Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
28 – 31 March 2023, 3 – 6 April 2023, 17 – 19 April 2023, 21 – 27 April 2023, 14 – 15 September 2023, 6 October 2023 and 30 October – 2 November 2023

Virtual Hearing

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Julie Warmington**
NMC PIN:	11A0134E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – January 2011 Nurse Independent/ Supplementary Prescriber – December 2018
Relevant Location:	Lancashire
Type of case:	Misconduct
Panel members:	Philip Sayce (Chair, Registrant member) Janine Ellul (Registrant member) Alan Greenwood (Lay member)
Legal Assessor:	John Moir
Hearings Coordinator:	Taymeka Brandy (27 – 31 March 2023) Tyrena Agyemang (28 – 31 March 2023) Ruth Bass (17 – 19, 21– 27 April 2023, 14 – 15 September 2023, 2 – 3 October 2023 and 5 – 6 October 2023) Monsur Ali (30 October – 2 November 2023)
Nursing and Midwifery Council:	Represented by Julian Norman, Counsel instructed by the NMC
Mrs Warmington:	Present and represented by Anna Chestnutt, Counsel instructed by the RCN, and Matthew Howarth on 6 April 2023
Facts proved by admission:	Charges 1a, 1b, 1c, 2a, 2b, 3a, 3b, 5b

Facts proved:	Charges 4a, 4b, 4c and 6 in the alternative in relation to charge 4a and 4c
Facts not proved:	1d
No case to answer:	Charge 5a
Fitness to practise:	Impaired
Sanction:	Suspension order (6 months)

Details of charge

'That you, a registered nurse:

1. On 10 November 2016:

a) Did not tell Patient A to come back if his symptoms worsened;

b) Did not develop a care plan for Patient A;

c) Did not arrange a GP appointment for Patient A;

d) Treated Patient A in a discourteous manner by opening the door for him to leave.

2. On 24 November 2016:

a) Did not see Patient A in person;

b) Did not escalate to a GP.

3. On 5 January 2017:

a) Did not carry out any observations on Patient A or arrange for another nurse to see him;

b) Did not escalate to a GP.

4. On 10 January 2017:

a) Did not ensure that observations were carried out;

b) Did not arrange for Patient A to be seen by a GP;

c) Refused to attend Patient A's cell later in the day.

5. On 11 January 2017:

a) Were slow to respond to the Code Blue emergency call;

b) Failed to take the emergency bag.

6. Your actions at one or more of charges 1 to 5 above contributed to the death of Patient A or in the alternative the loss of a chance of survival.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Norman, on behalf of the Nursing and Midwifery Council (NMC), pursuant to Rule 31, to allow the expert witness report provided to the inquest from Mr 1 and Mr 2's local and NMC witness statement into evidence. She submitted that both Mr Halliday and Ms Chestnutt had had sight of these documents and had agreed that this evidence should be admitted.

In relation to Mr 1's report, Ms Norman explained that the NMC had made efforts for Mr 1 to attend the hearing and adduce this evidence himself. However, his secretary had confirmed in an email dated 13 March 2023 that he was unable to attend the hearing. In response to him being asked whether he would be happy to answer questions for the purpose of this hearing in writing, he stated:

'The report was made with a comprehensive view of all available information. I am not a nurse and hence it would be wholly inappropriate for me to comment on the specific actions of a nurse. The opinion of a nurse expert would be far more appropriate.'

Ms Norman submitted that the NMC have sought this report as it is fair and relevant information that goes into considerable detail of the events that led up to Patient A's death. She submitted that it also supports Mr 1's witness statement which can be read alongside his report.

In relation to Mr 2's witness statement, Ms Norman submitted that Mr 2 made a contemporaneous statement in which he also exhibits a reflective account and reflective statement from Colleague 3 dated 28 July and 7 June 2017. She submitted that both Mr Halliday and Ms Chestnutt had had sight of these documents and had agreed that this evidence should be admitted, subject to some small redactions agreed by all parties.

Ms Norman invited the panel to consider the relevant principles as set out in the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) (*Thorneycroft*) when considering this application:

> *‘*
>
> *(i) whether the statements were the sole or decisive evidence in support of the charges;*
>
> *(ii) the nature and extent of the challenge to the contents of the statements;*
>
> *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
>
> *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
>
> *(v) whether there was a good reason for the non-attendance of the witnesses;*
>
> *(vi) whether the Respondent had taken reasonable steps to secure their attendance; and*
>
> *(vii) the fact that the Appellant did not have prior notice that the witness statements were to be read.’*

Ms Norman addressed the panel on the relevant factors in *Thorneycroft*. She submitted that Mr 1’s report and Mr 2’s witness statements were not sole and decisive evidence in support of the charges and that there was no challenge by either Mr Halliday or Ms Chestnutt to the content of this evidence. She submitted that neither party had made any suggestion of fabrication.

Ms Norman submitted that Mr 1 had explained in his correspondence to the NMC contained within the hearsay bundle, why he was unable to attend this hearing. She submitted that within the bundle there was also evidence of attempts made to try and secure Mr 2's attendance. She submitted that both Mr Halliday and Ms Chestnutt had prior notice of this material and this application.

Ms Norman invited the panel to adduce the evidence of Mr 1 and Mr 2 as hearsay for the reasons set out above.

In response to the panel's question Ms Norman confirmed that Mr 2's witness statements were signed and dated.

Mr Halliday, on behalf of Colleague 3 submitted that he made no objection to this application providing that the panel received the relevant advice and legal directions given in respect of hearsay evidence. He submitted that the evidence was fair and relevant and spoke to the issues in this case.

Ms Chestnutt submitted that she made no objection to this application providing that relevant legal advice was given in respect of admitting hearsay evidence, particularly how Mr 1's evidence should be treated in these circumstances. She also submitted that Mr 2 may be able to assist with providing clarity in respect of some charges.

The panel heard and accepted the advice of the legal assessor which included reference to the relevant cases of *Thorneycroft* and *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin). This included that Rule 31 provides that, subject only to the requirements of relevance and fairness, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

In reaching its decision, the panel took the factors as set out in *Thorneycroft* in turn. It did not consider Mr 1 and Mr 2's evidence to be sole and decisive. The panel concluded that there was no suggestion of fabrication of the evidence in this matter. The panel accepted that Mr Halliday and Ms Chestnutt did have prior notice of this hearsay application and that they did not oppose this. The panel therefore determined that the hearsay evidence should be admitted into evidence.

Ms Chestnut made an application for the hearing to be held partly in private on the basis that there would be reference to your health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Ms Chestnut made an application for the hearing to be held partly in private [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Norman, on behalf of the NMC, and Mr Halliday, on behalf of Colleague 3, both supported the application.

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.

[PRIVATE]. The panel determined to hold parts of the hearing relating to [PRIVATE] in private, so as to protect your right to privacy and the rights of any other participants.

Application to Adjourn the Hearing Until 17 April 2023

The panel heard an application from Mr Howarth on your behalf to adjourn the hearing, [PRIVATE]. Mr Howarth informed the panel that Ms Chestnutt would be unavailable for the foreseeable future, and invited the panel to adjourn the hearing in fairness to you.

Mr Howarth was unable to confirm whether the adjournment was for a short period, until 17 April 2023 or for later in the future.

Ms Norman on behalf of the NMC, did not oppose the application in light of the circumstances. She invited the panel to consider the timetabling of the hearing as Ms

Chestnutt [PRIVATE] would not be available to represent you if the hearing resumed later in the year.

Ms Norman submitted that she and Mr Halliday had looked at the remaining time allocated to the hearing and were of the view that if the hearing ran smoothly, it could be possible to finish the facts stage before the hearing went part heard.

Mr Halliday, on behalf of Colleague 3, agreed with the submissions of Ms Norman and confirmed that he was also of the opinion that the facts stage could be concluded in the remaining time allocated for this hearing.

The panel heard and accepted the advice of the legal assessor, which included reference to Rule 32(2) of the Rules.

The panel considered fairness to all parties, specifically you, in that you would not have the benefit of your original counsel Ms Chestnutt, or consistent representation if the application was not granted. The panel also bore in mind the impact the adjournment could have on Colleague 3 in her case, however, in light of the circumstances, the panel concluded that it was fair to allow the adjournment application.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Chestnut that there is no case to answer in respect of charge 5a. This application was made under Rule 24(7).

Ms Chestnut provided the following written submissions:

> *'…*
>
> *6. It is submitted that the crux of the evidence in respect of the Code Blue emergency callout was that Nurse Warmington did not initially hear the callout and did not take the emergency bag with her when it transpired that it was a Code Blue emergency.*

7. The evidence suggests that [Colleague 3] *and Nurse Warmington travelled to Patient A's cell together. There is no self-contained criticism of the timeliness of* [Colleague 3's] *response.*

8. Whilst there is evidence of some delay whilst the Registrants waited for an officer to escort them, the NMC's evidence from [Witness 4] *is that such a request was reasonable in the circumstances.*

9. One identical line of evidence is put forward in the witness statements of [Witness 5] *and* [Witness 4] *respectively regarding the timeliness of Ms Warmington's response:*

"There are also concerns with how long it took Nurse Warmington to respond to the call once she head (sic) *it"*

10. This will not have been based on their first-hand experience and it is submitted that, absent any explanation of what led them to this view, it is no more than a bare allegation. It is further submitted that neither witness took the opportunity to explain the rationale behind their conclusion in live evidence.

11. It is submitted that this evidence is so inherently vague and weak that a properly directed tribunal could not find Charge 5a to be proven to the requisite standard (limb 2 of Galbraith).

12. The Panel is respectfully invited to conclude that there is no case to answer in respect of Charge 5a.'

Ms Norman did not oppose the application on the basis that the evidence from Witness 4 and Witness 5 was that it had been reasonable for you to wait in the wing while the officers attended.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor which included reference to the leading case of R V Galbraith [1981] 1 WLR 1039, [127]:

> *'(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case. (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence. (a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case. (b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.'*

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer in respect of charge 5a. It noted that the application was not opposed by the NMC.

The panel noted that it had not been provided with any evidence as to what would have been a reasonable time for you to respond to a Code Blue emergency call in these particular circumstances, or what your response time was in getting to Patient A's cell. Furthermore, there was no evidence provided from those at the scene of the incident that there had been any delay by you in reaching the cell.

The panel noted that the only evidence presented in respect of charge 5a came from the investigators at HMP Garth (the Prison), Witness 4 and Witness 5. It had regard to the fact that neither Witness 4 nor Witness 5 had witnessed the incident. They made the

assumption that you had been slow to respond based on an overall impression gathered during their investigation, observing that: you had not initially heard that it was Code Blue emergency; that you were undertaking a medication round at the time of the emergency call; and you had decided to wait for three officers to attend Patient A's cell as per the Prison's protocol. The panel was of the view that this evidence was tenuous and weak and insufficient to find charge 5a proved. It had regard to the fact that you had been administering medication at the time of the emergency call and would have needed to make the medication administration area safe, and the evidence of Witness 4 and Witness 5 under cross-examination that you were entitled to wait for the required number of officers to attend before entering Patient A's cell in any event. As such, the panel found this weakened further the tenuous evidence before it.

The panel determined that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 5a proved. It therefore allowed Ms Chestnut's application.

Background

The charges arose whilst you were employed as a Band 5 Nurse by the Prison.

On 24 August 2015, Patient A was taken into custody at HMP Durham. On 31 March 2016 Patient A was transferred from HMP Durham to the Prison. Patient A underwent a medical review upon his arrival at the Prison. During his health screen he was found to have no physical health conditions and there were no outstanding medical appointments.

Patient A made his first complaint to the health care team on 18 May 2016, where he complained of having sharp abdominal pains and headaches on opening his bowels. He was booked for blood tests and a GP review.

On 31 May 2016, the Prison GP Dr 6 reviewed Patient A.

On 12 June 2016 Patient A complained of abdominal pain, rectal bleeding and vomiting and was seen by Mr 2. Clinical observations were recorded and a GP appointment was requested for the following day. However, Patient A was not seen by the GP the following day.

On 23 July 2016 Patient A experienced rectal bleeding overnight. Colleague 7 performed a full blood test and referred Patient A to a GP. Dr 8, a prison GP, recorded that the blood test results were borderline and noted that a repeat test was required in a week or so. There was no record of a repeat test taking place.

On 24 July 2016 Patient A was examined by a GP who found nothing unusual but severe piles. Patient A was referred to a colorectal specialist at hospital. An appointment was made for 11 October 2016 but was later cancelled by the hospital. Two further dates were offered to Patient A which were declined by the Prison. No dates were subsequently set.

On 6 November 2016 Patient A complained again to Colleague 7 of vomiting and chest pains. He said that he had experienced vomiting every night over the last month. Colleague 7 recorded that clinical observations and ECG undertaken were normal. Colleague 7 advised Patient A to rest and take fluids and recorded that Patient A should be seen by the GP the next day. Patient A was not seen by the GP the next day.

It is alleged that Wing officers approached you four days later and expressed concern that Patient A was still being sick. You examined Patient A and it is alleged that you recorded that his clinical observations were normal. You noted *'he has now been seen 3 times in a week and nil acute presentation or findings on either of the 3 appts'* you declined to issue Patient A with a sick note and advised him to apply for a GP appointment. You recorded that Patient A had become agitated and that you opened the door and indicated he should leave.

On 24 November 2016 Patient A called again complaining of vomiting and nausea. His complaint of persistent vomiting had reached its 18th day since he had been by

Colleague 4. You spoke to Patient A on the phone and told him to stay in his cell for 48 hours and use his cell bell if he needed anything.

On 2 December 2016 Dr 6 reviewed Patient A and recorded that he suspected a duodenal ulcer caused by H pylori bacteria. A stool sample was requested, and medication prescribed to reduce acid and prevent sickness.

On 7 December 2016 test results confirmed that Patient A did have H Pylori. On 16 December 2016, Dr 6 saw Patient A and started him on a seven-day course of triple therapy treatment. Dr 6 noted that he would review Patient A two weeks later if it had not settled.

On 29 December 2016, Patient A had a triage assessment over the phone due to continued vomiting, with Colleague 3. Colleague 3 advised Patient A to stay in his cell for 48 hours, and to fast or light diet with plenty of fluids. There was no record of a follow up but later in the day an officer opened an Assessment Care in Custody Teamwork (ACCT) for Patient A recording that his health problems were causing him to contemplate self-harm or suicide.

On 30 December 2016, Patient A was a part of the ACCT process. A care map was drawn up with a Mental Health Nurse and prison chaplain. The Mental Health Nurse booked Patient A into the GP clinic for that Sunday as it was urgent, but that appointment was cancelled and rebooked to a regular GP clinic for 6 January 2017.

On 5 January 2017 you spoke to the prison officer on the wing by telephone after Patient A complained of pain in his side which was so bad he could not get out of bed. It is alleged that you told the prison officer that Patient A's complaint did not warrant an immediate GP review nor a visit to healthcare. It is further alleged that you told the prison office that Patient A was to wait for his GP appointment and use his cell bell if necessary, and declared him fit for work.

On 6 January 2017 at a GP review, it was noted that the hospital had cancelled the appointment, that Patient A had lost 11.6kg total over the last 24 months, a history of

pain, *"coffee grounds"* vomit after eating and blood in his stool. Patient A was referred to the gastroenterology service at hospital.

On 7 January 2017, Colleague 3 recorded that she was called to see Patient A as a Code Blue emergency. A Code Blue emergency radio code indicated that someone was unconscious or not breathing, and immediately alerts healthcare staff and control room to call an ambulance.

It is alleged that Colleague 3 attended Patient A and recorded that he had vomited and had chest pain, and that his blood pressure and pulse were high, but his other observations were normal. Colleague 3 gave Patient A paracetamol and advised him to drink water. Later that day, Colleague 3 made an entry adding that you got the impression that Patient A was drug seeking. At the interview into Patient A's death Colleague 3 described Patient A as looking as though he was in pain, hunched up, and tachycardic but justified the belated entry regarding drug seeking on the basis that Patient A's reaction to being offered paracetamol was unexpected.

On 10 January 2017 Patient A told an officer that he was in a lot of pain. Witness 10 continued his duties but within 15 minutes returned as other prisoners were banging on their cell doors reporting that Patient A was dying. Witness 10 observed Patient A bent over and complaining of pain and called a code blue emergency. You arrived with a student nurse and two officers joined you shortly after. You stated in interview that Patient A was on all fours on his bed and swore at you when you asked him to sit up. It is alleged that you exited from the cell and said that you would not treat him while he was being aggressive.

Prisoners continued to express concern about Patient A and within an hour were refusing to attend work until Patient A was seen. Witness 9 spoke to you on the phone and it is alleged that you refused to see Patient A because of his earlier behaviour. Witness 9 remained very concerned about Patient A's condition. Patient A was unable to walk at this point, so the officer and several prisoners carried him up two flights of stairs in a wheelchair before the officer wheeled him into the GP.

Dr 6 saw Patient A at short notice. You provided Dr 6 with a summary prior to the consultation. Dr 6 noted abdominal, back and shoulder pain, also the anxiety and ACCT. Dr 6 diagnosed psychogenic hyperventilation and prescribed antacid. Patient A never collected this.

On 11 January 2017 officers unlocked Patient A's cell as part of the usual morning procedure. Patient A was observed to be gasping for breath. An officer remembered what Dr 6 had said and encouraged Patient A to breathe through his nose to prevent hyperventilation. The officer said it seemed to help so he left to complete his rounds.

At 09:10, during the routine check Witness 9 could not open Patient A's cell door and realised that Patient A was lying on the floor restricting the door from opening. Witness 9 called another officer for help, and they called a Code Blue emergency and squeezed through the gap in the doorway. These officers found Patient A collapsed on the floor unresponsive. They were unable to find a pulse and so started cardio pulmonary resuscitation (CPR). A supervising officer arrived having heard the Code Blue, and reiterated on the radio it was a Code Blue requiring an ambulance.

You said that you heard a call for assistance but did not realise it was a code blue. It is alleged that after being wary of the previous day's events you requested assistance from Colleague 3. While waiting with Colleague 3 for an officer near the wing, a prisoner approached and said that Patient A was not breathing. Colleague 3 said that it was a Code Blue and they did not have the emergency bag. You and Colleague 3 then set off to Patient A's cell after asking a Healthcare Assistant to collect the Code Blue emergency bag.

On Colleague 3's arrival at Patient A's cell, she could not find any signs of breathing or a pulse, and so continued. Other staff then arrived with the emergency bag. CPR continued until the paramedics arrived. The resuscitation attempt was unsuccessful and at 09:57 Patient A was pronounced dead.

The post-mortem concluded the cause of death was peritonitis caused by a perforated duodenal ulcer. Mr 1 said that Patient A had likely had a duodenal ulcer for some time which had likely perforated closer to the date of Patient A's death. Toxicological tests

confirmed that the only substances present were prescribed drugs at a therapeutic level which had played no role in Patient A's death.

It is alleged by the NMC, that although you were not responsible for every failing in Patient A's history, you are responsible for your own failings as set out in the charges above, and that one or more of your alleged failings contributed to Patient A's death, or alternatively, to the loss of chance of survival.

Decision and reasons on facts

The panel heard from Ms Chestnut, who informed the panel that you made full admissions to charges 1a, 1b, 1c, 2a, 2b, 3a, 3b, and 5b.

The panel therefore finds charges 1a, 1b, 1c, 2a, 2b, 3a, 3b, and 5b proved, 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 Ms Norman on behalf of the NMC and by Ms Chestnutt on your behalf.

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:

- Mr 2: Healthcare Manager at HMP Garth
- Colleague 3: Band 5 Registered Nurse

- Witness 4: Death in Custody Clinical Reviewer
- Witness 5: Fatal Incidents Investigator
- Witness 9: Prison officer at HP Garth at the time of incident
- Witness 10: Prison officer at HP Garth at the time of incident
- Witness 11: Nursing expert witness

The panel also heard evidence from you under affirmation.

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 Ms Chestnutt.

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

Charge 1d

'That you, a registered nurse:

1. On 10 November 2016:
d) Treated Patient A in a discourteous manner by opening the door for him to leave.'

This charge is found NOT proved.

In reaching this decision, the panel considered your note in Patient A's medical records for 10 November 2016 which states:

'Generally unwell
Fit to return to work
Plan – advised he needs to be seen by the GP and to follow the application process on the wing. No RIC [rest in cell] *issued and he stated that the wing will be giving him this, I informed him I have to call the wing and report no RIC for him. He is agitated so I've opened the door and indicated that he left. No further action at this time.*
No immediate action required
Seen in department…'
Consultation – Attended today for special sick as complaining of still being sick on a night only. Has been seen now 3 times in a week and nil acute presentation of findings on either of the 3 appointments...'

The panel noted that you had recorded that Patient A was agitated, had been seen in the clinic three times that week and had been declared fit to return to work by you. It accepted your evidence that Patient A was agitated and further that you wanted to conclude the consultation to avoid escalation of any agitation and so opened the door in the health room for him to leave.

The panel noted that there were no prison officers on the healthcare wing and that you were alone in the consultation with Patient A who was upset and agitated. It accepted your evidence that you were unable to help Patient A and felt that you needed to end the interaction as you were concerned about your safety. There was no evidence before the panel to suggest that this was not the case. The panel therefore accepted that you opened the door for Patient A to leave as a mechanism to end the consultation. It noted that there was no evidence of you shouting and accepted your evidence that you could not leave the room as that would have meant that Patient A was unsupervised in the consultation room with access to medical equipment and patient notes. In these circumstances the panel did not find that, while opening the door for Patient A to leave the room would not be the usual way to end a consultation, in the context of this consultation there was no evidence before it that suggested it was discourteous. It therefore found this charge not proved.

Charge 4a)

'4. On 10 January 2017:
a) Did not ensure that observations were carried out;

This charge is found proved.

In reaching this decision, the panel considered the note you made in Patient A's medical record on 10 January 2017 which states:

'Emergency Call – Seen by Nurse
Inappropriate referral
Emergency treatment
Healthcare emergency response
National Early Warning Score =0
informing of call - call out to ? abdo pain"
"Not able to take any observations due to becoming aggressive and moving off bed onto the floor
No further action required – at this time
Initial patient assessment - ? abdo pain called code blue no officer with patient on arrival. Sat on the bed on all fours with his head down. When asked his name he was shouting I explained will need to assess him and he came off the bed and then started to shout becoming aggressive. I then vacated the room. The SO on the wing stating that he has been seen recently for analgesia by mental health'.

You recorded contemporaneously in Patient A's medical record that you were unable to take any observations due to Patient A becoming aggressive. In your interview into the Investigation of Patient A's death on 11 January 2017 you admitted that you could not assess Patient A because he was *'on all fours. I need you to be sat up so that I can see you and I can assess you and take your blood pressure'.*

The panel found your contemporaneous evidence was conclusive that you did not carry out any observations of Patient A on this occasion. You specifically admitted this in your oral evidence.

The panel bore in mind the following contemporaneous notes that you made in Patient A's medical records:

- 10 November 2016 – *'Consultation – Wing called as patient still being sick and they are concerned with him'*
- 10 November 2016 – '*has been seen now 3 times in a week and nil acute presentation of findings on either of the 3 appointments.'*
- 24 November 2016 – *'Consultation – rang with vomiting and nausea…'*
- 5 January 2017 – *'Consultation - Rang today with on-going condition of pains in his side and not being able to get out of bed…This is an ongoing condition and needs to be seen by the GP and to follow the application process on the wing.'*
- 10 January 2017 – *'Emergency call…Not able to take any observations due to becoming aggressive and moving off bed onto the floor…sat on bed on all fours with his head down'.*

The panel concluded that by 10 January 2017 you were aware of Patients A's history of symptoms, and in the absence of undertaking the observations yourself, knowing this patients history and accounting for his abnormal presentation at this time, you should have ensured that observations were taken, even if this was carried out by someone else.

With regard to your evidence that you did not take Patient A's observations because he became aggressive and jumped towards you, the panel heard evidence from Witness 10 who was very concerned about Patient A's health. Witness 10, a prison officer, gave evidence that Patient A was unwell and bent over on his bed in pain. Witness 10 gave evidence that he was in between you and Patient A up until the time you withdrew from the cell and was of the view that there was adequate protection in place to maintain your safety.

Witness 10, a prison officer, gave evidence to the panel that Patient A was in a lot of pain and did not jump from his bed. When it was suggested during Witness 10's cross examination that '*Patient A began shouting and swearing, he then jumped from his bed and stepped towards Nurse Warmington',* Witness 10 stated *'No. I don't agree with that at all.'* Witness 10 stated that there was a prison officer in attendance and stated that when you were called back to the cell there would have been officers present.

The panel found Witness 10 to be credible stating when he could and could not recall details. The panel found Witness 10's evidence in this regard to be compelling. It was of the view that Witness 10 had given clear evidence regarding this incident which had clearly impacted him to a great extent. The panel accepted the evidence of Witness 10 that there was little risk of any harm to you.

The panel found that the risk of harm to you in these circumstances was minimal and that there was no need for you to withdraw. However, if you felt you could not undertake the observations given your belief that there was risk to your safety, knowing Patient A's medical history at this point, you should have ensured that the observations were undertaken by someone else, which you did not do. The panel therefore found this charge proved.

Charge 4b

'4. On 10 January 2017:

b) Did not arrange for Patient A to be seen by a GP'

This charge is found proved.

In considering this charge the panel had regard to your evidence that you had a discussion with Dr 6 about Patient A on 10 January 2017. It considered your interview regarding the investigation into the death of Patient A dated 19 January 2017 wherein you stated:

'… I went back and I arranged for the GP to see him. My intention was to slot him in with the GP. An officer rang from here who had just come on the shift and said he'd been down to see [Patient A], he was in a lot of pain and could somebody

come back and see him. I said, 'Well, I'm not prepared to come back and see him on that landing at this time for safety reasons, but I'm going to ask the GP to see him'. The GP did see him but I'm not, I said he had to be escorted down and the officers had to go in with the GP.
The GP did see him. I never had a chance to go back in and discuss with the GP then what had happened or what his consultation was because I had to come, you know, there's a regime and we have to be back at certain times to give out medications, etc. So I never actually got to find out the rest of that shift what had gone on.'

The panel noted that you initially stated that you had arranged for the GP to see Patient A but then went on to state that it was your intention to slot him in with the GP. You later stated *'I'm going to ask the GP to see him'* and further that you *'never had a chance to go back and discuss with the GP'*. The panel was of the view that your contemporaneous note was somewhat inconsistent and did not support that you had referred Patient A to the GP or had a discussion with the GP.

The panel has also had regard to your comment contained in Patient A's medical notes on 10 January 2017 quoted above.

The panel noted there was no contemporaneous mention of you having arranged for Patient A to see Dr 6 contained in your record.

The panel also had regard to the clinical review of Patient A's case by Witness 4 dated 3 April 2017 which states:

'During interview, Discipline Officer described the events which then began around 13:30hrs. He explained how all the prisoners on spur were very concerned about him and refused to attend work, until something was done about his condition. Officer 9 shared their concerns, he knew and believed he was seriously ill. He had previously tried to encourage to eat, he struggled to swallow and had requested supplement drinks. Officer and Officer obtained a wheelchair from an upstairs wing. Five prisoners carried up the stairs to the

wheelchair, the officers then took him to healthcare and requested a GP appointment. As the clinic was a restricted vulnerable prisoners (VP) clinic, this request was initially refused.
Officer was persistent and it was eventually agreed he would be seen as an 'add on' at the end of the clinic. Officer stayed with during the consultation, he recalled his presentation as weak and barely able to stand.'

It was clear to the panel from the clinical review that Patient A was seen by the Dr 6 at the request of Witness 9 who insisted that Patient A should be seen, and not due to any request from you. Witness 9 also confirmed in their evidence that Patient A was seen by Dr 6 at their request.

Having considered the contemporaneous evidence before it, the panel accepted the evidence of Witness 9 and did not accept that you had arranged for Patient A to be seen by a GP. It therefore found this charge proved.

Charge 4c

'4. On 10 January 2017:
c) Refused to attend Patient A's cell later in the day.'

This charge is found proved.

In reaching this decision the panel considered your interview in respect of the Investigation into the death of Patient A dated 11 January 2017 in which you stated:

'An officer rang from here who had just come on the shift and said he'd been down to see [Patient A], he was in a lot of pain and could somebody come back and see him. I said, 'Well, I'm not prepared to come back and see him on that landing at this time for safety reasons, but I'm going to ask the GP to see him…'

The panel noted from your interview that you had refused to go back and see Patient A.

You gave evidence to panel that Patient A had displayed aggressive behaviour towards you by swearing and jumping towards you from his bed, and it was due to concerns for your safety that you refused to go back and see Patient A in his cell when you were called. The panel therefore found this charge proved.

Charge 6

> *'Your actions at one or more of charges 1 to 5 above contributed to the death of Patient A or in the alternative the loss of a chance of survival.'*

This charge is found proved in respect of charges 4a and 4c, in the alternative that your actions contributed to a loss of chance of survival.

In considering this charge it is helpful to first set out the panel's approach to the alternatives in charge 6.

When considering whether your actions or inactions *'contributed to the death of Patient A'* the panel had regard to the consideration that issues of causation ordinarily require the NMC to prove, on the balance of probability, that, but for a registrant's actions or inactions, the patient would not have died. It recognised that the charge, as framed, referred to your contribution to the death. Nevertheless, it considered that it would be unfair to hold that your actions or inaction contributed to the death of Patient A if a) he would have died even without your actions or inactions or b) that actions or inactions by other clinicians, for which you were not responsible, broke the chain of causation.

The panel was satisfied that the interventions of more senior clinicians, namely Dr 8 on January 2017 and Dr 6 on 10 January 2017, were likely sufficient to break the chain of causation in relation to your prior actions and inactions. In any event the panel was not satisfied that an unbroken chain of causation had been proved. Accordingly, the panel was not satisfied that the first alternative in charge 6 had been proved.

When considering whether your actions or inactions *'contributed to the loss of a chance of survival'* in respect of Patient A*,* the panel considered that it had to be satisfied firstly

that, at any point in time they were considering, there was a real and substantial chance that Patient A would have survived, and secondly the NMC has to show, on the balance of probabilities, that the your actions or inactions contributed to the loss of that chance of survival.

The panel was aware that there were numerous potential factors which may have contributed to the loss of a chance of Patient A's survival, not least the lack of resources and health care staff at the prison in addition to the actions or inactions of other sometimes more senior healthcare providers. The panel considered that it would be unfair to hold that your actions or inactions contributed to the loss of chance of survival unless there was a sufficiently clear nexus in time and connection, between your actions or inactions and Patient A's death.

The panel accepted the hearsay evidence of Mr 1, which was not challenged by any party, that the fatal stage of septic shock was likely to have occurred overnight on 10 January/early hours of 11 January 2017. Accordingly, the panel was satisfied that, by that point, Patient A did not have a real and substantial chance of survival.

With regard to charges 1, 2, and 3 in their entirety, the panel was not convinced that the nexus of time between your actions or inactions were sufficiently connected to Patient A's death, together with the intervention of more senior clinicians, specifically Dr 6 and Dr 8, was sufficient to amount to a contribution of a loss of chance of survival.

In respect of charge 4a, the panel gave serious consideration as to whether your omission contributed to the death of Patient A. The panel ultimately is not satisfied that this has been proved on the balance of probabilities. However, it determined that it did contribute to a loss of chance of survival. You had a patient in your care with a history of abdominal/chest pain, "coffee ground" vomit and weight loss and increasing agitating. In the days before his death Patient A had sought medical attention on a number of occasions and there was increasing concern from prison staff and prisoners around Patient A's health and wellbeing. You had a duty therefore to Patient A to undertake observations, and if you could not have done it you should have ensured that it was carried out by someone else. The panel concluded that had you undertaken and

recorded the observations, or ensured they had been undertaken by somebody else at this point, the correct NEWS score would likely have been documented. The true condition of Patient A would likely have been reflected in the NEWS score which would likely have led to appropriate action being taken.

With regard to charge 4b, the panel did not find that this contributed to a loss of chance of survival as Patient A was seen by a GP, albeit at the insistence and assistance of the prison officers, who bore the duty to administer appropriate interventions at that time.

With regard to charge 4c, the panel had regard to the fact that the staff on the wing and the prisoners continued to have concerns over Patient A's condition and escalated these concerns to you. The panel found that your refusal to attend Patient A's cell later in the day further delayed the potential for appropriate assistance to be administered and an opportunity for essential observations which led to the loss of a chance of survival.

With regard to charge 5b, the panel considered the evidence of Mr 1 upon which the panel relied on his finding that the chance of survival was lost overnight on 10 January 2017 and therefore there was not a realistic chance of survival at the time of your failure to take the emergency bag on 11 January 2027. It therefore did not find that your inaction contributed to the loss of a chance of survival.

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.

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.

Submissions on misconduct

Ms Norman reminded the panel that the question of impairment involves a two-stage test and the panel first has to be satisfied that the facts proved amount to serious professional misconduct. Only if the panel is satisfied of that, can it go on to consider whether your fitness to practise is currently impaired.

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.'*

Ms Norman drew the panel's attention to the following provisions of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code). She submitted that that the following provisions of the Code have been breached:

> ***'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*
>
> ***2 Listen to people and respond to their preferences and concerns***

4 Act in the best interests of people at all times

7 Communicate clearly

10 Keep clear and accurate records relevant to your practice

13 Recognise and work within the limits of your competence

To achieve this, you must:

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

Ms Norman submitted that the facts found proved amount to misconduct on the grounds of public protection and also otherwise in the wider public interest.

Ms Chestnutt submitted that you accept that your behaviour amounted to misconduct.

Submissions on impairment

Ms Norman 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Norman submitted that your fitness to practise is currently impaired on the grounds of public protection and also otherwise in the wider public interest. She said, in terms of public interest, the panel has found that your conduct was a contribution to the loss of a chance of survival, which is a serious charge and could really damage public confidence in the profession were it not to find impairment.

Ms Norman said, in terms of public protection, there is a risk of repetition of the facts found proved. She said that, based on the evidence you provided to the panel, you were

asked if you would do anything differently over the course of all the interaction you had with Patient A, you said *“only the ones I have admitted”.* Ms Norman submitted that during the course of your evidence, the panel preferred the evidence of the prison officers about whether or not Patient A had approached you in a threatening manner the day before his death, and the panel preferred the evidence of the prison officer that Patient A had been hunched over in his bed due to pain he was experiencing.

Ms Norman submitted that you put responsibilities of your failures squarely on the working conditions rather than your practice. She said that this demonstrates a lack of insight into your misconduct. Further, on the day before Patient A’s death, she said that you refused to go back to Patient A even when it was reported to you that he was calm. Ms Norman submitted that this demonstrates an attitudinal issue which is hard to remediate and the panel may deem that this shows the lack of compassion shown by you, and on this basis, Ms Norman said that any insight you have developed now is essentially embryonic.

Ms Norman submitted that there is risk of repetition of your actions and therefore invited the panel to find that your fitness to practise is currently impaired on both public protection and public interest ground.

Ms Chestnutt submitted that it is apparent that you have reflected carefully on not only the admitted charges but all the charges proved against you. She said that it is essential the panel consider your insight and deep reflection when deciding whether your fitness to practice is currently impaired.

Ms Chestnutt stated that you left the prison healthcare almost immediately after the death of Patient A and had been practising in a primary care setting without any restrictions on your practice since then. She said that the charges gave you the opportunity to update and improve your clinical practice. You are now not only a nurse practitioner but also look out for different areas for improvement and there is evidence of you improving your practice exponentially since the events surrounding the death of Patient A.

Ms Chestnutt submitted that you now adopt an ‘err on the side of caution’ approach to patient care. Your reflective piece is an example of this and you now always advise your patients to come see you face to face following a telephone consultation and request double appointments with patients to conduct more thorough assessments with them. She submitted that you are now more resourced in a primary care setting than you were in prison health care which is directly relevant to whether your fitness to practice is currently impaired. She said that you have been in this setting since December 2018 without any concerns raised against you.

Ms Chestnutt submitted that you understand your previous shortcomings which led to the charges in response of Patient A and have done careful reflection, and the particular experience with Patient A, has led you into making careful decisions when receiving consent and that the patient fully understands the information given to them.

Ms Chestnutt directed the panel to the testimonials you provided and submitted that they demonstrated how you are well valued by your colleagues and there is evidence that you are well regarded and liked by your patients which is demonstrated by the various tokens of appreciation and gifts you received and the expression of thanks from them. She submitted that you are now in an environment where you can safely practice as you are in a setting where you are better supported.

Ms Chestnutt submitted that whilst there is no suggestion of shifting any blame away from you, it is her submission that the broader context of prison regime and the culture were very much relevant to the proven charges. Ms Chestnutt submitted that having taken all the difficulties you have experienced in prison care healthcare, you decided that was not viable for you.

Ms Chestnutt submitted that you acknowledge that there were breaches of the Code. However, the extent to which you have engaged in learning and professional development negates those breaches to the extent that you are not currently impaired. You now undergo targeted training such as escalation of complex management training.

Ms Chestnutt submitted that an exaggeration of the importance of the outcome for Patient A is not determinative when deciding impairment. It is important to focus on your specific conduct. You admitted that you did fall short and now have additional qualifications which would enable you to conduct yourself appropriately. She invited the panel to find that your fitness to practise is not currently 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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin) , and Cohen v GMC [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to breaches of the Code. Specifically:

> *'**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***
> *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 people's physical, social and psychological needs are assessed and responded to

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.

6 Always practise in line with the best available evidence

10 Keep clear and accurate records relevant to your practice

10.1 complete all 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

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

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

20 Uphold the reputation of your profession at all times

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel noted that your actions in charges 1, 2, 3b and 4b did fall below the standards expected of a registered nurse but are not so serious in the circumstances of this particular case to amount to misconduct. However, it was of the view that charges 3a, 4a and 6 are so serious that they individually amounted to professional misconduct.

The panel, therefore, 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 the 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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) *…'*

The panel finds limbs a-c are engaged. Your misconduct has breached the fundamental tenets of the nursing profession and has brought the reputation of the profession into disrepute. The panel finds that a patient was put at risk of unwarranted harm as result of your misconduct.

Regarding insight, the panel took into account the training you have undergone and it is of the view that some of that training demonstrates you have strengthened your practice. However, the panel considered your application of this learning in your reflection was limited and superficial. Furthermore, the panel determined that you do not

reflect on your failings roundly. You have failed to recognise how your failures impacted on the outcome of Patient A and what that would mean for the public confidence in the nursing profession. It determined that this demonstrates you have not yet developed sufficient insight into your failings and therefore there remains a risk of repetition.

The panel heard that you are now working in a very supportive environment. The panel heard that you have continued to practise without restriction and that in the seven years since the incidents in question, there have been no incidents or concerns. It read the many positive testimonials from colleagues and people who know you but decided to put some weight on the testimonials from the people who work with you and less weight on the testimonials from those who do not.

Having taken all of the above into consideration, the panel determined that as a result of your lack of full insight there remains a risk of repetition and therefore, your practice is impaired 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 ground is required because it considered that your misconduct to be very serious. The panel determined that the public would be concerned if there were no finding of impairment on the ground public interest. The panel concluded that it is important to mark the seriousness of your misconduct, and to send out a clear message to other professionals and to the public that this type of behaviour is unacceptable.

In addition, 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 your fitness to practise impaired on the ground of public interest.

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.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Norman informed the panel that in the Notice of Hearing, dated 27 February 2023, the NMC had advised you that it would seek the imposition of a suspension order for a period of 12 months if it found your fitness to practise currently impaired.

Ms Norman submitted that the aggravating features in this case are: this was not a single act of misconduct; the serious nature of the misconduct; the conduct increased the risk of harm to the patient; and lack of insight into your failings. She said this demonstrates a risk of repetition.

Ms Norman said the mitigating features are: you have begun to develop a degree of insight into your misconduct and provided positive testimonials. Nevertheless, she said, there remains risk of repetition until your insight is fully developed and because this is also a public protection case, she submitted that it is difficult to devise conditions that would protect the public and address the wider public interest. She therefore invited the panel to impose a suspension order for a period of 12 months with review.

Ms Chestnutt stated that you have never been subjected to any previous regulatory actions nor have you been subjected to an interim order in relation to this case. She said that you have been practising without any restrictions for the last seven years without any concerns. Ms Chestnutt submitted that it would be unnecessary to impose any sanctions in this case for the protection of the public and otherwise in the wider public interest.

Ms Chestnutt submitted that according to the panel's findings there were only two acts which contributed to the loss of chance of survival, both of which occurred on the same day. She submitted that none of the other charges individually or cumulatively are sufficiently serious to warrant a sanction.

Ms Chestnutt submitted that given the extent to which you have remediated the deficiencies in your practice and the panel does not need to only look at your reflective piece to ascertain insight. She said there are other external factors the panel should bear in mind. Ms Chestnutt invited the panel to treat your actions following the death of the patient as a demonstration of your insight. She said you acknowledged that you could not provide safe and effective care in prison healthcare so you left immediately. You have also funded a series of courses to strengthen your practise and expressed shame and regret in your reflective piece relating to the specific care you provided to Patient A.

Ms Chestnutt submitted that the panel should consider the public confidence if an unduly onerous sanction is imposed, having taken into consideration into the nature of the prison environment, your expression of remorse for your misconduct and the steps you have taken in the last seven years to strengthen your practice.

Ms Chestnutt submitted that you now work in a better environment in a primary care setting and there has been no further referral since you stopped working in prison healthcare. She said that if the panel deems that a sanction beyond a caution order was necessary, then the public protection and public interest issues could be maintained by a conditions of practice order requiring you not to return to a custodial setting for a period the panel deems appropriate.

[PRIVATE]

Ms Chestnutt submitted that a suspension order would be disproportionate based not only on the factual findings but also the impact such a sanction would have upon you. She said that if the panel concludes that a sanction is required in this case, then nothing more than a condition of practice order should be imposed, preventing you from

returning to a custodial environment. She said that this would protect the public and maintain public confidence in the profession and in the NMC as the regulator.

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 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:

- Serious nature of the misconduct
- Lack of insight into your failings
- Risk of repetition

The panel also took into account the following mitigating features:

- Seven years since the incidents without repetition of the misconduct
- Positive testimonials from people who work with you
- Prolonged delay in dealing with this case
- [PRIVATE]

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, the public protection and the public interest issues identified, an order that does not restrict your 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 your misconduct was not at the lower end of the spectrum and that a

caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether imposing a conditions of practice order on your registration would be a sufficient and appropriate response. The panel is of the view that there are no workable conditions that could be formulated, given the nature of the findings in this case. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not sufficiently meet the public interest.

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:

- *No evidence of harmful deep-seated personality or attitudinal problems; and*
- *No evidence of repetition of behaviour since the incident;*

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

The panel noted the hardship such an order may well 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 took into account the delay in these proceedings since the events in question amounted to over seven years. These proceedings have been hanging over you for this entire period. The panel considered that it was appropriate to mark the punitive effect of that delay in modifying the length of the order that it has imposed.

The panel determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct and to allow you the time reflect upon your misconduct.

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:

- A reflective piece which properly addresses your misconduct identified by this panel in its determination;
- Your continued engagement with the NMC, including your attendance at the next review of this order; and
- Testimonials from any caring role, paid or unpaid, which you may have undertaken during your period of suspension.

This decision will be confirmed to you in writing.

The panel considered that it was important for a proper understanding of the circumstances that led to the death of Patient A, to note that he had been subjected to systemic failings by the prison health service and that your failings were only a part of the much wider picture.

That concludes this determination.