 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 Ms Trow off the register. The effect of this order is that the NMC register will show that Ms Trow 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

Mr Sabbagh informed the panel that in the Notice of Hearing, dated 5 October 2023, the NMC had advised Ms Trow that it would seek the imposition of a striking-off order if it found Ms Trow's fitness to practise currently impaired.

Mr Sabbagh referred the panel to the case of *Professional Standards Authority for Health and Social Care v NMC (Chawo-Banda)* [2014] EWHC 4677, as well as the SG in respect of a suspension and a striking-off order.

Mr Sabbagh outlined aggravating factors he identified in this case:

- Conduct which put patients at risk of suffering harm;
- Pattern of misconduct over a period of time and repetition of failures;
- Lack of insight into failings;
- Dishonesty/lack of integrity.

Mr Sabbagh also outlined the mitigating factors he identified in this case:

- Good character and lack of previous fitness to practise history (though the NMC guidance in [SAN-1] state that '*there will usually be only limited circumstances where the concept of a 'previously unblemished career' will be a relevant consideration when they are deciding which sanction is needed, or in giving their reasons*.')
- No direct personal gain.

Mr Sabbagh submitted that Ms Trow's failings were numerous and many of them were similar in nature. He submitted that Ms Trow has demonstrated attitudinal issues through a refusal to follow standard practice and policy, despite her awareness of what she ought to do. He highlighted that many of Ms Trow's failings to conduct key checks or to record essential information created real risks of harm to the patients. Further, he submitted that Ms Trow's dishonest attempt to disguise her failing posed a further risk to the patient, as it meant that the patient might have been deemed as simply refusing assistance rather than requiring a follow up.

Mr Sabbagh submitted that Ms Trow's conduct raises fundamental questions about her professionalism and trust, with the majority of the concerns being clinical in nature. He submitted that the repetition of misconduct despite her knowledge that she ought to act differently, and the additional factor of dishonesty, means that there is an inherent risk of repetition.

Mr Sabbagh reminded the panel of its previous findings, in which it was not presented with any evidence of insight, remorse or strengthened practice. He submitted that in these circumstances, a significant sanction such as removal from the register will be appropriate to protect the public and maintain public confidence in the profession.

Mr Sabbagh acknowledged that the consequences of a striking-off order will usually be severe for a registrant. However, he submitted that in this case that is outweighed by the *'essential issue'* of the need to maintain public confidence in the profession, and to protect the public from the still-present risk of repetition.

Decision and reasons on sanction

Having found Ms Trow'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:

- Conduct which put patients at risk of suffering harm. It took into account that the concerns involved vulnerable patients [PRIVATE].
- Pattern of misconduct over a prolonged period of time and repetition of clinical failures relating to fundamental aspects of nursing.

- Lack of insight into failings.
- Dishonesty and a deliberate breach of professional duty of candour.

The panel also took into account the following mitigating features:

- No direct personal gain from conduct.
- Partial early admission at local investigation (in respect of the incident involving Patient A).

The panel also had regard to contextual factors which included Ms Trow's previous good character. It took into account that Ms Trow has practised as a nurse since 1977 with no previous referrals made in respect of her fitness to practise.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Trow'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 Ms Trow'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 Ms Trow's registration would be a sufficient and appropriate response. It noted that Ms Trow has indicated that she is in retirement and has disengaged with the NMC regulatory process. The panel is of the view that there are no practical or workable conditions that could be formulated in these circumstances as it could not be satisfied that Ms Trow would be

willing to comply with conditions. Furthermore, it had regard to the fact the concerns in this case relate to Ms Trow demonstrating a repeated failure to follow clinical protocols over a prolonged period of time and also includes dishonesty. In this respect the panel considered that her misconduct reflected deep-seated attitudinal problems. The panel therefore concluded that the placing of conditions on Ms Trow's registration would not adequately protect the public or meet the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

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

The panel considered that none of these factors applied in this case. It found that the concerns in this case do not relate to a single incident, but rather a pattern of misconduct repeated over a prolonged period of time. It noted that the misconduct in this case also involved dishonesty and reflected deep-seated attitudinal problems. The panel also took into account that it was not presented with evidence of insight or remorse, and therefore found a consequent high risk of repetition.

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 Ms Trow's actions is fundamentally incompatible with Ms Trow remaining on the register. In this particular case, the panel

determined that a suspension order would not be a sufficient, appropriate or proportionate sanction to protect the public or meet the public interest.

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?*

The panel noted that Ms Trow has demonstrated a significant lack of insight or remorse regarding her misconduct. Additionally, there was no evidence that Ms Trow had strengthened her practice in respect of any of the specific concerns in this matter. To the contrary, Ms Trow has indicated that she has retired and disengaged with the NMC regulatory process, failing to demonstrate that she will not behave in a similar manner in the future.

The panel considered that the misconduct in this case related to repeated clinical failings in fundamental aspects of nursing over a prolonged period of time and dishonesty. It found that Ms Trow has not demonstrated that she can be trusted as a registered nurse to keep patients safe from unwarranted risk of harm, which raises fundamental questions about her professionalism. Having balanced the aggravating factors with the mitigating factors in this case, the panel reached the conclusion that Ms Trow's misconduct was fundamentally incompatible with continued registration. It was satisfied that public confidence in the profession would not be maintained if Ms Trow remained on the register and that any sanction less than a striking-off order would be insufficient to uphold the NMC's overarching objective.

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

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

This will be confirmed to Ms Trow in writing.

Submissions on interim order

The panel took account of the submissions made by Mr Sabbagh. He submitted that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest. He invited the panel to impose an interim suspension order for a period of 18 months for the reasons stated in the panel's findings.

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 Ms Trow's own interest until the striking-off order takes effect.

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

Decision and reasons on interim order

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

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

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

That concludes this determination.