Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 30 October 2023 – Thursday, 02 November 2023,
Monday 06 November 2023 – Friday 10 November 2023,
Monday 13 November 2023 – Tuesday 14 November 2023

Virtual Hearing

Name of Registrant:	**Kamilla Maria Ahonle**
NMC PIN	11F2207E
Part(s) of the register:	Children's Nurse – Level 1 (March 2012) RSN – Specialist Practitioner: School Nurse (January 2014) V100 – Nurse Prescriber (March 2014)
Relevant Location:	Hackney
Type of case:	Misconduct
Panel members:	Greg Hammond (Chair, Lay member) Kim Bezzant (Registrant member) Caroline Taylor (Lay member)
Legal Assessor:	Tim Bradbury (30 October 2023 – 2 November 2023) Andrew Young (6 November 2023 – 14 November 2023)
Hearings Coordinator:	Daisy Sims (30 October 2023 –8 November 2023, 13 November – Tuesday 14 November 2023) Opeyemi Lawal (9 & 10 November 2023)
Nursing and Midwifery Council:	Represented by Conall Bailie, Case Presenter
Mrs Ahonle:	Present and represented by Simon Holborn
Facts proved by admission:	Charges 1, 2, 4, 6, 7, 8(a)(viii), 8(b), 11, 12, 14 and 15
Facts proved:	Charges 3, 5, 8(a)(i)(ii)(iii)(v), 10 and 16
Facts not proved:	Charges 8(a)(iv),(vi), (vii), 9 and 13

Fitness to practise: Impaired

Sanction: Suspension Order (6 months)

Interim order: Interim suspension order (18 months)

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

At the outset of the hearing, Mr Holborn, on your behalf, made a request that this case be held partly in private on the basis that proper exploration of your case involves [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Bailie, on behalf of the Nursing and Midwifery Council (NMC) indicated that he supported the application to the extent that any reference to [PRIVATE] should be heard in private.

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.

The panel determined to rule on whether or not to go into private session in connection with health and other personal matters as and when such issues are raised in order to protect your privacy and that of third parties.

[PRIVATE]

Details of charge

That you, a registered nurse:

1) Between September and October 2020, failed to attend one or more looked after children's homes to conduct required review health assessments.

2) On 18 November 2020, indicated to Colleague A that you had conducted the review health assessments referred to at charge 1.

3) Your actions at charge 2 were dishonest in that you knew you had not conducted the relevant review health assessments and were seeking to mislead Colleague A.

4) Between September and October 2020, failed to complete one or more review health assessments within a reasonable time of having visited the relevant looked after child's home.

5) Failed to raise safeguarding concerns in respect of Child A's parents' behaviour timeously or, in any event, at any point prior to your own practice in respect of Child A being called into question.

6) Used Child A's IPad for your own personal use.

7) Your actions at charge 6 breached professional boundaries with Child A.

8) On one or more occasions between 21 and 27 October 2020:

   a) administered medication to Child A:

      i) Without checking that the medication was in date.
      ii) Without checking the medication was in its true form.
      iii) Without shaking the medication bottle to ensure active ingredients are equally distributed.
      iv) Without checking Child A's MAR chart.
      v) Without checking medication to be given by syringe at eye level or otherwise in a manner which would allow you to check that the right amount had been withdrawn.
      vi) Without flushing when it would have been clinically appropriate to do so.
      vii) By way of a technique intended to obscure what is being administered from Child A's CCTV cameras.
      viii) With the lights in Child A's room turned off.

b) Failed to have appropriate regard to infection control procedures in that you provided care to Child A without any or any adequate personal protective equipment in place.

9) Your actions at charges 8avii and 8aviii were dishonest in that you intended to conceal from Child A's parents the quantity and/or type of medication which you were administering to Child A.

10) On 25 October 2020, failed to have appropriate regard to a Child A's dignity in that, without clinical reason, you allowed him to be naked/partially naked.

11) On 25 and 27 October 2020, took personal calls when you were responsible for Child A's 121 care.

12) On 25 and 27 October 2020, moved Child A in a manner contrary to his care plan.

13) On 27 October 2020, failed to immediately provide care to Child A in response to him having a seizure.

14) On 27 October 2020, worked a shift for First Options and claimed to have also worked at shift for Homerton Healthcare NHS Foundation Trust.

15) On 03 November 2020, worked a shift for First Options and claimed to have also worked at shift for Homerton Healthcare NHS Foundation Trust.

16) Your actions at charges 14 and 15 were dishonest in that you knew you had not simultaneously worked for First Options and Homerton Healthcare NHS Foundation Trust.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Bailie at the close of the NMC case on facts to amend the wording of charge 13.

Mr Bailie submitted that the purpose of the proposed amendment was to more accurately reflect the evidence before the panel. He submitted that the proposed amendment causes no injustice to you as the mischief in this charge is that you did not take any action as a result of Child A's deterioration. He submitted that the specific medical reason for Child A's deterioration is not the essence of this charge.

The proposed amendment reads as follows:

> "That you, a registered nurse:
>
> ~~13)~~On 27 October 2020, failed to immediately provide care to Child A **when it was clinically appropriate to do so in light of his presenting condition** ~~in response to him having a seizure.~~
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

The panel heard submissions from Mr Holborn. He submitted that charges are supposed to be clear and settled before a hearing takes place and that the NMC has had 3 years to put this case together and submitted that this proposed amendment is unfair to you because you need to know the case being made against you in order to properly prepare your case. He submitted that the proposed amendment brings an entirely new charge with a new set of circumstances for the panel to consider which is not fair to you. Further, he questioned the proposed wording of this charge and submitted that it is not clear what a '*presenting condition'* is.

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

The panel determined that you would be disadvantaged by the acceptance of the proposed amendment. It noted that the proposed amendment is not specific and would broaden the scope of the charge.

The panel focused on the disadvantage to you by this late amendment, namely, that initially this charge was a specific allegation to which you had responded, and the proposed amendment has substituted the charge to a more general and less particularised allegation which may have necessitated a different approach by you. The panel also considered that Mr Holborn, on your behalf, may have had further questions or a different approach to his questioning of the NMC witnesses who have already provided evidence to the panel.

The panel therefore determined that it would be unfair to you to allow the proposed amendment to the charge 13. Therefore, the panel rejected this application.

Background

You were referred to the NMC on 13 November 2020 by a Clinical Director at First Option Healthcare ('the Agency'). At the time of the incidents, you were employed as a nurse by the Agency to provide care as part of a team to Child A in their own home.

You were also employed as a Specialist Nurse for Looked After Children ('LAC') by Homerton University Hospital NHS Foundation Trust ('the Trust'). It is alleged that between September and October 2020, you failed to conduct required review health assessments on one or more LAC but told Colleague A that you had conducted these reviews. It is further alleged that between this time you failed to complete one or more review health assessments within a reasonable time of having visited the relevant LAC.

Child A was a young child who had a number of complex conditions, including a neurodegenerative disorder, seizure disorder, severe intermittent dystonia, profound cognitive impairment and sleep apnoea with nocturnal desaturations. Child A required round the clock care and you worked as part of a package of staff to provide this to him in his own home.

On or around 27 October 2020, you had cared for Child A during the day, following which, concerns were raised about his presentation, in that he was excessively sleepy and was difficult to rouse. You were contacted to ask what medication you had given Child A and you allegedly said that you had given 10mls of Paracetamol. The medication chart was checked and it was noted that you had only signed for 6.5mls.

You were called again, and you were asked what medication you had given as it did not look as though any Paracetamol had been used from the open bottle. It is alleged that you said that you must have made a mistake and had probably given Child A some Ibuprofen. The medication and the CCTV from Child A's room was reviewed. It was noted that there was approximately 98ml of Baclofen and 68ml of Trihexyphenidyl missing from Child A's medication stock. These concerns were passed on to the Agency the following day. It is alleged that you had safeguarding concerns in respect of Child A's parents' behaviour that you failed to raise at any point prior to your own practice in respect of Child A being called into question.

Further CCTV footage was reviewed from 21 October 2020 to 3 November 2020, and the following concerns were raised that whilst caring for Child A you had:

- Administered medication without checking this at eye level to ensure the right amount had been withdrawn, without checking it was in date, in its true form and without shaking the medication bottle to ensure active ingredients are equally distributed;
- Administered medication by way of a technique intended to obscure what is being administered from Child A's CCTV cameras;
- Failed to cross reference and check the Medication Administration Record ('MAR') when drawing up and recording medication administration;
- Turned the lights off while administering medication;
- Took personal calls when you were responsible for Child A's one to one care;
- Failed to use a flush following the administration of medication;
- Failed to respond to Child A while they were having a seizure as you were making a personal telephone call;

- Failed to maintain Child A's dignity in that you left him naked while you were eating your lunch;
- Failed to use the correct manual handling procedures when moving Child A;
- Failed to wear the correct Personal Protective Equipment ('PPE') when suctioning Child A.

Additionally, it is alleged that there are pictures of you on Child A's iPad. There was no reason for you to have used Child A's iPad for your personal use.

On 11 November 2020, you were suspended by the Agency pending the outcome of an investigation into the concerns raised regarding your practice.

On 16 November 2020, the Trust was contacted and informed of the allegations made against you during the course of your employment with the Agency. It then became apparent that on 27 October 2020 and 3 November 2020 you had submitted that you had been working for both the Agency and the Trust at the same time. On 18 November 2020, you were suspended from the Trust pending an investigation into your conduct.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Holborn, who informed the panel that you made admissions to charges 1, 2, 4, 6, 7, 11, 14 and 15.

At a later stage, during your case on facts, Mr Holborn informed the panel that you made further admissions to charges 8(a)(viii), 8(b) and 12.

The panel therefore finds charges 1, 2, 4, 6, 7, 8(a)(viii), 8(b), 11, 12, 14 and 15 proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Bailie and by Mr Holborn.

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: Interim Named Nurse for the Looked After Children (LAC) Team and your line manager at the time of the incidents

- Witness 2: National Clinical Lead for Learning Disabilities, Mental Health and Autism at the Agency

- Witness 3: Senior Nurse for Paediatrics at the Trust

- Witness 4: Social Worker of Child A at the time of the incidents

Witness 5 is a professional investigator contracted by the Trust and her evidence was agreed by the parties.

The panel also heard live evidence from the following witnesses called on your behalf:

- Witness 6:

- Witness 7: Occupational Therapist

At the end of Witness 6's evidence, the panel heard a request from Witness 6 that their evidence be heard entirely in private [PRIVATE]. The panel determined that any reference to Witness 6 would be heard in private [PRIVATE].

The panel also heard evidence from you under oath.

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

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

Charge 3

That you, a registered nurse:

2) *On 18 November 2020, indicated to Colleague A that you had conducted the review health assessments referred to at charge 1.*

3) Your actions at charge 2 were dishonest in that you knew you had not conducted the relevant review health assessments and were seeking to mislead Colleague A.

This charge is found PROVED.

The panel considered what your knowledge was at the time of the incident. It bore in mind your detailed evidence about the impact of losing your Rio Card in that you could not access information you needed to carry out your role at the Trust.

However, in Colleague A's written statement, in which she refers to two phone calls to you, it states:

'On 18 November 2020 I called Kamila to find out if she had seen the children/their carers for the October allocation. She said she had seen them but hadn't written the reports up. […]

There were seven children Kamila said she had seen in October 2020. […] I called all of the seven carers of the children and asked if they had been seen and they all confirmed they had not'.

The panel determined that these two phone calls by Witness 1 provided you with an opportunity to tell the truth on two separate occasions, which you did not. The panel determined that you had a duty to tell the truth to your line manager at this point and you also had a duty to tell the truth due to the consequences that not telling the truth could have had on the children in your care.

[PRIVATE] it determined that you must have known that you had not conducted the relevant review health assessments and you sought to mislead Colleague A during the two phone calls made to you. The panel considered that an ordinary decent member of the public would find this to be dishonest.

The panel therefore determined, on the balance of probabilities, that your actions at charge 2 were dishonest in that you knew you had not conducted the relevant review health assessments and were seeking to mislead Colleague A.

Charge 5

That you, a registered nurse:

5) Failed to raise safeguarding concerns in respect of Child A's parents' behaviour timeously or, in any event, at any point prior to your own practice in respect of Child A being called into question.

This charge is found PROVED.

The panel reviewed '*The Code: Professional standards of practice and behaviour for nurses and midwives (2015)*' ('the Code'), particularly 17:

> '***17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection'***

It determined that you, a registered nurse, did have a duty to raise safeguarding concerns immediately. Additionally, the panel recalled your oral evidence that you had safeguarding training both from the Trust and from the Agency, you explained that safeguarding concerns should be raised through a referral, and you should also discuss these with your line manager. It therefore determined that you had a clear understanding of safeguarding procedures.

The panel reviewed a Safeguarding referral dated 28 October 2020 which contains a statement from you outlining your safeguarding concerns. Some of these concerns are historic and you would have been aware of them significantly before the date of this referral. The panel noted that these concerns were investigated and not upheld, but that does not affect your duty.

Whilst the panel noted in your oral evidence that you believed a social worker was already aware of the safeguarding concerns, it determined that it is your duty as a registered nurse to ensure that safeguarding concerns are referred to the appropriate authorities. The panel also noted your oral evidence in which you stated your main concern being the parents declining to call an ambulance when they were worried about Child A's condition, but that this was not in the list of safeguarding concerns in the written referral.

The panel therefore determined, on the balance of probabilities, that it is more likely than not that you failed to raise safeguarding concerns in respect of Child A's parents' behaviour timeously or, in any event, at any point prior to your own practice in respect of Child A being called into question.

Charge 8a(i), (ii), (iii) & (v)

That you, a registered nurse:

8) On one or more occasions between 21 and 27 October 2020:

   a) administered medication to Child A:

      i) Without checking that the medication was in date.
      ii) Without checking the medication was in its true form.
      iii) Without shaking the medication bottle to ensure active ingredients are equally distributed.
      iv) *Dealt with below*
      v) Without checking medication to be given by syringe at eye level or otherwise in a manner which would allow you to check that the right amount had been withdrawn.

These charges are found PROVED.

The panel first considered the CCTV footage of Child A's bedroom provided to it. The panel noted that the CCTV footage is not in its pure form in that selected clips had been presented by the NMC, some of which are sped up, slowed down or repeated. Nevertheless, the panel was able to clearly view you preparing and administering medication to Child A on more than one occasion.

The panel considered that in order for you to check that the medication you were administering was in date, in its true form and to ensure that the right amount had been withdrawn, you would have had to analyse the medication bottles and/or syringe up close.

The panel viewed one CCTV clip where you are seen to check a medication bottle at eye level when the syringe was in the bottle. The panel heard from Witness 2 who stated that this was safe practice. However, this directly contrasts your actions in the other CCTV clips before the panel where you are seen to prepare medication in the

medication drawer without looking at the bottles and their labels before drawing up the medication to ensure that it was in date and in its true form. You also did not check the amounts in the syringes by viewing them at eye level [PRIVATE].

The panel bore in mind your evidence that you adopted a '*table approach'* [PRIVATE] in that you would check that the right amount of medication had been withdrawn by placing the syringes on a table. However, none of the CCTV footage before the panel showed you doing this. The panel also noted the expert witness evidence provided by Witness 7 who explained that you could have used your other arm to check the medications at eye level. The panel determined that you were capable of checking medication at eye level as you are seen to do this in one of the CCTV clips.

The panel noted that within the CCTV there was no evidence of you shaking any medication bottle to ensure the active ingredients were evenly distributed. [PRIVATE]

The panel therefore determined, on the balance of probabilities, that it is more likely than not that on one or more occasion between 21 and 27 October 2020 you administered medication to Child A without checking that the medication was in date, in its true form, shaken to ensure active ingredients are equally distributed and without checking medication to be given by syringe at eye level or otherwise in a manner which would allow you to check that the right amount had been withdrawn.

Charge 8(a)(iv)

That you, a registered nurse:

8) On one or more occasions between 21 and 27 October 2020:

  a) administered medication to Child A

    iv) Without checking Child A's MAR chart.

This charge is found NOT PROVED.

The panel bore in mind your oral evidence that there was medication information on the wall closest to Child A's medication cabinet. It also noted your evidence that Child A's Medication Administration Record ('MAR') chart was on the floor next to the chair in Child A's room. You explained to the panel that you would administer medication to Child A and then document this on Child A's MAR chart afterwards.

The panel noted that the CCTV evidence where you are seen administering medication to Child A stops after you are seen administering medication and does not show whether or not you then go to the area of the room where the MAR chart was located. It also noted that in some of this CCTV evidence you are seen to glance at a poster on the wall next to the medication cabinet. The panel also noted that it had not seen enough CCTV footage from before you started administering medication.

The panel determined that the CCTV evidence provided is not sufficient to determine, on the balance of probabilities, whether or not you administered medication to Child A without checking Child A's MAR chart as the CCTV clips have been cut in a way that does not provide enough of a timeline to determine whether or not you did check Child A's MAR chart.

The panel therefore determined that the NMC has not discharged its burden of proof in relation to this charge and so found this charge not proved.

Charge 8(a)(vi)

That you, a registered nurse:

8) On one or more occasions between 21 and 27 October 2020:

   a) administered medication to Child A

      vi) Without flushing when it would have been clinically appropriate to do so.

This charge is found NOT PROVED.

The panel noted the evidence provided by Witness 2 in their witness statement which states '*the process of flushing involved bottles of cold boiled water and there was always a prescribed amount required'.* [PRIVATE].

The panel viewed the CCTV clips provided. It noted that you can be seen drawing up a flush in one of the CCTV clips. However, it considered that it was not possible to determine whether or not you were flushing medication as it was not possible to identify the contents of the syringes seen on the CCTV.

The panel determined that the CCTV evidence provided is not sufficient to determine, on the balance of probabilities, whether or not you administered medication to Child A without flushing when it would have been clinically appropriate to do so.

The panel therefore determined that the NMC has not discharged its burden of proof in relation to this charge and so found this charge not proved.

Charge 8(a)(vii)

That you, a registered nurse:

8) On one or more occasions between 21 and 27 October 2020:

   a) administered medication to Child A

      vii) By way of a technique intended to obscure what is being administered from Child A's CCTV cameras.

This charge is found NOT PROVED.

The panel viewed the CCTV clips in which you administer medication to Child A. It noted that in these clips you are seen to administer medication to Child A in a number of different positions. The panel bore in mind the evidence provided to it of [PRIVATE] which provides some explanation for the different positions you adopted to administer medication.

The panel determined that the CCTV evidence provided is not sufficient to determine, on the balance of probabilities, that you administered medication to Child A by way of a technique intended to obscure what is being administered from Child A's CCTV cameras.

The panel therefore determined that the NMC has not discharged its burden of proof in relation to this charge and so found this charge not proved.

Charge 9

That you, a registered nurse:

9) Your actions at charges 8avii and 8aviii were dishonest in that you intended to conceal from Child A's parents the quantity and/or type of medication which you were administering to Child A.

This charge is found NOT PROVED.

The panel only considered whether your actions at charge 8(a)(viii) was dishonest as charge 8(a)(vii) has been found not proved.

The panel bore in mind your evidence that it was regular practice to turn off the main light in Child A's bedroom at night. You stated that the room was never fully in darkness as there were other lamps that remained on. [PRIVATE].

The panel also noted that the CCTV footage is still clear once the main light had been turned off. It was possible to see that a lamp was still lit in the room. The panel therefore determined that, on the balance of probabilities, your actions at charge 8(a)(viii) were not dishonest as the CCTV footage is still clear after the light had been turned off and so you did not conceal the quantity and/or type of medication which you were administering to Child A.

The panel therefore finds this charge not proved.

Charge 10

That you, a registered nurse:

10) On 25 October 2020, failed to have appropriate regard to a Child A's dignity in that, without clinical reason, you allowed him to be naked/partially naked.

This charge is found PROVED.

The panel determined that you, a registered nurse, have a duty to preserve patient's dignity as outlined under the header *'Prioritise people'* in the Code:

> '*You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved, and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.'*

The panel noted the evidence before it that Child A suffers with dystonia along with spikes in temperature. This meant that Child A would frequently be undressed in order to assist in relieving his symptoms or to bring his temperature down. The panel also considered the clear evidence [PRIVATE] reviewed the CCTV footage confirmed that even during these periods Child A should be covered with a light covering, and that there is not a clinical reason for him to be left partially naked, particularly during the extended period when you are seen taking a break on the armchair with a plate of food on your lap.

The panel therefore determined that on the balance of probabilities, it is more likely than not that on 25 October 2020, you failed to have appropriate regard to Child A's dignity in that, without clinical reason, you allowed him to be naked/partially naked.

Charge 13

That you, a registered nurse:

13) On 27 October 2020, failed to immediately provide care to Child A in response to him having a seizure.

This charge is found NOT PROVED.

The panel considered Child A's care plan which states:

> '*I have been diagnosed with Seizure disorder, Dysautonomia and Severe intermittent dystonia which is a movement disorder characterised by attacks of involuntary movements.*
>
> *This makes it often difficult to differentiate between involuntary movement and seizure activity.'*

The panel considered the evidence provided by Witness 2 in their CCTV log under CCTV clip 4 which is dated 27 October 2020. It states; *'See K* [Kamila] *on her phone Child A can be seen to clearly start to have a seizure'.* However, the panel also considered the contrary evidence [PRIVATE] that the movement of Child A seen in the CCTV footage is not a seizure but was a dystonia attack. The panel bore in mind that you also stated that Child A was showing signs of a dystonia attack in your oral evidence.

The panel preferred the evidence provided by you [PRIVATE] as you both had direct longstanding experience with Child A. The panel therefore determined, on the balance of probabilities, that Child A was having a dystonic attack and not a seizure.

The panel therefore determined that it is more likely than not that on 27 October 2020, you did not fail to immediately provide care to Child A in response to him having a seizure.

Charge 16

That you, a registered nurse:

16) Your actions at charges 14 and 15 were dishonest in that you knew you had not simultaneously worked for First Options and Homerton Healthcare NHS Foundation Trust.

This charge is found PROVED.

The panel first considered what your knowledge/belief was at the time of the incident on or around 27 October 2020 and 03 November 2020.

The panel noted your oral evidence that, at the time, you had changed from working full time for the Trust to working part time from Monday-Wednesday for the Trust. You told the panel that this started on 1 October 2020. The panel noted that this was four weeks prior to the first incident and so, at the time, you would have been aware of your working pattern. You told the panel that you would be flexible when working to accommodate foster carers on other days if they were not able to meet with you between Monday-Wednesday. However, the panel noted that your managers at the Trust provided no evidence to confirm your working pattern was flexible. Additionally, there is no evidence before the panel that you did meet the foster carers at another time. You also told the panel that you received a call from Child A's mother on 26 October 2020 '*begging'* you to help her with Child A on 27 October 2020.

You stated that you were confused at the time due to your personal circumstances affecting your home life. You stated in your reflective piece:

> '*I was so muddled and exhausted by everything around me'.*

However, the panel determined that this mitigation provided by you does not outweigh the evidence which has satisfied the panel that you did have clear knowledge/belief that

you had worked for First Options (the Agency) on two occasions when you should have been working for Homerton Healthcare NHS Foundation Trust (the Trust).

The panel therefore determined that your actions at charges 14 and 15 were dishonest, under the definition of ordinary decent people, in that you knew you had not simultaneously worked for Frist Options and Homerton Healthcare NHS Foundation Trust.

Decision and Reasons on Application to Adjourn

At the start of stage two of the hearing, Mr Holborn informed the panel that you were unable to attend the hearing today due to a work commitment that you were unable to change. Mr Holborn then made an application to adjourn the hearing to obtain [PRIVATE].

Mr Holborn submitted that allowing time to seek and facilitate the provision of [PRIVATE].

Mr Holborn submitted that having [PRIVATE] would be in the interest of justice by providing a fair hearing and would assist the NMC and the panel. He is aware that documentation has already been provided [PRIVATE].

Mr Holborn invited the panel to allow for a short adjournment to find time to get [PRIVATE], which may take up to two months, as he has not yet identified [PRIVATE].

Mr Baillie submitted that in the case management form completed on your behalf, the section on expert evidence stated that:

> *'[PRIVATE]'.*

He also submitted that on the form it was noted that:

> *'[PRIVATE]'.*

Mr Baillie further submitted that adjourning at this stage to allow time to [PRIVATE] is something that could have been avoided as you knew that this was going to be an important issue before this hearing commenced and you could have found [PRIVATE] to provide evidence at this stage.

Mr Baillie objected to the application to adjourn for the length of time suggested. In fairness, Mr Baillie submitted that he had no objection to this hearing being adjourned until tomorrow to give you the opportunity to be present and to give further evidence, particularly in relation to [PRIVATE].

The panel heard and accepted advice from the legal assessor.

The panel took into account the NMC guidance CMT-11 and considered the following factors:

- Mr Holborn had had sufficient time to obtain evidence [PRIVATE] given the amount of notice for the hearing and your own stated intention in the case management form to produce and rely upon such evidence.
- Mr Holborn did not identify any expert who he would want to instruct to provide further information or indicate what that expert might say, which would assist the panel in determining the next stages.
- There is a public interest in the expeditious disposal of the case and this is a very late application.
- Potential inconvenience to parties is of less relevance now the witnesses have appeared but there is still an inconvenience to the NMC to have a part-heard case.
- Not adjourning the hearing will not be unfair as the panel has before it the unchallenged reports [PRIVATE], which set out in detail your [PRIVATE]. The panel also heard further details from you [PRIVATE] in your detailed reflections, which the panel can take into account in its decision making. Furthermore, it was not clear to the panel what further relevant evidence might be provided by an [PRIVATE].

The panel therefore decided to refuse the application to adjourn.

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 your 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. An alternative question which the NMC suggests is a suitable question for the panel to ask itself in helping to decide whether a registrant's fitness to practise is impaired is: can the nurse practise kindly, safely, and professionally?

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, your fitness to practise is currently impaired as a result of that misconduct.

You gave evidence under oath.

Submissions on misconduct and impairment

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 Baillie invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr Baillie identified the specific, relevant standards where your actions amounted to misconduct. He referred to the Codes that he submitted were engaged which were 1, 1.2, 3, 13, 16, 18, 19, 19.1, 20, 20.1 and 20.2.

Mr Ballie submitted that the alleged concerns raised against you were acts and omissions which were repeated. They gave rise to real potential harm as children were involved, and you were dishonest.

Mr Baillie submitted that your actions were serious and fall well short of what would be expected of a registered nurse in the circumstances in which you found yourself and that they involved a serious departure from the expected standards.

Mr Baillie 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).

Mr Baillie submitted that it is a matter for the panel as to whether the misconduct in the charges found proved is easily remediable, whether it has been remedied and whether it is highly unlikely to be repeated. He emphasised that there's no acceptance of fault or wrongdoing in relation to the medication errors, despite your recent training in relation to the safer handling of medication.

Mr Baillie further submitted that the concerns that relate to your care of Child A have not been remedied and therefore are likely to be repeated if you are put in a position again where you are required to care for a vulnerable child.

Mr Ballie invited the panel to find that your fitness to practise is currently impaired. He submitted that impairment is a necessary finding on the grounds of public protection and in particular because of the findings of dishonesty. Mr Baillie submitted that a finding of impairment is necessary because the trust that the public has in the nursing profession and its regulatory body would be undermined if a finding of impairment were not made. The public would expect in the circumstances some action to be taken in order to promote safe and good practice.

Mr Holborn provided written submissions which included the following:

> *'…*
> *In conclusion,* [PRIVATE]. *The Registrant has accepted her responsibility in the present allegations and work to remedy them in full.* [PRIVATE].
>
> *The registrant has taken significant steps to address her issues and protect patient safety, which should be taken into account when assessing the issues of misconduct and impairment.*
>
> *We respectfully request that the panel considers the impact* [PRIVATE]*, and the steps taken to prevent similar incidents in determining the issue of misconduct and impairment.*
>
> [PRIVATE] *All these issues are now under control and mean that she is focused and a strengthened practitioner and should therefore not be seen as presently impaired.'*

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *R (on the application of Remedy UK Limited) v GMC* [2010] EWHC 1245.

Decision and reasons on misconduct

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

The panel determined that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to numerous breaches of the Code, specifically the following:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

[2 Listen to people and respond to their preferences and concerns]

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

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

8.5 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

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

13 [Recognise and work within the limits of your competence

To achieve this, you must:]

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

13.4 take account of your own personal safety as well as the safety of people in your care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

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

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

To achieve this, you must:

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

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times […]

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

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

[21 Uphold your position as a registered nurse, midwife or nursing associate]

To achieve this, you must:

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with […]'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel determined that charge 8(a)(viii) does not amount to misconduct as turning the light of in Child A's room was part of his normal routine and no dishonesty was found in relation to this charge. However, the panel determined that all of the remaining charges found proved amount to misconduct both individually and collectively. It determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of your misconduct, your 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 regard to making a decision on whether your fitness to practice was impaired in the past the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC*

and Grant [2011] EWHC 927 in reaching its decision. 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 Child A was put at risk and could have been caused physical and/or emotional harm as a result of your misconduct, and the lack of proper checks on the LAC also risked harm to them. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

In making its decision on whether your fitness to practice is currently impaired by reason of your misconduct the panel considered the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) where the court set out three matters which

it described as being *‘highly relevant’* to the determination to the question of current impairment:

> *‘1. Whether the conduct that led to the charge(s) is easily remediable*
> *2. Whether it has been remedied*
> *3. Whether it is highly unlikely to be repeated’*

The panel considered that the following categories encapsulate the charges proved in this case and made its decision on current impairment through these categories:

- Dishonesty (Charges 2, 3, 14, 15 and 16);
- Not completing assigned tasks for LACs (Charges 1 and 4);
- Safeguarding concerns (Charge 5);
- Professionals boundaries (Charges 6, 7 and 11);
- Medication administration (Charge 8(a)(i), (ii), (iii) and (v));
- Personal Protective Equipment (PPE) concerns (Charge 8(b));
- Protecting Child A’s dignity (Charge 10);
- Moving and Handling (Charge 12).

Regarding the dishonesty concerns, the panel acknowledged that this is inherently difficult to remediate dishonesty. However, the panel determined that the dishonesty in this case is capable of being remedied as the panel found that it was largely unpremeditated. In determining whether this dishonesty has been remedied, the panel considered the detailed reflections you have provided [PRIVATE]. In your reflection you explained that the choices you made at charges 1, 2, 14 and 15 were wrong and you identified how you would act differently in the future. It determined that these reflections do show that you understand the crucial importance of honesty for a registered nurse and that you have identified the influencing factors in your dishonest acts.

In considering the likelihood or otherwise of repetition, [PRIVATE]. On this basis the panel determined that, whilst you have shown insight into the dishonesty concerns and it is unlikely that these actions will be repeated, it cannot be satisfied that the high bar of actions being ‘*highly unlikely’* set out in the third question of *Cohen* has been met. The panel determined that, in relation to dishonesty, a finding of current impairment is

necessary on public protection grounds due to the current risk of repetition whilst [PRIVATE]. The panel also determined that, in relation to dishonesty, a finding of impairment is otherwise necessary on public interest grounds as a well-informed member of the public would be concerned if dishonesty charges were not dealt with seriously.

In relation to the second category outlined above, the panel determined that your actions in not completing assigned tasks for LAC are remediable. The panel determined that you have partly remediated this concern through your lengthy reflections in which you expressed remorse, explained what you would do differently in the future, provided examples of training you have undertaken to address this concern, and explained [PRIVATE]. However, the panel was not satisfied that these actions are '*highly unlikely to be repeated'* because [PRIVATE]. The panel determined [PRIVATE], it cannot be satisfied that it is highly unlikely that these actions would be repeated at this time due to [PRIVATE]. The panel therefore determined that a finding of current impairment is necessary on public protection grounds due to the risk of repetition. The panel determined that a finding of current impairment is also necessary in the public interest as a well-informed member of the public would be concerned that a panel who found a risk of repetition did not find current impairment.

In relation to the safeguarding concerns the panel determined that these can be remedied. The panel determined that through your reflections you have provided clear reasons why you did not escalate safeguarding concerns and you recognised what you should have done in this situation. You provided an example of how you have raised safeguarding concerns in your current working position. The panel determined that the safeguarding concerns have been remedied and it is highly unlikely for you to repeat this behaviour. It therefore determined that a finding of impairment is not necessary in relation to safeguarding concerns.

Regarding professional boundaries and taking personal calls on duty, the panel determined that these can be remedied. It determined that the reflection provided is sufficient in that you have explained why these actions were wrong and you have explained what you do differently in your current employment to ensure this does not

happen again. The panel therefore determined that it is highly unlikely that you would repeat these actions and so determined that a finding of current impairment is not necessary in relation to professional boundaries or taking personal calls on duty.

In relation to the medication administration concerns, the panel determined that this is possible to be remedied. The panel noted your reflections in which you explained what you would do differently. Whilst the panel determined that the medication administration concerns can be remedied, it determined that your reflections have not met the high bar of showing that these actions are '*highly unlikely'* to be repeated and you have yet to demonstrate practical remediation, specifically in relation to the administration of medication to children. The panel determined that a finding of impairment is necessary on public protection grounds due to the risk of repetition. Due to this risk the panel determined that a finding of current impairment is otherwise necessary on public interest grounds.

The panel determined that the PPE concerns are capable of remediation. It noted your reflections in which you explained the importance of PPE and stated that you now wear PPE in your current employment as you understand the importance of infection control. The panel determined that the reflections provided are sufficient to show that it is highly unlikely that these actions would be repeated and so determined that a finding of current impairment, in relation to PPE concerns, is not necessary.

In considering the concerns relating to the maintenance of Child A's dignity, the panel determined that these can be remediated. The panel considered your reflections including how important you find maintaining your current employer's dignity is and you acknowledged why maintaining Child A's dignity was important. The panel was satisfied that it is highly unlikely that you would repeat these concerns based on your reflections. Additionally, the panel determined that the concerns relating to incorrect moving and handling can be remedied and that you have shown sufficient remediation of these concerns through your reflections together with examples you have outlined in how you are using correct moving and handling techniques in your current employment. The panel therefore determined that a finding of current impairment is not necessary in relation to maintaining patient dignity or moving and handling techniques.

In summary, the panel determined that a finding of current impairment is necessary on public protection grounds and is otherwise necessary in the public interest in relation to the concerns relating to:

- Dishonesty;
- Not completing your assigned tasks for LAC; and
- Medication administration.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired in relation of dishonesty concerns not completing assigned tasks for LAC and medication administration concerns, but not in relation to any of the other findings of misconduct identified earlier in this determination.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Mr Baillie submitted that it is appropriate and proportionate to impose a striking off order. He took the panel through the aggravating features in this case including that your conduct put vulnerable children at risk of suffering harm, that this was not an isolated incident but was a pattern of unprofessional behaviour and that there remains a risk of repetition.

Mr Baillie submitted that no further action or a caution order would not be proportionate or in the public interest given the risk of repetition found in this case. He submitted that whilst a conditions of practice order could address the clinical concerns identified in medication administration, it would not address the dishonesty elements in this case. He submitted that a conditions of practice order would not reflect the seriousness of your conduct.

Mr Baillie submitted that a suspension order would reflect the seriousness of the dishonesty found in this case, as you created a real risk of harm to multiple vulnerable children and were dishonest and so submitted that these actions are fundamentally incompatible with your remaining on the register.

The panel also bore in mind the written submissions provided by Mr Holborn which are as follows:

1. ***'Introduction:***
    1.1. *The Registrant wishes to provide a comprehensive submission on the issue of sanction concerning the fitness to practise findings of misconduct and impairment against the Registrant and is grateful to the panel for its evident understanding of her situation.*
    1.2. *The Panel has identified specific areas of concern, and she acknowledges the gravity of the situation and the need to address this with the seriousness that is required.*
    1.3. *In considering an appropriate sanction, the Registrant submits that imposing suitable conditions of practice is a constructive and proportionate approach.*
    1.4. *The Registrant submits this application for sanction consideration and the following section provides a concise summary of the main points derived from the judgment on misconduct and impairment, highlighting both the findings and positive matters for the registrant's future professional development.*
    1.5. *The NMC has indicate throughout that it suggests a strike off but the Registrant submits that in this particular case, based on the specific facts as has been revealed as a part of this whole process and based on the specific findings of the panel as well as the evidence given by the Registrant such a decision should not be made and the that Conditions of Practice are the appropriate outcome.*
    1.6. *The principal aim of sanctions is protection of the public, uphold the standards and reputation of the profession and maintenance of public confidence. Panels are to consider the least restrictive sanction which will*

have this affect and in this case this can be safety and properly achieved by a comprehensive set of conditions of practice.

2. ***Summary of Misconduct Findings:***
   2.1. *The panel identified specific areas of concern, highlighting instances where breaches of professional standards occurred, including aspects related to patient care, professional boundaries, medication administration, and safeguarding. On a number of occasions the panel indicated that the issues were capable of or had already been remedied. This process will continue and this must be sufficient to satisfy the public need for protection and the upholding of standards.*
3. ***[PRIVATE]***
4. ***Breach of Professional Standards:***
   4.1. *Instances where the Registrant fell short of expected standards were acknowledged and reflected upon at length with appropriate recognition by the Panel of such efforts.*
5. ***Dishonesty Charges:***
   5.1. *Charges related to dishonesty were found proven and taken seriously by the Registrant; however, the panel considered the context* [PRIVATE]*. The Registrant wishes to reassure the Panel and the Regulator that she will maintain and continue the efforts now started on the path to fuller understanding of the implications of the charges and the need to strengthen her practice further.*
   5.2. *Reflections by the Registrant demonstrated insight into the wrong choices made during the dishonesty charges. The panel acknowledged the registrant's understanding and commitment to change and accepted the capability of these issues being remedied.*
6. ***Impact on Patient Safety:***
   6.1. *The panel noted the potential risk to Child A and the Looked After Child due to the registrant's actions as well as the Registrants reflections on the issues.*
   6.2. *Consideration was given to the lack of proper checks and its potential harm. The panel recognised that the Registrant acknowledgment of these risks and her commitment to future vigilance, her acceptance and commitment to change.*

7. ***Breaches of Fundamental Tenets:***

    7.1. *The Registrants actions were found to breach fundamental tenets of the nursing profession, affecting its reputation but this has been accepted and remediation started.*

    7.2. *The Registrant submits that in all outstanding areas identified by the Panel needing further remediation that she is making efforts to strengthen her practice and deal with those issues. She is committed to tackling work records, safeguarding, medication, professional boundaries and any outstanding concerns.*

8. ***Remediation and Capability of Remedy:***

    8.1. *Importantly, it is submitted that the panel acknowledged aspects of the misconduct that are capable of being remedied, with specific recognition of the Registrants reflections showing understanding and commitment to change and growth.*

9. ***Positive Matters for the Registrant:***

    9.1. *The Registrant acknowledges the findings of misconduct and in the way she has handled this hearing has indicated a sincere commitment to rectify and learn from past actions. The Panel have helpfully recognised the Registrants proactive approach to learning and her commitment to ongoing professional development which she is committed to continue.*

10. **[PRIVATE]**

    10.1.

11. ***Proactive Safeguarding Measures:***

    11.1. *The Registrant demonstrated proactive measures in raising safeguarding concerns in her current position, indicating an understanding of the importance of escalation. The Panel has noted the Registrants commitment to ensuring the safety of patients.*

12. **[PRIVATE]**

13. ***Looking Forward:***

    13.1. *In moving forward, the Registrant is committed to continuous improvement, maintaining professional standards, and ensuring patient safety. The positive matters highlighted, combined with proposed conditions*

of practice, provide a comprehensive framework for the registrant's future development.

13.2. The acknowledgment of remediation potential adds another layer of assurance regarding the registrant's commitment to learning and growth. The Registrant hopes that the Panel will consider these factors in determining a fair and proportionate sanction that balances accountability with rehabilitation in view of their findings on the capability of remediation and the removal of residual impairment and strengthened practise.

14. ***Consideration of Alternatives:***

15. ***Strike Off:***

15.1. Rationale Against Strike Off:

15.1.1. **[PRIVATE]**

15.1.1.1. It is submitted that Striking off would be disproportionate and unfair in the specific facts of this case, given the registrant's commitment to acknowledging and addressing the issues, [PRIVATE].

15.1.2. ***Potential for Rehabilitation:***

15.1.2.1. A striking-off order could hinder the potential for rehabilitation. It is essential to recognise the registrant's commitment to rectify and learn from past actions.

15.1.2.2. The intention is not to negate accountability but to provide an opportunity for the registrant to demonstrate growth and improvement and to strengthen her practise and continue to grow as a suitable professional.

16. ***Suspension:***

16.1. Rationale Against Suspension:

16.1.1. ***Punitive Nature:***

16.1.1.1. A suspension might be seen as punitive without offering a structured path for remediation. It could hinder the Registrants opportunity for growth and learning from identified shortcomings.

16.1.1.2. [PRIVATE].

16.1.2. ***Lack of Structured Remediation:***

16.1.2.1. *Suspension lacks a structured approach to remediation. It imposes a hiatus without a clear framework for addressing the identified areas of concern.*

16.1.2.2. *The goal should be to provide the registrant with a clear path for remediation, ensuring that the suspension period is utilised for meaningful learning and improvement.*

17. ***Rationale for Conditions of Practice:***

17.1. *Balancing Accountability and Rehabilitation:*

17.1.1. *Conditions of practice aim to strike a balance between holding the Registrant accountable for the misconduct and providing a clear pathway for remediation. It demonstrates a commitment to both public safety and the registrant's professional development.*

17.1.2. *The conditions proposed are specific, measurable, and tailored to address the identified areas of concern, ensuring a focused and effective approach to rehabilitation.*

17.2. [PRIVATE]

17.3. *Proactive and Preventive Measures:*

17.3.1. *By proposing conditions, we proactively address the root causes of the misconduct, ensuring that the Registrant engages in targeted learning, supervision, and reflective practice to prevent future lapses.*

17.4. *Encouraging Professional Growth:*

17.4.1. *Conditions of practice foster an environment for continuous professional development, allowing the Registrant to learn from experiences, engage in reflective practice, and gradually reintegrate into the profession.*

17.5. *Public Confidence and Trust:*

17.5.1. *Conditions of practice are transparent and provide reassurance to the public that measures are in place to address the concerns identified. This approach supports the restoration of public confidence in the nursing profession.*

18. ***Conclusion:***

18.1. *The Registrant submits that the most suitable and appropriate Sanction in this case on these facts and in line with the Panels observations on*

misconduct and impairment is the imposition of Conditions of practice which represent a nuanced and proportionate response to the findings against the Registrant.

18.2. This approach recognises the gravity of the misconduct, proves proper public protection, [PRIVATE]*, and ensures a structured and monitored pathway for rehabilitation. It is the Registrants submission that this approach aligns with the principles of fairness, accountability, and public safety.'*

Mr Holborn then set out a list of suggested conditions of practice which he invited the panel to adopt should it decide to impose a conditions of practice order.

Decision and reasons on sanction

Having found your 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 Sanctions Guidance ('SG') and the advice of the legal assessor. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel first took account of the NMC's guidance on *Considering sanctions for serious cases*, specifically the guidance on dishonesty. The panel found that whilst there were two instances, they were not premeditated and did not constitute a pattern of behaviour. In the first case, your lack of honesty about the work you had not done caused indirect risk to the LAC, but the panel considered this to be an unplanned reaction brought about by your stress. In the second case, you may have gained financially from the shifts worked for the agency when you should have been working for the Trust, but the panel determined that any gain was incidental and not the motivation for your action which was responding to a plea for urgent assistance from Child A's mother. [PRIVATE]. Weighing all of these factors, the panel found your dishonesty to be at the lower end of the spectrum.

The panel took into account the following aggravating features:

- The patients in your care, both Child A and the LAC, were vulnerable and were put at potential risk of harm;
- There is a risk of repetition in the clinical concerns;
- Dishonesty concerns, albeit at the lower end of the scale, are always serious.

The panel also took into account the following mitigating features:

- [PRIVATE];
- [PRIVATE];
- The significant insight and remorse shown through your in-depth reflections;
- Evidence of your efforts to strengthen your practice;
- The difficult working environment and lack of staffing resources at the Trust at the time of the concerns;
- Positive testimonials provided, including one from a registered nurse and another from your current employer, both of whom had full knowledge of the concerns.

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 your practice would not be appropriate in the circumstances. 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that practicable and workable conditions could be formulated to address the clinical concerns in this case as the panel could impose conditions for a period of supervised practice to ensure that you are on top of your workload and that you are administering medication safely. However, whilst the panel determined that the dishonesty concerns in this case are at the lower end of the scale of seriousness, it determined that there are no practicable or workable conditions that could be formulated to address this at this time. It noted that dishonesty is inherently difficult to rectify through conditions as it is not something that can be monitored or assessed. The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of the dishonest elements of this case and would not satisfy the public interest in this regard.

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;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with your remaining on the register. The panel considered the dishonesty in this case is at the lower end of the spectrum of seriousness and does not show evidence of a deep-seated attitudinal problem. The panel noted that this is not a single instance of misconduct, but it was satisfied that you have shown significant insight. The panel considered that a suspension order would be sufficient to satisfy the public interest in this case in marking that dishonesty is unacceptable.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case 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 took account of the NMC Guidance that, in a dishonesty case, it does not only have a choice between suspending a nurse or removing them from the register, but on the facts of this case the panel concluded that a conditions of practice order would be too lenient and a striking-off order would be too harsh a sanction.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

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 determined that a suspension order for a period of 6 months was sufficient to mark the seriousness of the dishonesty in this case.

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:

- Your continued engagement and attendance at the review hearing;
- Written evidence of your efforts to keep up to date with professional practice in your field, including completion certificates of courses if available;
- Testimonials;
- [PRIVATE];
- [PRIVATE].

This will be confirmed to you in writing.

Interim order

As the suspension 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 your own interests until the suspension 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 Baillie. He submitted that an 18-month interim suspension order is appropriate and proportionate in this case given the panel's determination on sanction.

The panel also took into account the submissions of Mr Holborn. Mr Holborn suggested that an interim suspension order could be imposed for the same amount of time as the substantive suspension order, that being 6 months, rather than for 18 months.

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 considered Mr Holborn's submission on a shorter interim suspension order; however, it bore in mind that if no appeal is sought then this interim suspension order will fall away, and if an appeal is sought, this interim order will be reviewed every 6 months. The panel therefore imposed an interim suspension order for a period of 18 months on the basis that the appeal process, if launched by you, might last for that period of time.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.