Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Tuesday 18 July 2023

Virtual Hearing

Name of Registrant:	**Catherine Anne Rose**
NMC PIN	08F0562E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – (October 2008)
Relevant Location:	Norfolk
Type of case:	Misconduct
Panel members:	Rachel Ellis (Chair, Lay member) Beth Maryon (Registrant member) Rachel Cook (Lay member)
Legal Assessor:	Lachlan Wilson
Hearings Coordinator:	Zahra Khan
Nursing and Midwifery Council:	Represented by Unyime Davies, Case Presenter
Miss Rose:	Not present and not represented at the hearing
Order being reviewed:	Suspension order (12 months)
Fitness to practise:	Impaired
Outcome:	**Suspension order (9 months) to come into effect at the end of 28 August 2023 in accordance with Article 30(1)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Rose was not in attendance and that the Notice of Hearing had been sent to Miss Rose's registered email address by secure email on 5 June 2023.

Further, the panel noted that the Notice of Hearing was also sent to Miss Rose's representative at the Royal College of Nursing (RCN) on 5 June 2023.

Ms Davies, 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 substantive order being reviewed, the time, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Rose'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 Rose been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Rose

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

Ms Davies referred the panel to the documentation from Miss Rose's representative at the RCN which included a letter dated 17 July 2023, stating:

'The Registrant will not be attending the hearing, nor will they be represented. No disrespect is intended by their non-attendance. The Registrant has received the notice of hearing and is happy for the hearing to proceed in their absence. She remains keen to engage with the proceedings.'

The panel accepted the advice of the legal assessor.

The panel has decided to proceed in the absence of Miss Rose. In reaching this decision, the panel has considered the submissions of Ms Davies, the representations made on Miss Rose's behalf, and the advice of the legal assessor. It has had particular regard to any relevant case law and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Rose or her representative;
- Miss Rose's representative has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure Miss Rose's attendance at some future date; and
- There is a strong public interest in the expeditious review of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Miss Rose.

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

At the outset of the hearing, Ms Davies made a request that part of this case be held in private on the basis that proper exploration of Miss Rose's case involves reference to her personal life and a family member's health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Miss Rose's representative stated, in a letter dated 17 July 2023, that:

‘This is a case that falls under Rule 19(3) of the Nursing and Midwifery Council (FTP) Rules 2004. In accordance with this rule, hearings may be held, wholly or partly, in private if the Committee is satisfied that this is justified and outweighs any prejudice by the interests of any party or of any third party or by the public interest.

We submit that any public interest in this case or any third-party interest would not outweigh the need to protect the privacy and confidentiality of the registrant and therefore the hearing should remain in private.

The Registrant does not give permission for the following paragraphs to be disclosed to the referrer as they contain matters that are private and/or health related.’

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 this case refers to Miss Rose’s personal life and a family member’s health, the panel determined to go into private session as and when such issues were raised in order to protect their privacy.

Decision and reasons on review of the substantive order

The panel decided to confirm the current suspension order and extend it for a further period of nine months.

This order will come into effect at the end of 28 August 2023 in accordance with Article 30(1) of the ‘Nursing and Midwifery Order 2001’ (the Order).

This is the first review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 29 July 2022.

The current order is due to expire at the end of 28 August 2023.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

'That you, a registered nurse;

1. *On the 5 July 2018 you failed to ensure that hourly observations of Patient A were taken for:*

    1.1. Respiration rate; ***[PROVED BY ADMISSION]***
    1.2. Respiratory distress; ***[PROVED BY ADMISSION]***
    1.3. Oxygen saturation; ***[PROVED BY ADMISSION]***
    1.4. Blood pressure; ***[PROVED BY ADMISSION]***
    1.5. Heart rate; ***[PROVED BY ADMISSION]***
    1.6. Consciousness; ***[PROVED BY ADMISSION]***
    1.7. Temperature. ***[PROVED BY ADMISSION]***

2. *During the nightshift of 4-5 July 2018 you failed to complete a Rapid Tranquilisation Monitoring Form for Patient A.* ***[PROVED BY ADMISSION]***

3. *At a time and date after 2300 hrs on 5 July 2018 you printed off a Rapid Tranquilisation Monitoring Form for Patient A and completed entries for;*

    3.1. 5 July 2018 at 0015 hrs; ***[PROVED BY ADMISSION]***
    3.2. 5 July 2018 at 0415 hrs. ***[PROVED BY ADMISSION]***

4. *Your actions in charge 3) were dishonest in that;*

    4.1. You deliberately sought to represent that you had taken observations described in charge 3) when you knew that you had not; or in the alternative ***[FOUND PROVED]***
    4.2. You deliberately sought to conceal that the entries were made retrospectively. ***[PROVED BY ADMISSION]***

5. *On 9 July 2018 you told Colleague A;*

    5.1. *That you had printed off Patient A's Rapid Tranquilisation Monitoring Form at around 0200 hrs on the 5 July 2018 or words to that effect;* ***[PROVED BY ADMISSION]***

    5.2. *That you had completed Patient A's Rapid Tranquilisation Monitoring Form during the night shift of 4-5 July 2018 or words to that effect;* ***[PROVED BY ADMISSION]***

    5.3. *That you had taken Patient A's respiration rate using the clock on the wall or words to that effect;* ***[PROVED BY ADMISSION]***

    5.4. *That you had taken Patient A's respiration rates using his watch or words to that effect.* ***[PROVED BY ADMISSION]***

6. *Your actions in charge 5)a) and or 5)b) were dishonest in that you;*

    6.1. *You deliberately sought to represent that you had taken observations described in charge 3) when you knew that you had not; or in the alternative* ***[FOUND PROVED]***

    6.2. *You deliberately sought to conceal the facts of charge 2).* ***[PROVED BY ADMISSION]***

7. *Your actions in charge 5)c) and or 5)d) were dishonest in that you deliberately sought to conceal the fact that you had not taken hourly observations.* ***[PROVED BY ADMISSION]***

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

The original panel determined the following with regard to impairment:

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

The panel noted that nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Miss 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, Miss 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 concluded that all four limbs of this test were engaged. It determined that Patient A was placed at an unwarranted risk of harm. Colleague A's evidence was that Patient A needed to be monitored hourly, given the Trust policy, his age and physical health and that monitoring was crucial. Colleague B's evidence was that there was no patient harm but that Patient A could have died from the RT if he experienced adverse effects and so you needed to monitor him. Observations were not carried out and a patient's record was not completed when it was required to be. In addition, it considered that your actions have breached fundamental tenets of the nursing profession. Further, the panel noted that you accept that if the public were to hear about these clinical concerns and your dishonesty, they would be 'horrified'. In this regard, it determined that your actions brought the nursing profession into disrepute.

When considering whether you have remediated your practice, the panel had regard to the case of Cohen v General Medical Council, in which the court set out three factors which it described as being 'highly relevant' to the determination of the question of current impairment:

'(a) Whether the conduct that led to the charge(s) is easily remediable?
(b) Whether it has been remedied?
(c) Whether it is highly unlikely to be repeated?'

The panel was satisfied that the clinical concerns in this case are capable of remediation. In respect of the dishonesty concerns, the panel noted that your dishonesty took place in a clinical setting where you were caring for elderly highly vulnerable patients and that this dishonesty was perpetuated over an extended

period of time. The panel therefore decided your dishonesty was on the serious end of the spectrum. On this basis, the panel was of the view that your dishonesty would be difficult to remediate.

In assessing current risk, the panel considered whether you have developed any insight. It bore in mind that you made early admissions to these regulatory concerns and that you are remorseful. Furthermore, the panel had regard to your reflective statement dated 15 July 2022 in which you demonstrate an understanding of the importance of monitoring patients as well as the duty of candour. You have also told the panel that you are aware of the wider impact of your misconduct on the nursing profession and on the public's confidence in the profession.

Notwithstanding, the panel was of the view that your insight is limited. The panel considered that, while you have stated that you accept responsibility for your actions, you have also continued to deflect blame. You have stated that the reason why you acted dishonestly was because you misread the policy, there were staffing issues, and there was inadequate RT training at the Trust. You told the panel that the support workers had more experience in mental health than you did. You stated that you expected them to raise with you if they noticed anything untoward in their general hourly observations, even though you had not specifically delegated Patient A's RT observations to them. The panel determined that you have shown little insight into your specific roles and responsibilities as the registered nurse in charge.

You gave evidence that you have not told your employers about the allegations of dishonesty but that you were dismissed for an error at work. The panel determined that you continue to deflect blame in your reflective statement. In addition, it noted that although you have now accepted the panel's findings, you maintained your dishonesty throughout the local investigation for a long period of time. On the basis of all of the above, the panel determined that your insight remains at a low level.

The panel considered whether you have taken steps to strengthen your practice. Whilst you have said that you have completed mandated training, the panel did not have any evidence to support this or to demonstrate the relevance of this training. Additionally, although you told the panel that you were working in a care setting

after this incident, the panel did not have sight of any testimonials or references from your employers, either previous or current. As such, the panel was of the view that you have not addressed the clinical concerns in this case.

On this basis and given your low level of insight into your dishonesty, the panel decided that there is a risk of repetition and that a finding of impairment is necessary on the grounds of public protection.

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

In this regard, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It therefore also finds your fitness to practise impaired on public interest grounds.

Therefore, the panel finds your fitness to practise is currently impaired on both public protection and public interest grounds.'

The original panel determined the following with regard to sanction:

'The panel then went on to consider whether a suspension order would be an appropriate sanction. It had regard to the SG which 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; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel took into account that you maintained your dishonesty over a prolonged period of time and that this would be difficult to remediate. Notwithstanding, the panel acknowledged that this stemmed from a single clinical incident of misconduct; that there is no evidence that you have deep-seated personality or attitudinal issues; and that you have developed some insight into the impact of your dishonesty on patients, the public and the profession and the need for accurate, contemporaneous record-keeping.

Additionally, the panel considered that you have engaged fully with these proceedings, demonstrated remorse, accepted that you have acted in a dishonest way and have told the panel that it will not happen again. The panel also noted that you have no previous regulatory findings against you and accepted Mr Hall's submissions that these proceedings have been a salutary experience for you. Whilst it would be difficult to remediate this dishonesty, the panel considered that it would be fair and proportionate to give you an opportunity to continue to develop your insight and to fully remediate your dishonesty. Furthermore, the panel considered that there was a public interest in allowing you, an otherwise competent and qualified registered nurse, to be given the opportunity to return to safe, unrestricted practice on the Register.

On the basis of the above, the panel was satisfied that in the particular circumstances of this case, your misconduct was not fundamentally incompatible with remaining on the Register.

The panel gave serious consideration to whether a striking-off order would be proportionate. Taking account of all the information before it, the panel concluded that it would be disproportionate and would not give you the opportunity to further develop your insight and fully remediate your dishonesty. Whilst the panel acknowledges that a suspension may have a punitive effect, it considered that it would be unduly punitive to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction. The panel considered that this order is 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.

The panel decided to make this suspension order for a period of 12 months with a review.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- *Testimonials and references from your line manager with specific reference to your honesty in the workplace and your performance in undertaking and recording required observations in a timely manner*
- *Certificates of learning on duty of candour and honesty, observations and contemporaneous record-keeping*
- *A further reflective piece which demonstrates your insight into your dishonesty'*

Decision and reasons on current impairment

The panel has considered carefully whether Miss Rose's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle, and written submissions made on Miss Rose's behalf. It has taken account of the submissions made by Ms Davies.

Ms Davies provided a detailed background to the case including the charges found proved by Miss Rose's admissions and by the original panel's findings. She submitted that Miss Rose had put patients at an unwarranted risk of harm.

Ms Davies referred the panel to the letter from the RCN dated 17 July 2023. [PRIVATE].

Further, Ms Davies submitted that there has been no new information that changes the finding of the original panel in regard to the risk of repetition and risk of harm to patients. She submitted that Miss Rose has not provided any information regarding her developing insight and that there is no update as to her work position.

Ms Davies also submitted that there have been no testimonials or references from Miss Rose's line manager with specific reference to honesty within the workplace. She submitted that there has been no remediation in regard to Miss Rose's actions.

Ms Davies invited the panel to find that Miss Rose's fitness to practise remains impaired both on public protection and public interest grounds for the same reasons set out by the original panel. She invited the panel to extend the current substantive suspension order for a further period of six months to give Miss Rose the opportunity to provide to the panel some material information, or to attend the next review hearing to assist the panel when it considers whether she is still impaired.

The panel also had regard to the written submissions made on Miss Rose's behalf, dated 17 July 2023, which stated:

> *'At the Fitness to Practice Committee hearing on 29 July 2023, the Registrant was given a 12- month suspension order. Since the substantive suspension order was imposed, the Registrant has [PRIVATE] which have made making preparations for these review proceedings impracticable, or indeed before 22 August 2023 (the latest the order can be reviewed). [PRIVATE].*
>
> *[PRIVATE]*

[PRIVATE]. The Registrant estimates that this process could take six months to complete and that it would be beneficial to have her current suspension order extended by this length of time to follow through the process and prepare for the next review proceedings.

We invite the Panel to continue the current suspension order for six months in order to [PRIVATE] to give her the opportunity to prepare comprehensively in time for the next review proceedings.'

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether Miss Rose's fitness to practise remains impaired.

The panel noted that the original panel found that Miss Rose had made early admissions to these regulatory concerns. The original panel also found that Miss Rose had demonstrated an understanding of the importance of monitoring patients as well as the duty of candour. However, the original panel found that Miss Rose had deflected blame and that her insight was limited. It gave her the opportunity to develop her insight and remediate her dishonesty.

At this hearing, the panel noted that Miss Rose has been unable to prepare for this review hearing due to [PRIVATE]. Therefore, the panel have not seen any new evidence of remediation or further insight.

The original panel determined that Miss Rose was liable to repeat matters of the kind found proved. Today's panel has received no new information. In light of this, this panel determined that Miss Rose is still liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required. For these reasons, the panel finds that Miss Rose's fitness to practise remains impaired.

Decision and reasons on sanction

Having found Miss Rose's fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

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 Miss Rose'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 Rose's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice order on Miss Rose's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved at the original hearing, including findings of dishonesty, and concluded that a conditions of practice order would not adequately protect

the public or satisfy the public interest. The panel was not able to formulate conditions of practice that would adequately address the concerns relating to Miss Rose's misconduct.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow Miss Rose further time to fully reflect on her previous failings. It considered that Miss Rose also needs to gain a full understanding of how the dishonesty of one nurse can impact upon the nursing profession as a whole and not just the organisation that the individual nurse is working for. The panel concluded that a further suspension order would be the appropriate and proportionate response and would afford Miss Rose adequate time to further develop her insight and take steps to strengthen her practice. It would also give Miss Rose an opportunity to approach past and current colleagues to attest to her honesty and integrity in the workplace.

The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined to extend the current suspension order for a further period of nine months. It was of the view that this time frame would provide Miss Rose with an opportunity to engage with the NMC and demonstrate full insight and remediation, as well as [PRIVATE]. It considered this to be the most appropriate and proportionate sanction available.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 28 August 2023 in accordance with Article 30(1).

Before the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Miss Rose's attendance at the next review hearing
- Testimonials and references from any employer (both paid and unpaid) with specific reference to Miss Rose's honesty in the workplace

- Certificates of learning on duty of candour and honesty, observations and contemporaneous record-keeping
- A further reflective piece which demonstrates Miss Rose's current insight into her dishonesty

This will be confirmed to Miss Rose in writing.

That concludes this determination.