Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Tuesday 17 January 2023 – Friday 27 January 2023,
Thursday 4 May 2023 – Friday 5 May 2023

Virtual Hearing

Name of Registrant:	Catherine Purrott
NMC PIN	01U0343E
Part(s) of the register:	Registered Nurse – Adult Sub Part 1 (Level 1), Effective – 27 September 2004
Relevant Location:	Southampton
Type of case:	Misconduct
Panel members:	Bernard Herdan (Chair, Lay member) Linda Pascall (Registrant member) Alison Lyon (Lay member)
Legal Assessors:	Angus Macpherson (Tuesday 17 January 2023 – Friday 27 January 2023) Jayne Salt (Thursday 4 May 2023 – Friday 5 May 2023)
Hearings Coordinator:	Amanda Ansah
Nursing and Midwifery Council:	Toby Pleming, Case Presenter (Tuesday 17 January 2023 – Friday 27 January 2023), and Rakesh Sharma, Case Presenter (Thursday 4 May 2023 – Friday 5 May 2023)
Miss Purrott:	Not present and not represented
Facts proved:	Charges 1, 2, 3, 4, 5, 6, 7, 8, 9a, 9c, 9d, 11a, 11b, and 12
Facts not proved:	Charges 9b, 10a, 10b, 10c, and 10d

Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Purrott was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 5 December 2022, and she acknowledged this email on the same day.

Mr Pleming, 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 allegations, the times and dates that the hearing was to be held virtually, including instructions on how to join. The notice, amongst other things, contained information about Miss Purrott'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 Purrott has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Purrott

The panel next considered whether it should proceed in the absence of Miss Purrott. It had regard to an email from Miss Purrott 15 January 2023 advising that she was unwell and would not be able to attend the hearing. The panel noted that Miss Purrott is not represented, and within the NMC documentation, she had previously expressed her interest in attending the hearing and had engaged with the NMC including the completion of the Case Management Form ('CMF'). The panel considered adjourning for a few days to allow Miss Purrott to attend should she have sufficiently recovered. It had regard to Rule 21 and heard the submissions of Mr

Pleming who invited the panel to continue in the absence of Miss Purrott despite the recent correspondence received. He submitted that it was the NMC's position that although Miss Purrott indicated that she was currently unwell, the panel should note that there is no medical evidence regarding her fitness to participate in the hearing.

Mr Pleming further submitted that it is in the public interest that there is an expeditious disposal of the case and that a large number of witnesses who have been scheduled to give evidence would be inconvenienced should the panel choose to adjourn. He told the panel that, whilst there has been some engagement from Miss Purrott previously it is fairly limited. She did ask whether she had to attend the hearing and whether her attendance was compulsory.

Mr Pleming also noted that in the CMF, Miss Purrott does not say she will attend the hearing. However, in her email to the NMC dated 3 August 2022, Miss Purrott stated that she does *"hope to attend"* the hearing. Mr Pleming submitted that despite this, Miss Purrott has not requested an adjournment. He reminded the panel that the guiding principle which the panel should apply is whether it is fair, appropriate, and proportionate to proceed. He submitted that, in these circumstances, the panel should proceed in the absence of the registrant.

The Hearings Coordinator received an email from Miss Purrott dated 17 January 2023 in which she stated that she would attend the hearing should she be well enough to do so. Mr Pleming submitted that the NMC's position is neutral regarding this information and that as she has still not attended, this should be balanced with the availability of the witnesses and the potential inconvenience to them should the hearing be adjourned. He further submitted that even with this recent email from Miss Purrott, there is still no application for an adjournment.

The panel decided to allow a short adjournment of four days, until Monday 23 January 2023 to give Miss Purrott time to recover her health, alternatively to update the NMC on her position regarding her wellbeing and, if possible, attend the hearing. The panel directed Mr Pleming to change the schedule of the witnesses assuming it might be possible to resume the hearing on 23 January 2023. An email was sent to

Miss Purrott on 17 January 2023 explaining this decision, encouraging her to seek an appointment with her General Practitioner ('GP') if she remained unwell, and to provide the panel with a statement from her GP following this consultation. Miss Purrott replied on the same day to confirm that she was still unwell. On Monday 23 January 2023, the panel received an email from Miss Purrott sent to the Hearings Coordinator on 22 January 2023 in which she stated that she was still unwell, and that the hearing should continue in her absence *"if required"*. She also stated:

> *"…in my mind, I have retired from nursing, once I am medically fit, I will seek new employment in due course..."*

At this juncture, the panel further considered whether it should proceed in the absence of Miss Purrott. It received further submissions from Mr Pleming. It 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 decided to proceed in the absence of Miss Purrott. In reaching this decision, the panel has considered the submissions of Mr Pleming, the email from Miss Purrott dated 22 January 2023, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5 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 Miss Purrott.
- Miss Purrott has informed the NMC that she has received the Notice of Hearing and confirmed on 22 January 2023 that she was content for the hearing to proceed in her absence.

- The panel allowed Miss Purrott time to provide medical evidence or to attend the hearing if she felt better.
- There is no reason to suppose that adjourning would secure her attendance at some future date given her email dated 22 January 2023 in which she stated that she has retired from nursing.
- All the witnesses being called by the case presenter had been rescheduled for the next four-day period and a number of witnesses are ready today to give live evidence. Others are due to attend later in the week.
- If the panel does not proceed, the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services may be inconvenienced.
- The charges relate to events that occurred in 2020.
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Purrott in proceeding in her absence. However, the panel noted that although the evidence upon which the NMC relies has been sent to her at her registered address, she has made only a limited response to the allegations and denies most of them. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. In any event, the disadvantage is the consequence of Miss Purrott's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide oral evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charges

The panel heard an application made by Mr Pleming to amend the wording of charges 3, 10(c), and 11(b).

The proposed amendments were to change the date in charge 3 from 21 January 2021 to 22 January 2021, thereby reflecting the witness statements of Witness 2 and 3.

The other proposed amendments were merely typographical errors.

It was submitted by Mr Fleming that the proposed amendments above would provide clarity and more accurately reflect the evidence. The amended charges read as follows:

> *"That you, a registered nurse:*
>
> *3) On ~~21~~ **22** January 2021 incorrectly completed patient records in that you completed a body map when you had not examined the patient.*
>
> *10) On 15 November 2020, in relation to Patient A:*
>
> *c) Having been informed of the low blood pressure reading in charge ~~8a)~~ **10a)** above failed to escalate this to the nurse in charge and/or the doctor;*
>
> *11) On 28 January 2021:*
>
> *b) Failed to check the expiry date of the pre-prepared syringe in charge ~~9a)~~ **11a)** above.*
>
> *And in light of the above, your fitness to practise is impaired by reason of your misconduct."*

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such amendments, as applied for, were in the interests of justice. The panel was satisfied that there would be no prejudice to Miss Purrott and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to accurately reflect the evidence and ensure clarity within the charges.

Details of charges (as amended)

'That you, a registered nurse:

1) *On 18 October 2020 incorrectly completed patient records in that you completed a body map when you had not examined the patient.*

2) *Your actions in charge 1 above were dishonest in that you knew at the time you completed the body map that you had not examined the patient.*

3) *On 22 January 2021 incorrectly completed patient records in that you completed a body map when you had not examined the patient.*

4) *Your actions in charge 3 above were dishonest in that you knew at the time you completed the body map that you had not examined the patient.*

5) *On 23 January 2021 incorrectly completed patient records in that you completed 'Turnaround' charts when you had not been involved in the turning or checking of skin integrity of the patients.*

6) *Your actions in charge 5 above were dishonest in that you knew at the time of completing the 'Turnaround' charts that you had not been involved in the turning or checking of skin integrity of the patients.*

7) *On 23 January 2021 incorrectly signed Patient H's hydration chart indicating they had been drinking and passing urine.*

8) *Your actions in charge 7 above were dishonest as you had not checked Patient H's hydration.*

9) *On 15 November 2020 in relation to Patient G:*

   a) *Failed to check the patient when notified by colleague A that they had a NEWS score of 7;*
   b) *Failed to escalate the NEWS score of 7;*
   c) *Failed to check the patient when notified by colleague A that they had a NEWS score of 5;*
   d) *Failed to follow up your escalation to the Doctor to ensure a medical review was carried out.*

10) *On 15 November 2020, in relation to Patient A:*

   a) *Having been informed by colleague B of a low blood pressure reading, failed to re-take the patient's blood pressure, alternatively*
   b) *Having re-taken the patient's blood pressure, failed to document this in the patient's observations;*
   c) *Having been informed of the low blood pressure reading in charge 10a) above failed to escalate this to the nurse in charge and/or the doctor;*
   d) *Inappropriately administered the anti-hypertensive medication Candesartan to the patient.*

11) *On 28 January 2021:*

   a) *Failed to follow the correct controlled drug procedure in that you failed to sign out a pre-prepared Morphine and Ketamine syringe;*

b) Failed to check the expiry date of the pre-prepared syringe in charge 11a) above.

12) Between 17 May and 14 June 2021 breached the conditions of an interim conditions of practise order imposed by the Investigating Committee of the NMC on 23 March 2021 in that you commenced working for an employer other than 'National Locums' as specified in condition 1.

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

Background

The charges arose whilst Miss Purrott was employed as a registered nurse by University Hospital Southampton NHS Foundation Trust ("the Trust"), at Southampton General Hospital.

Upon starting her employment at the Trust, Miss Purrott had a two-week period to familiarise herself with the work required on the ward. She was supernumerary at this time. The first concern arose on 18 October 2020 when Miss Purrott had allegedly completed a body map for a patient indicating that their pressure areas were intact when she had not examined this patient. This was raised at Miss Purrott's probationary meeting where it alleged, she admitted that she had completed the body map without examining the patient. In addition to this, there were areas of Miss Purrott's knowledge that seemed inadequate. Her supernumerary two-week probation was therefore extended as a result of this observation, with additional objectives set.

The next concern arose on 15 November 2020 when a Healthcare Assistant (Witness 7) allegedly informed Miss Purrott that a certain Patient (Patient A) had a National Early Warning Score (NEWS) of seven, something which, according to the NEWS guidance, should have triggered immediate action and escalation. However, Miss Purrott allegedly asked Witness 7 to retake observations in an hour. When this was done by Witness 7, the NEWS had dropped to 5. Nevertheless, this still required immediate action

according to statements given by witnesses who state that any NEWS above 3 ought to be reported. Miss Purrott did mention the score to a Doctor (Witness 11) who was leaving the ward at the time who then asked Miss Purrott if Patient A required an immediate review. Miss Purrott said this was not required although, at that point, she still had not reviewed the patient herself. Witness 11 left the ward and forgot to check on Patient A. It is alleged that Miss Purrott had a duty to follow this up with Witness 11 and failed to do so, although no patient harm was caused, and the patient's NEWS dropped to 3 later that day.

There was a further concern on 15 November 2020 when Miss Purrott, having been informed by Witness 7 of a low pressure reading for Patient A, allegedly failed to retake the patient's blood pressure, alternatively, if she did retake the blood pressure, she failed to record it. Allegedly she also failed to escalate a low blood pressure reading in respect of Patient A. It is also alleged that later that evening the patient was administered Candesartan (an anti-hypertensive medication) despite having low blood pressure. It is alleged that this had the potential to cause serious harm.

On 22 January 2021, it was allegedly discovered that Miss Purrott had again completed a body map for a patient whom she had not examined. Pressure sores must be properly and accurately documented in order to avoid going unnoticed and the next staff member on shift not turning the patient as regularly as needed. It is alleged that this could result in the patient developing a serious pressure sore.

On 23 January 2021, Miss Purrott allegedly completed turnaround project charts for patients she had not been involved in turning. These charts are important as they document turns and skin integrity. For one of these patients, Miss Purrott documented that they had *"declined"* being turned. This could have led to the patient developing a pressure sore which would not have been detected.

The next incident allegedly occurred on 28 January 2021 when Miss Purrott took a pre-prepared syringe of morphine and ketamine from the controlled drugs store without following the procedure for the management and storage of controlled drugs. As Miss Purrott was not competent to administer patient-controlled analgesia, another nurse

(Witness 9) administered the drug and neither they nor Miss Purrott noticed that the medication had just expired.

As a result of these concerns and errors, a final probationary meeting was scheduled, but Miss Purrott resigned before this could take place. A referral was then made to the NMC on 23 February 2021 detailing the concerns. Following this, an interim order hearing was scheduled, and, in the meantime, Miss Purrott began working for the National Locums agency.

An interim conditions of practice order was imposed on Miss Purrott's practice on 23 March 2021; the first condition stipulated that she work only for the National Locums Agency. However, Miss Purrott applied for a nursing position at Bluebird Care. She was successful and began working for them on 17 May 2021. Miss Purrott did notify Bluebird Care of her conditions of practice order and also informed the NMC of her new employment. However, she did not apply for a variation of her interim conditions of practice order and was therefore in breach of the order. In June 2021, a review hearing of the interim conditions of practice resolved this as the panel determined to vary the condition to allow her to work for Bluebird Care. Her breach of the order forms the basis of Charge 12.

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 Pleming.

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.
The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Ward Leader at Southampton General Hospital.
- Witness 2: Health Care Assistant ('HCA') at Southampton General Hospital.
- Witness 3: HCA at Southampton General Hospital.
- Witness 4: HCA at Southampton General Hospital.
- Witness 5: Senior HCA at Southampton General Hospital.
- Witness 6: Senior Staff Nurse at Southampton General Hospital.
- Witness 7: HCA at Southampton General Hospital.
- Witness 8: Head of Care Operations at Bluebird Care.
- Witness 9: Clinical Nurse Specialist in Pain Management at Southampton General Hospital.
- Witness 10: Nurse Team Leader at Southampton General Hospital.

The panel also had regard to written statements from the following witnesses:

- Witness 11: Foundation Year 1 Doctor at Southampton General Hospital.

- Witness 12: Ward Sister at Southampton General Hospital.
- Witness 13: Band 6 Ward Sister at Southampton General Hospital.

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)

> *"On 18 October 2020 incorrectly completed patient records in that you completed a body map when you had not examined the patient."*

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence. It noted that it did not have the name or any other identification of the patient that was examined nor did it have sight of the body map or other contemporaneous patient records. However, it was clear from Witness 2's evidence that Miss Purrott had not seen the patient in question on 18 October 2020, nor spoken to the HCA involved. The panel also considered the probation review discussion that took place on 23 October 2020 in which it was stated that a concern had been raised by a colleague that Miss Purrott had *"completed body map of a patient whose skin she had not seen, marking body map intact when there was pressure damage present.",* and she was to *"ensure all documentation is accurate".* When challenged about why she failed to do this, Miss Purrott reported that *"this was lack of communication"* and she *"will do better in the future."*

The panel was of the view that Miss Purrott had failed to examine the patient and incorrectly completed their records as a result. It noted Witness 2's statement in which she stated that the patient had vulnerable skin and his pressure sores were not intact as Miss Purrott had documented. Had Miss Purrott enquired of Witness 2, or any other HCA involved in the patient's care as to whether the patient had any vulnerable skin or pressure sores, she would not have completed the patient's body map in the way she did.

The panel therefore found that Miss Purrott completed the body map incorrectly as she knew she had not examined the patient, and moreover could have caused patient harm by leaving a pressure sore untreated and not alerting colleagues to the situation. The panel therefore finds this charge proved.

Charge 2)

> *"Your actions in charge 1 above were dishonest in that you knew at the time you completed the body map that you had not examined the patient."*

This charge is found proved.

In reaching this decision, the panel considered its reasons for finding charge 1 proved. It was satisfied that Miss Purrott completed the body map when she knew she had not examined the patient. The panel concluded that she knew that she should not have completed the body map without having examined the patient in question or having received information as to their skin condition or pressure sores. Therefore, the panel concluded that ordinary decent people would regard Miss Purrott's actions as dishonest. The panel therefore found that Miss Purrott's actions in this regard were dishonest. It recognised that although Miss Purrott's dishonesty may not have been intended for personal or financial gain, and may have been without malice, nevertheless it was dishonest. The panel therefore finds this charge proved.

Charge 3)

"On 22 January 2021 incorrectly completed patient records in that you completed a body map when you had not examined the patient."

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's evidence. It noted that it did not have the name or any other identification of the patient that was examined nor did it have sight of the body map or other contemporaneous patient records. However, Witness 3 explained that she had washed and turned the patient in question, whereas Miss Purrott had not. Witness 3 said remembered the particular patient as having bad pressure sores. Witness 3 stated that when she went to complete the patient's body map, she became aware that Miss Purrott had already completed it, and noted that the pressure sores were fine. She challenged Miss Purrott about this. Miss Purrott insisted that she had checked the patient and they were fine.

The panel noted that Witness 3 knew that she had not witnessed Miss Purrott examining or turning this patient, and that if she had done so, she would have observed the pressure damage, and would not have documented that the pressure areas were *"fine".* Again, the panel recognised that Miss Purrott's completion of the body map in these circumstances had the potential to cause patient harm. The panel therefore finds this charge proved.

Charge 4)

"Your actions in charge 3 above were dishonest in that you knew at the time you completed the body map that you had not examined the patient."

This charge is found proved.

In reaching this decision, the panel considered its reasons for finding charge 3 proved. It was satisfied that Miss Purrott completed the body map when she knew she had not examined the patients. The panel concluded that she knew that she should not have completed the body map without having examined the patient or received information as

to their pressure sores. Therefore, the panel concluded that ordinary decent people would regard Miss Purrott's actions as dishonest in these circumstances. Consequently, the panel finds that Miss Purrott's actions in this regard were dishonest.

The panel was of the view that when Witness 3 challenged Miss Purrott as to why she had recorded on the body map that the patient's sores were fine when they were not, Miss Purrott could have used the opportunity to admit that she had not checked the patient, not documented correctly, and she could have discussed with Witness 3 the concerns Witness 3 had regarding this patient in order to accurately record the body map. However, Miss Purrott did not do this. The panel considered that serious harm could have been caused to the patient if Miss Purrott's error had gone unnoticed, the patient would not have been turned as regularly as needed, thereby risking the development of a significant pressure sore. The panel therefore finds this charge proved.

Charge 5)

> *"On 23 January 2021 incorrectly completed patient records in that you completed 'Turnaround' charts when you had not been involved in the turning or checking of skin integrity of the patients."*

This charge is found proved.

In reaching this decision, the panel took into account evidence provided by Witness 5 and Witness 10. The panel has not been informed of the identities of the patients involved in this incident, nor has the panel seen the relevant turn charts as these had allegedly been lost. However, the panel has been informed of the bays occupied by the patients in particular the patient in *"bed 1 of bay 8"*, on the day in question.

Witness 5 provided a handwritten statement dated 23 January 2021, which the panel determined to be contemporaneous given that the incidents had occurred on that date. It was clear from this statement that Miss Purrott was not involved in caring for the particular patient in *"bed 1 of bay 8"*. Witness 5 recalled that she apologised to Miss

Purrott that she (Witness 5) had not yet completed the turn charts or body maps for her patients, whereupon Miss Purrott replied that she had done them herself.

Witness 5 then looked at the documentation in respect of the patient in *"bed 1 of bay 8"* and noted that Miss Purrott's documentation was incorrect. She had completed the turn chart to state that the patient had been on his back for a few hours and declined to be moved. This was incorrect as Witness 5 had been turning him on his sides – he had not declined to be turned. Witness 5 completed a new turn chart to reflect the patient's status. This statement was supported by Witness 10 who had been assisting Witness 5 in caring for this particular patient, including turning him. The incorrect charts were put in a drawer to be raised with Witness 1 straightaway.

The panel noted that Witness 5 and Witness 10 painted a graphic picture of what was going on at the time as they spent a lot of time with the patient. Witness 10 particularly, gave evidence that falsifying turn charts in the way Miss Purrott had by stating that the patient declined to being turned, is very dangerous as they could develop a severe pressure sore. The panel accepted that Miss Purrott was not involved in caring for this patient as evidenced by Witness 5 and Witness 10, and therefore incorrectly completed their records. The panel therefore finds this charge proved on the balance of probabilities.

Charge 6)

> *"Your actions in charge 5 above were dishonest in that you knew at the time of completing the 'Turnaround' charts that you had not been involved in the turning or checking of skin integrity of the patients."*

This charge is found proved.

In reaching this decision, the panel considered its reasons for finding charge 5 proved. It was satisfied that Miss Purrott completed the turnaround chart when she knew she had not been involved in the turning of the patient and checking upon his skin integrity. The panel concluded that she knew that she should not have completed the turnaround

chart without having examined the patient or received information as to their pressure sores. Therefore, the panel concluded that ordinary decent people would regard Miss Purrott's actions as dishonest in these circumstances. The panel therefore found that Miss Purrott's actions were dishonest in this regard. It recognised that although Miss Purrott's dishonesty may not have been intended for personal or financial gain, and may have been without malice, nevertheless it was dishonest. The panel therefore finds this charge proved.

Charge 7)

> *"On 23 January 2021 incorrectly signed Patient H's hydration chart indicating they had been drinking and passing urine."*

This charge is found proved.

In reaching this decision, the panel took into account Witness 10's evidence. Witness 10 spent much time with this patient, Patient H; even if she was not in the room with him, she would have been just outside the room. She stated that the longest period of time that she was away from Patient H on that shift would have been 5 minutes. Patient H had complex needs. They could not have possibly gone to the toilet on their own as they could not walk and could not take water as they were in a very agitated state of mind. It would not have been possible for this patient to have undertaken these activities unaided. Nevertheless, on the hydration chart, Miss Purrott had ticked that Patient H had gone to the toilet and had drunk water. Witness 10 detailed the risks which this incorrect information would have posed for Patient H. In fact, the patient required catheterisation which was provided the following day. The panel therefore finds this charge proved.

Charge 8)

> *"Your actions in charge 7 above were dishonest as you had not checked Patient H's hydration."*

This charge is found proved.

In reaching this decision, the panel considered its reasons for finding charge 7 above proved. It was satisfied that Miss Purrott completed the hydration chart when she knew she had not examined Patient H. The panel concluded that she knew that she should not have completed the hydration chart without having examined Patient H or having received information from Witness 10 as to their condition. Therefore, the panel concluded that ordinary decent people would regard Miss Purrott's actions as dishonest. It recognised that although Miss Purrott's dishonesty may not have been intended for personal or financial gain, and may have been without malice, nevertheless it was dishonest. The panel therefore finds this charge proved.

Charge 9a)

"On 15 November 2020 in relation to Patient G:

a) Failed to check the patient when notified by colleague A that they had a NEWS score of 7."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4 (Colleague A)'s evidence. Witness 4 stated that she had observed that Patient G had a *"NEWS of 7"*, which is a high score. She stated that any *"NEWS over 3"* should be escalated to a doctor. She reported the score to Miss Purrott and showed her the iPad upon which the score was recorded. Miss Purrott told her to complete the observations again in an hour. She stated that Miss Purrott did not check Patient A to see if they were ok.

The panel noted the account which Witness 4 gave to Witness 1 of this incident which was typed up by Witness 1 on 26 January 2021. This reflected Witness 4's evidence.

The panel had sight of the NEWS2 Trigger Scoring Chart by the Royal College of Physicians ('RCP') which states that there should be a continuous monitoring of vital

signs should a patient score seven or more. The panel concluded that Miss Purrott as the registered nurse on duty for that patient did have the responsibility to go and check the patient herself. The panel concluded that she failed to check Patient G after being told they had scored seven on the NEWS chart. The panel therefore finds this charge proved.

Charge 9b)

"On 15 November 2020 in relation to Patient G:

b) Failed to escalate the NEWS score of 7."

This charge is found NOT proved.

In reaching this decision, the panel took into account the file note of a conversation which Witness 1 had with Witness 11, produced by Witness 1. In that file note, Witness 11 acknowledged that Miss Purrott mentioned to him as he was leaving the ward that one of her patients, the patient in *"bay 7, bed 1"*, had a NEWS score of seven. He acknowledged, in his witness statement, that this amounted to an escalation. He asked Miss Purrott if he needed to review Patient G immediately. Miss Purrott replied that it was *"nothing to worry about"* and that the *"patient is fine"*. Notwithstanding that Miss Purrott reassured Witness 11 about Patient G, perhaps inappropriately, this evidence demonstrates that Miss Purrott did escalate Patient G's NEWS to Witness 11. The panel therefore finds this charge not proved.

Charge 9c)

"On 15 November 2020 in relation to Patient G:

c) Failed to check the patient when notified by colleague A that they had a NEWS score of 5;

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's evidence. Witness 4 did check Patient G's NEWS after the elapse of an hour. It had fallen to five. Notwithstanding the evidence that the patient's score had fallen to five, Miss Purrott still had a duty to check Patient G as this was still a high score. The panel noted that the NEWS2 Trigger Scoring Chart by the RCP states that there should be a minimum of one hourly check of vital signs should a patient score five or more. Witness 4 stated that as Miss Purrott was the registered nurse on duty, it was her responsibility to have checked the patient and assess the situation for herself, yet this was not done. The panel was of the view that Miss Purrott had a responsibility to check the patient as per the NEWS chart and had failed to do so. The panel therefore finds this charge proved.

Charge 9d)

"On 15 November 2020 in relation to Patient G:

d) Failed to follow up your escalation to the Doctor to ensure a medical review was carried out."

This charge is found proved.

In reaching this decision, the panel noted that under the 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code), there was an obligation upon Miss Purrott to act in the best interests of her patients, and to act as an advocate on their behalf. In these circumstances, in the panel's view, that entailed an obligation to ensure that the escalation she made was followed up within a short period. In telling Witness 11 that Patient G's condition was *"nothing to worry about"* and that *"the patient is fine",* Miss Purrott failed to comply with her obligation under the Code. The panel therefore finds this charge proved.

Charges 10a) and 10b)

"On 15 November 2020, in relation to Patient A:

a) *Having been informed by colleague B of a low blood pressure reading, failed to re-take the patient's blood pressure, alternatively*
b) *Having re-taken the patient's blood pressure, failed to document this in the patient's observations;"*

These charges are found NOT proved.

In reaching this decision, the panel decided to consider these charges together. The panel noted that the charges do not define a timescale during which the alleged failures occurred.

The panel had regard to Witness 7 (Colleague B)'s evidence that she had completed the observations of Patient A which showed that Patient A had a very low blood pressure of 70 systolic over 40 diastolic. She informed Miss Purrott who was the senior nurse on duty and responsible for Patient A's care. She stated that Miss Purrott then said that the blood pressure was normal for Patient A. Witness 7 then documented the observation on the iPad, which registered a high NEWS score. She said that she did not see Miss Purrott retaking Patient A's blood pressure after she had reported it to her during the rest of the shift.

In her evidence, Witness 7 was not certain when she had taken the relevant reading. However, she had a discussion with Witness 6 about the NEWS score towards the end of the late shift before handover. i.e., shortly after 18:00, and considered she may have taken the reading during the course of that late shift.

The panel had regard to Patient A's blood pressure chart. There were two occasions when the chart may be read to disclose a Blood Pressure ('BP') reading of about 70/40, at circa 11.00 and at circa 19:00. There are no recorded readings between circa 11.00 am and 15:00, and there are recorded readings thereafter at circa 17:00, 19:00 and 21:00. In addition, the panel noted the following entries allegedly made by Miss Purrott within Patient A's record:

"12 noon when it was recorded as BP low,

2.00 pm when it was recorded as 98/58,
5.00 pm when it was recorded as 82/62
6.00 pm where it was recorded as BP dropped."

In the light of the uncertainty as to the timing of Witness 7's observation and the fact that Miss Purrott appeared to have observed Patient A's blood pressure on a number of occasions, some of which were recorded, the panel did not feel able to reach a conclusion that Miss Purrott had not checked Patient A's blood pressure after Witness 7's reading, and / or conclude that, if she did, that she had not documented it. The panel therefore finds these charges not proved on the balance of probabilities.

Charge 10c)

"On 15 November 2020, in relation to Patient A:

c) Having been informed of the low blood pressure reading in charge 10b) above failed to escalate this to the nurse in charge and/or the doctor;"

This charge is found NOT proved.

In reaching this decision, the panel took into account the uncertain time scale to which it referred above. In addition, it noted that at 17:00, Miss Purrott appears, from her detailed handwritten notes on the patient record (Daily Assessment and Evaluation of Care), to have *"bleeped Dr* A [PRIVATE]*"* for a review following the BP record of 82/62, and that at 18:00, when the BP had *"dropped"* following the administration of the anti-hypertensive medication Candesartan, Associate Practitioner A [PRIVATE]was present and in talks with doctors. Further, the panel took into account the fact that Witness 6 had become aware of the low NEWS score. In the light of these matters, the panel was unable to conclude, on the balance of probabilities, that Miss Purrott had not escalated Witness 7's low blood pressure reading to *"the nurse in charge and / or a doctor"*. The panel therefore finds this charge not proved.

Charge 10d)

"On 15 November 2020, in relation to Patient A:

d) Inappropriately administered the anti-hypertensive medication Candesartan to the patient."

This charge is found NOT proved.

In reaching this decision, the panel took into account the admission Miss Purrott made in the probationary review meeting and the evidence of administration around 18:00 that day. However, there was no expert witness evidence on this point and none of the witnesses explained why the administration of Candesartan was inappropriate in this particular situation. The panel therefore finds this charge not proved.

Charge 11a)

"On 28 January 2021:

a) Failed to follow the correct controlled drug procedure in that you failed to sign out a pre-prepared Morphine and Ketamine syringe;"

This charge is found proved.

In reaching this decision, the panel took into account the evidence provided by Witness 9 who stated that there was a procedure which should be followed with regards to controlled drugs. That procedure, the medication management/controlled drugs policy was produced by Witness 1. It establishes a regime for the administration and checking of all Schedule 2 Controlled Drugs and provides that before administration, they should be checked by a registered nurse and another suitably qualified person.

The panel also considered Witness 12's statement. It was brought to her attention that a Morphine and Ketamine syringe was missing from the controlled drugs cupboard. She discovered that a new Morphine and Ketamine syringe had been given to a patient and was in situ. She asked Miss Purrott about this. Miss Purrott explained that it had come from the controlled drugs cupboard. She had removed it because Witness 9, a more

experienced member of staff, had asked to obtain it, but she had not signed it out. She had therefore not followed the correct procedure. When challenged about this, Miss Purrott stated that she had not signed it out because Witness 9 asked her to get the syringe. In her case management form Miss Purrott explained that she had not been trained in Patient Controlled Analgesics ('PCA').

The panel was of the view that Miss Purrott was required to follow the correct procedure regardless of who asked her to get the syringe. It heard that Miss Purrott was trained and experienced in the policy required to remove drugs from the cupboard. Witness 9 explained that he had assumed that Miss Purrott had signed out the drug as he had assisted her earlier in the shift in signing out a methadone prescription from the controlled drugs cupboard for the same patient. The panel considered that, as the registered nurse, Miss Purrott should have followed the procedure before bringing the syringe to Witness 9. The panel therefore finds this charge proved.

Charge 11b)

"On 28 January 2021:

b) Failed to check the expiry date of the pre-prepared syringe in charge 11a) above."

This charge is found proved.

In reaching this decision, the panel took into account Witness 12's evidence, which detailed the procedure set out in how you access and take out controlled drugs from their cupboard. The panel specifically considered section 3.8.2 where it states:

> "*Both parties must satisfy themselves that the stock balance is accurate and that the drug is within its expiry date, before preparation."*

The panel considered that Miss Purrott failed to follow this procedure as if she had, she would have realised that the medication had expired. (The panel also noted that Witness 12 had recognised that he should have also checked the expiry date.) The panel therefore finds this charge proved.

Charge 12)

> *"Between 17 May and 14 June 2021 breached the conditions of an interim conditions of practise order imposed by the Investigating Committee of the NMC on 23 March 2021 in that you commenced working for an employer other than 'National Locums' as specified in condition 1."*

This charge is found proved.

In reaching this decision, the panel took into account the admission Miss Purrott made that she had breached the conditions of the interim conditions of practice order dated 23 March 2021. The first condition provided that she must only work through National Locums Agency. Witness 8 gave evidence that Miss Purrott obtained direct employment with Bluebird Care from 17 May 2021 to 11 February 2022. Witness 8 explained that Miss Purrott did disclose to her at the interview on 7 May 2021 that she was subject to conditions; there was therefore no attempt by Miss Purrott to conceal the conditions.

Witness 8 did seek clarification as to Miss Purrott's position under the conditions and references from both the Agency and the NMC. She was informed by the Agency that Miss Purrott could work for Bluebird Care. Witness 8 was not able to obtain any information from the NMC at the time; her contact with the NMC was unsuccessful as she could not reach them by telephone and her email was left unanswered. Bluebird Care made the decision to employ Miss Purrott. In June 2021, the NMC contacted Bluebird Care, and it became apparent that Miss Purrott was not permitted under the conditions to work directly for them. Bluebird Care placed Miss Purrott in a different role which did not require registration. On 14 June 2021, the interim conditions were amended to permit Miss Purrott to only work at Bluebird Care.

The panel noted that although Miss Purrott's conditions of practice were later varied at a review hearing, this variation should have been sought prior to her obtaining employment other than through National Locums Agency. The panel therefore finds this charge proved.

Decision and reasons on service of Notice of Resuming Hearing

The panel was informed at the start of the resuming hearing that Miss Purrott was not in attendance and that the Notice of Resuming Hearing letter had been sent to her registered email address by secure email on 3 April 2023.

Mr Sharma, on behalf of the NMC, submitted that it had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Purrott's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence. Mr Sharma submitted that Miss Purrott received the Notice of Hearing as she provided a response on the same day it was sent saying *"received thank you".*

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

Decision and reasons on proceeding in the absence of Miss Purrott

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

Mr Sharma submitted that Miss Purrott advised that she is retired and there has been no further information that her position has changed since January 2023. Miss Purrott was previously satisfied with the hearing proceeding in her absence so there is no reason to believe that an adjournment would secure her attendance on some future occasion. Mr Sharma further submitted that all the witnesses have been heard and facts have been handed down so the opportunity for Miss Purrott to challenge anything if she wished to attend has already passed. He reminded the panel that the events in this case occurred as far back in 2020 and are therefore becoming relatively historic. He submitted that there is a strong public interest in reaching a decision in this case and since she is retired, it is also in her interest that a decision is reached.

Mr Sharma submitted that given these circumstances, it would be appropriate to proceed in Miss Purrott's absence and there would be no need for the panel to draw inferences from her absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Miss Purrott. In reaching this decision, the panel has considered the submissions of Mr Sharma 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 Miss Purrott;
- Miss Purrott has informed the NMC that she has received the Notice of Hearing and has not requested for an adjournment or made any objection to the hearing proceeding in her absence;

- There is no reason to suppose that adjourning would secure her attendance at some future date;
- The charges relate to events that occurred in 2020 so are becoming fairly historic; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Purrott in proceeding in her absence. The panel noted that there has been a response bundle provided by Miss Purrott but as she is not attending, she will not be able to answer any questions the panel may have regarding it or provide further clarification should the panel require this. However, the panel have balanced this against the fact that there is a public interest in completing the case given the length of time passed since the incidents occurred back in 2020.

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

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Purrott's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Miss Purrott's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard 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.'*

Mr Sharma invited the panel to take the view that the facts found proved amount to misconduct. He asserted the panel should have regard to the terms of The Code in making its decision.

Mr Sharma identified specific standards which he considered relevant.

Mr Sharma submitted that the conduct in the proven charges can be categorised into four main categories for the purposes of considering misconduct:

i) Documentation errors (charges 1,3,5,7)
ii) Medication and/or clinical errors (charges 9a,11a,11b)
iii) Dishonesty (charges 2,4,6,8)
iv) Regulatory misconduct (charge 12)

Mr Sharma further submitted that it is suggested that the documentation errors and dishonesty charges may be considered in groups of associated charges for the purposes of misconduct. Whilst it could be accepted that not all documentation errors would be deemed serious professional misconduct, when considered with the associated dishonesty charge, these become particularly serious.

Mr Sharma also submitted that it is the NMC's position that charges 11a and b are particularly serious as they involve controlled and potentially dangerous drugs. The panel are reminded that the patients involved in this case were particularly vulnerable and

reliant on nursing care for their wellbeing. An example of this is patients who require regular turning to maintain their skin integrity such as in charge 5.

Mr Sharma submitted that the conduct in charge 12 is similarly very serious. Any breach of regulatory intervention not only introduces a risk to patients but also shows a disregard for the regulatory process and therefore undermines the regulator in the eyes of the public. In the circumstances of this case, he submitted that it is the NMC's position that it is easy to see how fellow practitioners would view these matters as reprehensible conduct both individually and collectively.

Mr Sharma submitted that the NMC accept that breaches of the Code will not be conclusive as to the issue of misconduct, these are fundamental requirements for the nursing profession. In a case of such conduct, breaches of the relevant parts of the Code should be carefully considered by the panel. In concluding this part of the consideration, it is the NMC's position that the conduct found proved clearly amounted to serious professional misconduct.

Submissions on impairment

Mr Sharma 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. This 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 *Zgymunt v General Medical Council* [2008] EWHC 2643 (Admin).

Mr Sharma submitted that the panel are likely to find the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) instructive. Taken from that case, he further submitted the appropriate test involves asking the following questions:

'Do the findings of fact in respect of Miss Purrott's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that her fitness to practise is impaired in the sense that she:

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

Mr Sharma submitted that in addressing each of these questions, the NMC's position is as follows; firstly, although there is no allegation of actual patient harm, Miss Purrott's conduct had the potential to place those under her care at risk of harm and therefore the answer to the first question is yes.

In relation to the second question, Mr Sharma submitted that most of the charges had the potential to bring the profession into disrepute and by Miss Purrott's actions she has done just that. The panel may wish to consider how an informed member of the public would view these charges compared to what they expect the conduct of a registered professional to be. Mr Sharma further submitted that cases involving dishonesty and breaches of regulatory requirements are viewed very dimly by the public. Considering this, he submitted that the answer to the second question is yes.

Mr Sharma noted that the NMC guidance (at DMA-1), assists in determining what the fundamental tenets of the profession are and that they can be obtained by looking at the main themes of the Code. He submitted that there are a number of breaches of these themes (as detailed above) and therefore the answer to the third question is yes.

Mr Sharma reminded the panel that 4 charges of dishonesty have been found proved. These were all dishonesty in recording false information in clinical records. He submitted that for this reason the final question can also be answered – yes.

Mr Sharma reminded the panel that it may next consider if there are elements of the context of how, when and where this misconduct occurred which have a bearing on impairment. He submitted that there are no contextual factors which could go even some way to explaining or excusing such behaviour. There appears no reason for Miss Purrott to have demonstrated the conduct found proved. Whilst the NMC accept mistakes in clinical practice can happen, the requirements on a registered professional are clear in relation to honesty and integrity.

The questions, Mr Sharma submitted, which remain are whether Ms. Purrott is currently and is she liable in the future to remain impaired. Current impairment can be found either on the basis that there is a continuing risk to the public or that the public confidence in the nursing profession and the NMC as regulator would be undermined if such a finding were not made.

Regarding current and future risk, Mr Sharma submitted that the panel will likely find assistance in the questions asked by Silber J in *Cohen*, namely:

a) *'is the misconduct easily remediable,*
b) *has it in fact been remedied and*
c) *is it highly unlikely to be repeated.'*

Dealing then with Silber J's questions, Mr Sharma submitted that the conduct found proved in the documentation, clinical and medication error charges may be remediable, but that the dishonesty and regulatory breach charges are particularly serious and also difficult to remediate. Conduct involving dishonesty may come from deep seated attitudinal problems which are not easy to put right.

Insight is an important concept when considering impairment. In this case, Miss Purrott has not attended, nor has she an adequate reflection on these matters. Although the NMC

does not invite any adverse inference, the panel have nothing to suggest any insight has been shown. Mr Sharma noted that Miss Purrott has provided evidence of further training since the concerns came to light. However, the panel will need to decide on the relevance of these training sessions considering the facts found proved. Further, these training sessions were completed in 2021, and the panel do not have any evidence of recent safe practice or alternatively, applying the skills learnt in these training sessions. Mr Sharma submitted that in the absence of this, the concerns have not been remedied.

Mr Sharma further submitted that the fact that Miss Purrott resigned before her final probationary meeting could take place at the Southampton General Hospital, combined with her subsequent breach of the conditions of her interim conditions of practice order, she has demonstrated a lack of any insight into the concerns or the potential to harm occasioned by her conduct. These factors indicate a real risk of repetition for this type of misconduct.

In light of all of the reasons above, Mr Sharma submitted that Miss Purrott's actions were serious, and a finding of current impairment is required in order to uphold proper professional standards and maintain public confidence in the profession.

Decision and reasons on misconduct

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

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 Miss Purrott's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to breaches of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*

1.2 make sure you deliver the fundamentals of care effectively

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

4 Act in the best interests of people at all times

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Miss Purrott made a number of significant errors that had potentially serious patient safety implications. Further, she made other errors in her documentation and failed to escalate certain matters to a colleague. The panel was also of the view that there were issues in Miss Purrott's handling of controlled drugs and her dishonesty in terms of completing records for patients incorrectly on multiple occasions also had potentially serious patient safety implications.

The panel considered that the regulatory matter referred to in charge 12, while found proven, was not so serious and there were mitigating factors. Miss Purrott had told her prospective new employing agency, about her interim order conditions and tried unsuccessfully to obtain advice from the NMC on how they should proceed. The agency was also apparently given incorrect advice that Miss Purrott was allowed to work for them.

The panel considered Miss Purrott's response bundle and noted that she sought to provide mitigation for her failings. The panel noted that she referred to health issues and distractions during her health rounds and poor communication by her colleagues. However, the panel was not satisfied with these reasons for mitigation and did not accept them. The panel determined that Miss Purrott's practise was unsafe and was of the view that she sought to blame others for her failings.

The panel found that Miss Purrott's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct which would be considered deplorable by members of the nursing profession and well-informed members of the public.

Decision and reasons on impairment

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

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's *"test"* which reads as follows:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that patients were put at risk of harm as a result of Miss Purrott's misconduct. Miss Purrott'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 impairment.

Regarding insight, the panel considered Miss Purrott's statement in relation to the concerns and determined that it had nothing before it to suggest that any effort had been made to remediate any of the misconduct. The panel was of the view that Miss Purrott sought to blame other members of staff for what happened and did not show any remorse or understanding of how her actions impacted patient safety.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Miss Purrott has taken steps to strengthen her practice. The panel took into account the training sessions she undertook and noted that these were one day courses that did not address the charges found proved, except one on catheter care and catheterisation. Further, the panel noted that Miss Purrott has not provided a comprehensive reflective statement to demonstrate her understanding of how her actions impacted patient safety and negatively on the reputation of the nursing profession. The panel had sight of four testimonials from former colleagues who spoke positively of Miss Purrott's performance. However, the panel did not find these relevant to the charges.

The panel concluded that there is a risk of repetition based on Miss Purrott's lack of sufficient insight and evidence of strengthened practice. The panel was of the view that Miss Purrott resigned before being called to account and did not show any remorse or any insight.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because Miss Purrott has not demonstrated any understanding of how her actions impacted patient safety. The public would also find it unacceptable in light of these circumstances if such a finding were not made. Further, the panel was of the view that any suitably informed member of the public would find Miss Purrott's actions in dishonestly completing patient records and failing to escalate deteriorating patients deplorable and extremely concerning.

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 Miss Purrott's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Purrott's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Purrott's name off the register. The effect of this order is that the NMC register will show that Miss Purrott 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 Sharma submitted that when considering the NMC guidance on sanction, the panel may find of assistance the comments of Collins J in *Council for the Regulation of Health*

Care Professionals v (1) General Medical Council and (2) Leeper [2004] EWHC 205 (Admin):

> '[the GMC's indicative sanctions guidance] *helps to achieve a consistent approach to the imposition of penalties where serious professional misconduct is established. The [panel] must have regard to it although obviously each case will depend on its own facts and guidance is what it says and must not be regarded as laying down a rigid tariff'.*

Mr Sharma reminded the panel that when considering sanctions, the panel should have regard to their purpose and although sanctions are intended to protect the public interest and not intended to be punitive, they may have that effect. He further reminded the panel that it should start by considering whether the least restrictive sanction would be sufficient to protect the public and uphold the public interest in light of those factors. If the least restrictive sanction is not sufficient, the panel should work through the available sanctions in ascending order of severity, until they find the order that is considered sufficient.

Mr Sharma submitted that to ensure the sanction imposed is not disproportionate, the panel should consider each sanction in ascending order and not simply arrive at the chosen sanction by the process of elimination; rather, specific reasons should be given as to why the chosen sanction is no more than necessary, (as outlined in *Brennan v Health Professions Council* [2011] EWHC 41 (Admin)), something which may include a consideration and rejection of the next most severe sanction.
Mr Sharma submitted that Miss Purrott has not engaged with this hearing so the panel have not had the benefit of hearing from her directly, although she has provided a response bundle which contains some information about her personal circumstances which the panel may wish to consider. He further submitted that Miss Purrott has not had any previous regulatory findings against her and although this is not a mitigating factor, the seriousness of this case is not raised by such matters.

Mr Sharma further submitted that the panel may wish to consider that the repeated nature of Miss Purrott's conduct, the risk of patient harm and the dishonesty associated with patient records are all aggravating factors in this case.

Mr Sharma informed the panel that the NMC seek the imposition of a striking-off order. He submitted that in taking each sanction starting from the least restrictive, no further action, the case is too serious to be addressed by this option. The NMC's main concerns if no action were to be taken would be the lack of protection afforded to patients and the wrong message being sent to both the public and fellow registered professionals. He submitted that the matters in this case are serious and require a robust sanction.

Mr Sharma submitted that in considering whether a caution order would be appropriate, the panel will have to evaluate any insight shown by Miss Purrott. He submitted that there is no evidence of developed insight in this case and the conduct found proved is too serious to be dealt with by a caution order.

Mr Sharma further submitted that a conditions of practice order is not appropriate. Although there are identifiable areas of Miss Purrott's practise which require further training and or evaluation, there are other concerns such as the dishonesty and breach of regulatory requirement which would not be suitable for conditions. He submitted that it would not be possible to formulate workable conditions which would adequately protect the public and uphold professional standards.

Mr Sharma outlined the NMC sanction guidance on suspension orders where it suggests that this sanction may be appropriate where there is a single incident and there are no underlying attitudinal concerns. Mr Sharma submitted that this case involved repeated similar concerns each with associated dishonesty and the breach of interim conditions. In his view, this supports his submission that Miss Purrott has a harmful deep seated attitudinal problem, and a lack of insight. Mr Sharma submitted that for these reasons, a suspension order is not suitable.

Mr Sharma submitted that the remaining available sanction is a striking-off order, and this would be appropriate as Miss Purrott was responsible for serious professional misconduct

including dishonesty and has shown no insight. He further submitted that there are concerns regarding her underlying attitude towards remediation and strengthening her practice.

Decision and reasons on sanction

Having found Miss Purrott'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:

- Miss Purrott's lack of insight
- Dishonesty relating to more than one charge
- Pattern of misconduct over a period of time, repeated incidents
- Dishonest conduct was in the context of clinical practice
- The concerns relate to the treatment of vulnerable patients
- Conduct which put patients at risk of suffering harm.

The panel also acknowledged the following mitigating features:

- Miss Purrott's various health issues
- The working relationships – her struggle to fit in an existing team.

The panel had noted the written statements which Miss Purrott had submitted to the NMC sometime ago and also considered the email response Miss Purrott provided upon being notified that her fitness to practice has been found impaired on the previous day. Miss Purrott indicated that she does not wish to continue practising as a nurse and is not currently practising as a nurse.

The panel took account of the guidance in the SG concerning the need to assess the seriousness of dishonesty in such a case. it recognised that not all dishonesty is equally serious, and it considered carefully the SG guidance which sets out which types of dishonest conduct could call in question whether a nurse should remain on the register. It concluded that, while the dishonesty in this case was not at the top end of the spectrum, it did not relate to a one-off incident and did have the possibility of direct risk of harm to vulnerable patients. It recognised however that the dishonesty was not related to personal gain.

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

The panel next considered whether placing conditions of practice on Miss Purrott's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The dishonesty identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Purrott's registration would not adequately address the seriousness of this case and would not protect the public or ensure that public trust in the nursing profession was not undermined.

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

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that Miss Purrott's dishonesty represents a serious breach of the fundamental tenets of the profession. The panel concluded that this case was not a single case of misconduct. It determined that whilst Miss Purrott's dishonesty was not at the top end of the spectrum, it is fundamentally incompatible with her remaining on the register.

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

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

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

Miss Purrott's actions were a significant departure from the standards and professionalism expected of a registered nurse. Her behaviour was fundamentally

incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Purrott's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after seriously considering 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 Miss Purrott's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary, not only to protect the public, but also 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 Miss Purrott in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Purrott's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Sharma. He submitted that the NMC seek an interim suspension order for a period of 18 months to cover any

subsequent appeal. He submitted that 18 months is sufficient given that any appeal process is unlikely to be concluded in a shorter period of time.

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 protect the public.

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

That concludes this determination.