Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday 12 October 2023 – Friday 13 October 2023
Monday 16 October 2023 – Friday 20 October 2023

Virtual Hearing

Name of Registrant:	Anna Louise Williams
NMC PIN	86K0177E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – March 1990 Occupational Health Nurse – Sub Part 2 September 1995
Relevant Location:	North Wales
Type of case:	Misconduct
Panel members:	Peter Fish (Chair, lay member) Pauline Esson (Registrant member) David Anderson (Lay member)
Legal Assessor:	Charles Apthorp
Hearings Coordinator:	Shela Begum
Nursing and Midwifery Council:	Represented by Yusuf Segovia, Case Presenter
Mrs Williams:	Not present and unrepresented at the hearing
Facts proved:	Charges 1a, 1b, 2, 3, 4, 5a, 5b, 5c, 5d, 6, 7, 10, 11a, 11b, 12a, 12b, 13e and 13f
Facts not proved:	Charges 8, 9, 13a, 13b, 13c, and 13d (i, ii, iii)
Fitness to practise:	Impaired
Sanction:	**Striking off order**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Williams was not in attendance and that the Notice of Hearing letter had been sent to Mrs Williams' registered email address by secure email on 30 August 2023.

Further, the panel noted that the Notice of Hearing was also sent to Mrs Williams UNISON representative on 30 August 2023.

Mr Segovia, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mrs Williams

The panel next considered whether it should proceed in the absence of Mrs Williams. It had regard to Rule 21 and heard the submissions of Mr Segovia who invited the panel to continue in the absence of Mrs Williams. He submitted that Mrs Williams had voluntarily absented herself.

Mr Segovia referred the panel to the documentation which showed an email from Mrs Williams UNISON representative dated 20 September 2023 at 14:42 and at 14:47:

> *"In the interest of ensuring a expeditious hearing, we have no concerns with the bundles going to the panel. […]*
>
> *Instructions are clear that she will no longer be attending the hearing. As per our terms of representation I will not be attending either. Ms Williams does not wish to postpone the hearing as this would not change her willingness to engage and only serve to further prolong the case unnecessarily. Ms Williams is aware of the potential implications this will have on the decision making and outcome of the hearing."*

Mr Segovia submitted that these emails informed the panel that neither Mrs Williams or her representative will be in attendance and importantly, what's also mentioned within the written submission is that Mrs Williams does not wish for the hearing to be relisted, so there certainly is no application whatsoever for the panel to vacate this hearing for any reason and to relist it at any future date.

Mr Segovia submitted that there is a public interest in this case being heard and that this case concerns an allegation of misconduct which should be determined as soon as possible.

In closing, he invited the panel to proceed in the absence of Mrs Williams and her representative.

The panel accepted the advice of the legal assessor.

The panel had regard to the letter from Mrs Williams UNISON representative which stated:

"Please note that the Registrant, nor I, will be in attendance throughout the hearing. No discourtesy is intended. The Registrant does not wish for the hearing to be relisted.
[PRIVATE]."

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

The panel has decided to proceed in the absence of Mrs Williams. In reaching this decision, the panel has considered the submissions of Mr Segovia, the representations made on Mrs Williams's behalf, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Williams;
- Mrs Williams' UNISON representative has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness has been warned to attend today to give live evidence,
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and

- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Williams in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered contact details, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Williams's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

That you, a registered nurse, whilst working as the Manager of the Occupational Health Unit ("OHU") at North Wales Police:

1. Failed to ensure staff were undertaking tasks within their training and/or competency, in that:
    a. Colleague 1 [C1] conducted vision, hearing and spirometry testing without any written evidence of competence,
    b. Colleague 2 [C2] undertook blood pressure monitoring prior to fitness testing despite not being a nurse and/or without having the relevant qualifications,

2. Failed to undertake monthly 1:1s and/or Personal Development Reviews ("PDR"s) with staff despite being told to do so,

3. Informed Colleague 3 [C3] that you had been undertaking monthly 1:1s with staff when you had not been doing so,

4. Your conduct at charge 3 was dishonest, in that you intended for Colleague 3 to believe that you had been undertaking monthly 1:1s with staff,

5. Failed to keep evidence that systems and procedures were implemented at the OHU, in that:
    a. There were no clinical policy documents, supporting procedures, or guidance in place,
    b. There was a lack of records regarding staff competency, supervision, or training,
    c. There were no records of your own professional developments,
    d. There were no record keeping audits,

6. Failed to complete all staff medicals,

7. Instructed Colleague 4 [C4] to invite only key roles for staff medicals and/or to forget about undertaking staff medicals for drivers under 45,

8. Informed Colleague 3 that there were 130 overdue medicals, when there were actually 724,

9. Your conduct at charge 8 was dishonest, in that you intended for Colleague 3 to believe that you had ensured staff medicals were being carried out, such that only 130 were overdue, when in fact, 724 were overdue,

10. Provided the Keystone machine to colleagues when the machine had not been calibrated and/or the colleagues had not been trained on the machine,

11. Failed to implement an updated and comprehensive Mental Health Welfare screening matrix, in that you:
    a. Refused to collaborate with the Mental Health and Welfare Lead Practitioner,
    b. Were obstructive in respect of any process change,

12. Failed to act on the notes taken by Colleague 4 at Health and Wellbeing meetings, stating to Colleague 4:
    a. That you “couldn’t care less” or words to that effect,
    b. “If it all goes tits up, then they’ve only got themselves to blame” or words to that effect,

13. Failed to adequately support staff, in that you:
    a. Failed to include in Colleague 4’s PDR that they had been working above their grade, despite requests to do so,
    b. Spoke to Colleague 4 in a rude and/or dismissive manner,
    c. Failed to support Colleague 4 when she was spoken to in a rude and/or dismissive manner by Colleague 1,
    d. Assigned a disproportionate number of appointments per remote clinic to Colleague 5 [C5], in that you:
        i. Assigned Colleague 5 more appointments than yourself,
        ii. Did not give Colleague 5 travel and administration time,
        iii. Refused to assist Colleague 5 when informed that they were struggling with their workload,
    e. Advised an unknown member of staff to take a career break due to a mental health issue instead of taking a period of absence and/or referring them to the mental health team,
    f. Failed to escalate Colleague 6’s [C6] ill health to the Occupational Heath Consultant physician,

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

Decision and reasons on application to admit written statement as hearsay evidence

The panel heard an application made by Mr Segovia under Rule 31 to allow the written statement of Colleague 4 into evidence. Colleague 4 was not present at this hearing and, Mr Segovia submitted that whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend today. Mr Segovia referred the panel to the documentation which evidenced the NMC attempts to engage with the witness including invitations to the hearing itself.

Mr Segovia told the panel that Colleague 4's evidence is relevant to charge 7, charge 10, charge 12 and charge 13 a – d.

Mr Segovia referred to the case of Thorneycroft v the Nursing Midwifery Council 2014 EWHC 1565 (Admin) which sets out the relevant principles for the panels consideration when determining whether or not to admit hearsay evidence.

Mr Segovia submitted that the panel should consider whether there is good reason for the non-attendance of the witness. However, he submitted that if there is not good reason, this does not automatically result in the exclusion of the evidence.

Mr Segovia also invited the panel to consider whether the evidence itself is demonstrably reliable or whether the evidence can be tested for its reliability. Mr Segovia conceded that in relation to charges, 10, 12 and 13a – 13d, Colleague 4's written statement was the only evidence in support of these charges. However, he submitted that Colleague 4's evidence is not the sole or decisive evidence in respect of charge 7.

Mr Segovia submitted that this case relates to serious charges of misconduct as they relate to Mrs Williams work as a senior member of staff within the occupational health unit and a number of alleged failures. He accepted that there is a potential for adverse findings to have an effect on Mrs Williams career.

Mr Segovia submitted that the NMC has taken reasonable steps to secure the attendance of Colleague 4. He submitted that the NMC has continued to try and engage with her from February 2023 to September 2023. [PRIVATE].

Mr Segovia submitted that whilst there is a reference to Colleague 4 wanting to retract her statement, there is no evidence of any suggestion of reasons to fabricate the contents of her statement.

Mr Segovia confirmed to the panel that Mrs Williams has been informed by way of her UNISON representative that the NMC are making an application to admit Colleague 4's statement as hearsay evidence given that she will no longer be attending.

In the preparation of this hearing, the NMC had indicated to Mrs Williams in the Case Management Form (CMF), that it was the NMC's intention for Colleague 4 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Colleague 4, Mrs Williams made the decision not to attend this hearing. On this basis Mr Segovia advanced the argument that there was no lack of fairness to Mrs Williams in allowing Colleague 4's written statement into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Colleague 4 serious consideration. The panel noted that Colleague 4's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by her.

The panel gave regard to the case of *Thorneycroft*.

The panel considered whether Colleague 4's statement was the sole or decisive evidence in support of any of the charges. The panel found that the Colleague 4's evidence was the sole or decisive evidence in respect of charges 10, 12 and 13a – 13d. The panel noted that in respect of charge 7, the evidence is very close to being the sole or decisive evidence, but it noted that Witness 1 also speaks to this charge.

The panel noted that Colleague 4 emailed the NMC on 13 September 2023 explaining that she would like to add to her statement and then in a subsequent email on 18 September 2023 she indicated that she would like to retract her statement in its entirety. The panel considered this and noted that the reasons for Colleague 4 wanting to retract her statement was because she was worried about the repercussions this would have on Mrs Williams. The panel found that there has been no reason to believe that the contents of Colleague 4's statement were fabricated or that she had any reason to fabricate the allegations.

The panel considered whether there was good reason for the non-attendance of Colleague 4. [PRIVATE].

The panel considered whether Mrs Williams would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Colleague 4 to that of a written statement. The panel noted that Mrs Williams representative was informed on 2 October 2023 that the NMC will be putting forward Colleague 4's written statement as hearsay evidence given her non-attendance. The panel considered that Mrs Williams had been provided with a copy of Colleague 4's statement and, as she has decided to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case.

The panel also concluded that there is a public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 1 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The charges arose when Mrs Williams was employed as an Occupational Health Manager since 1996 by the North Wales Police (the Force). Mrs Williams was referred to the NMC in October 2020 by the Head of Medical Services and Wellbeing at the Force.

Mrs Williams role as the manager of the Occupational Health Unit (OHU) included overall responsibility for undertaking all aspects of that management role, and that included managing the staff in the OHU, and promoting, maintaining and improving the health and well-being of the staff.

A review of the OHUs' systems and processes by Mrs Williams' line manager identified potential serious failings with regard to non-compliance with the foundation occupational health standards for Police Forces.

Decision and reasons on facts

At the outset of the hearing, Mr Segovia referred the panel to the case management form (CMF) which was returned by Mrs Williams UNISON representatives to the NMC on 12 April 2023. The boxes on the CMF relating to the charges had been ticked "*admitted*" in relation to charges 5a and 5d but ticked "*not admitted*" in relation to the other charges.

The panel noted that the CMF was an unsigned document and therefore it was not prepared to accept the admissions to charges 5a and 5d given that Mrs Williams is not present at the hearing to confirm the admissions.

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

The panel has drawn no adverse inference from the non-attendance of Mrs Williams.

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 witness called on behalf of the NMC:

- Witness 1/Colleague 3: Head of Medical Services and Wellbeing, North Wales Police

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 Mrs Williams.

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

[PRIVATE].

Charge 1

1. Failed to ensure staff were undertaking tasks within their training and/or competency, in that:
    a. Colleague 1 [C1] conducted vision, hearing and spirometry testing without any written evidence of competence,

b. Colleague 2 [C2] undertook blood pressure monitoring prior to fitness testing despite not being a nurse and/or without having the relevant qualifications,

These charges are found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1.

The panel had regard to the Force's "*Occupational Health Manager*" post profile. The panel noted that this was an unsigned and undated document but noted that it was able to see the name of the file which reflected Mrs Williams name and reflected that this document was the job description. The panel noted that this document had been adduced by Witness 1 who informed the panel that this document derived by a reliable source, namely the Human Resource (HR) department of the Force. The panel had seen evidence which confirmed that Mrs Williams was employed in this role and that this would have been the relevant job description document at the time that Mrs Williams commenced her role as the Occupational Health Manager.

The panel noted that the post profile sets out the following under duties and responsibilities:

> *"the development of staff within OHU, identifying training and development needs thereby ensuring appropriate levels of competence and performance are established in order to comply with PREP, legislative and Force requirements"*

The panel was satisfied that this establishes that there was a duty on Mrs Williams to ensure staff were undertaking staff within their training and/or competency which included the requirement to provide documentary evidence of competencies. Having established the duty, the panel went onto consider whether Mrs Williams had failed to fulfil this.

The panel had regard to the written statement of Witness 1 in which she states:

"I also discovered that Anna's staff had been working outside of their training and competency. An Occupational Health Nurse Advisor, [Colleague 1], was permitted to undertake vision, hearing and spirometry testing without any written evidence of competence. [Colleague 1]'s training record as at 8 June 2020 is exhibited as Exhibit [Witness 1]/4. I asked Anna how she ensured competency and she couldn't show me any evidence as there was no standard operating procedure or clinical competencies completed, nor was there any evidence of record keeping or case management. For example, there was no evidence of record keeping audits or dip sampling of assessments to assure clinical quality. There was another instance whereby the Physical Training Instructor, [Colleague 2], was found to be undertaking blood pressure monitoring prior to fitness testing despite not being a nurse and not having the relevant qualifications. [Colleague 2] therefore would not have the necessary understanding of the importance of cuff size, infection control procedures or when to escalate. When I queried this with Anna, she said she had shown [Colleague 2] how to do it but there was no record of this. There was also no evidence of any signed clinical competency incorporating the knowledge base of normal parameters and when to escalate to a nurse as required."

During the hearing, the panel heard from Witness 1 who was consistent and clear that there was no written evidence of any competency assessment which was relevant to vision, hearing and spirometry having been completed for Colleague 1.

The panel also heard from Witness 1 during the hearing that similarly, there was no documentary evidence of any competency assessment which was relevant to blood pressure monitoring prior to fitness testing having been completed for Colleague 2.

The panel had regard to the notes from the 1:1 meeting with Mrs Williams dated 11 June 2020 which state:

"[Witness 1] discussed clinical competencies, how was [Colleague 2] deemed competent at taking blood pressures, where are the clinical competencies and evidence? Anna tried to recall this and she stated that she had shown [Colleague 2] how to undertake blood pressures, [Witness 1]'s concern is, did [Colleague 2] understand normal parameters of blood pressures as [Witness 1] witnessed the cuff applied incorrectly." [Witness 1] expressed further concerns as to how [Colleague 1] was deemed competent in the department; Anna will confirm when she started in the department? 2016, 2017. The Amplivox courses which [Witness 1] identified had not been undertaken but she was undertaking vision assessments etc. Anna highlighted that [Colleague 1] shadowed […] the previous OHU nurse, but there are no written competencies."

The panel also had regard to Colleague 1's training record which supported Witness 1's evidence.

The panel found that Mrs Williams did fail to produce evidence of any competencies for Colleague 1 and Colleague 2. The panel concluded that, based on all the evidence before it, it is more likely than not that that Mrs Williams did fail to ensure staff were undertaking tasks within their training and/or competency. It therefore finds these charges proved.

Charge 2

2. Failed to undertake monthly 1:1s and/or Personal Development Reviews ("PDR"s) with staff despite being told to do so,

This charge is found proved.

In reaching this decision, the panel took into account the live and documentary evidence of Witness 1 as well as the documentary evidence which included the notes of 1:1 meetings with Mrs Williams and with Colleague 2.

The panel had regard to the post profile which sets out that Mrs Williams would have had the following duties and responsibilities:

- *"Clinical supervision of nursing staff*
- *[…]*
- *Personal development reviews"*

The panel was satisfied that this established that there was a duty on Mrs Williams to have undertaken 1:1s and/or PDRs with staff. The panel next went on to consider whether she had failed to fulfil this requirement.

The panel had regard to Witness 1's written statement which states:

> *"On 14th May 2019 I requested that Anna undertake monthly 1:1 meetings and Personal Development Reviews (PDR) with her staff as per organisational standards and to support them and develop their roles to ensure clinical competency, which would in turn improve the OHU. Each month Anna would confirm the 1:1's were being undertaken and PDRs were completed but that was not the case. I exhibit notes from my 1:1 meeting with Anna on 18th March 2019, 11th June 2020, and 2nd September 2020 in which the above was addressed as Exhibit [Witness 1]/2. A 1:1 which I conducted with [Colleague 2] on 6th May 2020 is exhibited as Exhibit [Witness 1]/3. It shows that I had to explain the process of a 1:1 as [Colleague 2] did not recall having one before. It is also stated that she did not have an active PDR and could not recall when the last one was completed."*

It also had regard to minutes of the meeting dated 11 June 2020 in which it states:

> *"[Witness 1] questioned Anna with regards to why PDR's have not been completed, Anna responded with "Just haven't done them" [Witness 1] highlighted that as the manager of the department she is responsible for developing the staff and*

addressing any developmental requirements. [Witness 1] highlighted that [Colleague 2] states she has "not had one in 32 years""

Based on all the evidence before it, the panel determined, it is more likely than not that, Mrs Williams failed to undertake monthly 1:1s and/or Personal Development Reviews ("PDR"s) with staff. It therefore finds this charge proved.

Charge 3

3. Informed Colleague 3 [C3] that you had been undertaking monthly 1:1s with staff when you had not been doing so,

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 as well as the documentary evidence.

Witness 1's written statement states:

"*Each month Anna would confirm the 1:1's were being undertaken […] but that was not the case. I exhibit notes from my 1:1 meeting with Anna on 18th March 2019, 11th June 2020, and 2nd September 2020 in which the above was addressed as Exhibit [Witness 1]/2. A 1:1 which I conducted with [Colleague 2] on 6th May 2020 is exhibited as Exhibit [Witness 1]/3. It shows that I had to explain the process of a 1:1 as [Colleague 2] did not recall having one before."*

The panel had regard to the minutes of the 1:1 meeting between Witness 1 and Mrs William dated 28 October 2019 in which it states:

"Anna continues to undertake 1:1's, but due to the departmental shortage this has not been possible the last week or so"

It also had regard to the minutes of the 1:1 meeting between Witness 1 and Mrs William dated 7 January 2020 in which it states:

> *"One to One's will recommence within the team now Christmas and New Year is over"*

A further document showing the minutes of the 1:1 meeting dated 11 June 2020 stated:

> *"Anna stated that she will continue with the team 1:1's. [Witness 1] highlighted that whilst she was off recently, the staff stated that they have never had any 1:1's. Anna highlighted that these have occurred; [Witness 1] requested that Anna sends her the evidence"*

It also had regard to minutes of the 1:1 meeting between Witness 1 and Colleague 2 dated 3 May 2020 which stated:

> *"[Witness 1] explained the progress of a 1:1 as [Colleague 2] has never had a formal one to one before;"*

The panel noted that the notes of each of the 1:1 meetings had been signed by Mrs Williams.

Based on all the evidence before it, the panel found that Mrs Williams did inform Colleague 3 that she had been undertaking monthly 1:1's when she had not been doing so. The panel therefore finds this charge proved.

Charge 4

4. Your conduct at charge 3 was dishonest, in that you intended for Colleague 3 to believe that you had been undertaking monthly 1:1s with staff,

This charge is found proved.

In reaching this decision, the panel considered whether it was more likely than not that Mrs Williams intended for Colleague 3 to believe that she had been undertaking 1:1's when she knew she had not been. The panel noted that in coming to its decision, it should consider the state of Mrs Williams knowledge at the time of what is alleged and finally whether her actions would be considered dishonest by the standards of ordinary decent people.

The panel identified that the evidence sets out that Mrs Williams was a nurse of a significant level of experience who was holding the position of a senior nurse, responsible for managing the occupational health department for a number of years and was required to carry out duties for developmental progress of staff which included undertaking 1:1's as well as other duties.

The panel took into account that it has documentary evidence signed by Mrs Williams that the 1:1's had been discussed during meetings, and that these discussions included Mrs Williams being asked to undertake the 1:1's and Mrs Williams confirmations that the 1:1's had been undertaken.

The panel considered the state of Mrs Williams knowledge at the time she informed Colleague 3 that she had been undertaking monthly 1:1's with staff.

The panel determined that, Mrs Williams would have been aware that she had not completed the 1:1's at the time that she was declaring that she had undertaken them. The panel found that Mrs Williams was clear in her assertion that the 1:1's undertaken and there was no ambiguity around the statements she was making relating to the 1:1's and that she had more than once, misleadingly confirmed that she had undertaken the 1:1's.

The panel determined that by the standards of ordinary, decent people, Mrs Williams actions would be considered as dishonest.

The panel therefore concluded that Mrs Williams actions as set out in charge 3 were dishonest, in that she intended for Colleague 3 to believe that she had been undertaking monthly 1:1s with staff. It therefore finds this charge 4 proved.

Charges 5a 5b and 5d

5. Failed to keep evidence that systems and procedures were implemented at the OHU, in that:
    a. There were no clinical policy documents, supporting procedures, or guidance in place,
    b. There was a lack of records regarding staff competency, supervision, or training,
    d. There were no record keeping audits,

These charges are found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Force's job description for the "*Occupational Health Manager*" post which sets out that the post holders responsibilities include to:

> *"Develop and implement OH policies and procedures to ensure that a comprehensive and high standard of Occupational Health care is provided within the Force"*

The panel noted that this does not specifically state to "keep evidence" in relation to this. However, it determined that this was implicit and therefore it was satisfied that this

established the duty on Mrs Williams to keep evidence that systems and procedures were implemented. The panel went on to consider whether Mrs Williams failed to fulfil this duty.

It had regard to Witness 1's written statement in which she stated:

> *"Anna's record keeping was also substandard. She failed to keep staff records as mentioned above and she also failed to show any evidence of her own professional development, clinical policies, and procedures in the department. The review and maintenance of external contracts as well as a record of health surveillance staff medicals were non-existent which posed a risk to the nursing staff, Force, and overall general public. Some of the failures were highlighted in the internal audit conducted by tiaa entitled "Advisory Review of Occupational Health Standards 2020/21" exhibited as Exhibit [Witness 1]/6."*

The panel had regard to the Tiaa Internal Audit Report of 2020/2021 which under Key findings and management action plan (MAP):

> *"Standard B1.1 - The Occupational Health Unit (OHU) maintains a Clinical Audit Spreadsheet detailing the number of cases per individual. There is no formal documented process for clinical record keeping utilising a standard template to ensure a consistent approach is adopted."*

In relation to charges 5a and 5d, the panel took into account that it had regard to the unsigned CMF form which was returned to the NMC by Mrs Williams UNISON representative. It noted that the form indicated that Mrs Williams has made admissions to charges 5a and 5d and whilst at the outset of this hearing the panel did not accept the admissions in their entirety given the form was unsigned, in its consideration of these charges, it has noted that Mrs Williams has accepted them.

Based on the evidence before it, the panel found that Mrs Williams did fail to keep evidence that systems and procedures were implemented at the OHU, in that there were

no clinical policy documents, supporting procedures, or guidance in place, and that there was a lack of records regarding staff competency, supervision, or training and that there were no record keeping audits. The panel therefore finds these charges proved.

Charge 5c

5. Failed to keep evidence that systems and procedures were implemented at the OHU, in that:
   c. There were no records of your own professional developments,

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1. Her written statement stated:

> *"Anna not address the poor attitude and behaviours of staff although tasked to do so and did not develop herself or her team. She would also often give the impression of being not bothered and would shrug her shoulders and not show any insight or address concerns raised. When questioned in June 2020, Anna said she believed she possessed excellent communication and leadership skills and perceived no need for any improvement.*
>
> *[…]*
>
> *She failed to keep staff records as mentioned above and she also failed to show any evidence of her own professional development, clinical policies, and procedures in the department."*

The panel also had regard to the minutes of the 1:1 meeting between Witness 1 and Mrs Williams dated 11 June 2020 which states:

"[Witness 1] asked Anna in view of the lack of PDR's, policy updates, staff competencies, medical backlog, does she feel that she possesses the leadership or management skills to manage the OHU department. Anna stated that she feels this is something she needs to go away and reflect upon. [Witness 1] highlighted that she needs assurance that this department is well led and is suitably risk managed which currently there is limited evidence off."

The panel found that the evidence of Witness 1 was consistent with the documentary evidence.

Charge 6

6. Failed to complete all staff medicals,

This charge is found proved.

In reaching this decision, the panel took into account the Force's job description for the "*Occupational Health Manager*" post which sets out that the post holders responsibilities include:

"To oversee, or where applicable, assist the Occupational Health Nurse (s), in providing all aspects of health supervision of staff including:
[…]
Statutory medicals"

The panel also had regard to the written statement of Witness 1 which stated:

"On 16th April 2019 I discovered that there was a potential backlog in driver staff medicals. I questioned Anna regarding this and asked Anna to prepare and implement an action plan to work through them. Anna confirmed on 14th May 2019 that the backlog list was nearly completed. The matter was discussed at OHU team

meetings on 4th June, 10th July, 15th August and 17th December 2019, the minutes if which are exhibited as Exhibit [Witness 1]/7. On 26th September 2019 Anna updated that there were "no remaining reds" (red being those overdue for more than 12 months) and she was starting the amber list. However, she provided the same update again on 28th October 2019 indicating that no progress had been made. On 14th January 2020 Anna sent me an email stating there was only 32 red and 18 amber medicals and a total of 130 overdue medicals due. The email is exhibited as Exhibit [Witness 1]/8."

The panel also had regard to the emails from Mrs Williams to Witness 1 dated 14 January 2020 in which she sets out that there are a number of staff medicals outstanding and therefore confirming that all staff medicals were not complete.

The panel therefore determined that, based on the evidence before it, this charge is found proved.

Charge 7

7. Instructed Colleague 4 [C4] to invite only key roles for staff medicals and/or to forget about undertaking staff medicals for drivers under 45,

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Colleague 4.

Colleague 4 stated:

"On 9 April 2014, I highlighted to Anna that we couldn't book all the monthly medicals to [Person 1] but instead of adding some to her own calendar, Anna told me to "invite only key roles in for medicals and forget standard drivers under 45". By "key roles" she meant firearms. I was shocked by that response as she was the

manager and I was bringing an issue to her and her response was for me to forget certain staff who still needed medicals. When Anna gave me instructions like this, I would write notes or put it in an email to Anna but she would never reply to me so I have no responses or written evidence that she had given those instructions."

The panel also had regard to the handwritten note by Colleague 4 dated 9 April 2014 which stated:

"No space for medicals.
[…] invite only key roles in for medical or over 45.
Forget standard drivers under 45."

The panel noted that this documentary evidence was admitted as hearsay and therefore the panel was not able to test it during the hearing. However, it noted that the handwritten note is a contemporaneous record of what had occurred. The panel also noted the evidence of Witness 1, that this note was provided to her by Colleague 4 with a consistent account.

The panel determined that, based on the evidence before it, it is more likely than not that Mrs Williams did instruct Colleague 4 to invite only key roles for staff medicals and/or to forget about undertaking staff medicals for drivers under 45. It therefore finds this charge proved.

Charge 8

8. Informed Colleague 3 that there were 130 overdue medicals, when there were actually 724,

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence.

The panel had regard to the email from Mrs Williams to Witness 1 dated 14 January 2020 in which she stated:

> *"As discussed this afternoon I have reviewed the 'Overdue Driver Medical' report and our Bring Forward file and have to raise the issue that with current resources we are struggling to keep up with the demand for statutory medicals.*
>
> *From the original overdue list of 108 drivers we have completed the initial 58 Red ones however as time has now moved on the amber ones have become Red and the Green ones have become amber!*
>
> *[…]*
>
> *We therefore have a total of 130 overdue medicals – each medical takes 45-60 minutes per appointment, equates to 130 hours of work, based on 7 per day = 18.5 days of work doing only these and nothing else!"*

The panel determined that it did have evidence before it to confirm that Mrs Williams did inform Colleague 3 that there were 130 staff medicals overdue.

The panel had regard to the written statement of Witness 1 which stated:

> *"I requested that admin staff give me an assurance that there were no red medicals left to do. However, admin could not make sense of Anna's records. I asked the Wellbeing Lead, […], to run a report which showed there were 724 outstanding medicals. Due to Anna's previous updates and assurances, I thought that figure must be incorrect, so the Head of People and Organisational Development, […], asked one of the analysts, […] to generate a report. The second report confirmed that the original report was correct and there were 724 outstanding medicals."*

The panel considered that Mrs Williams email is dated 14 January 2020 and so there is the possibility that on the date she had ran the report, the figures would have been different to the ones produced when Witness 1 had arranged for the reports to be run again. The panel noted that the later report was dated 10 June 2020. The panel determined that the analysis in the report took place six months after the date of Mrs Williams report, and as such it was not possible to determine what the correct figure of outstanding medicals on the date that Mrs Williams informed there were 130 outstanding.

The panel was not satisfied, on the basis of the evidence before it, the NMC has proved that there were 724 staff medicals outstanding at the time that Mrs Williams informed that there were 130. It therefore finds this charge not proved.

Charge 9

9. Your conduct at charge 8 was dishonest, in that you intended for Colleague 3 to believe that you had ensured staff medicals were being carried out, such that only 130 were overdue, when in fact, 724 were overdue.

This charge is found NOT proved.

As the panel has found charge 8 not proved, charge 9 falls away given it is formed on the basis of charge 8.

Charge 10

10. Provided the Keystone machine to colleagues when the machine had not been calibrated and/or the colleagues had not been trained on the machine,

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Colleague 4. She stated:

> *"Anna advised that she had given the Taser Trainers the Keystone machine (this is used to test vision). This was to enable the trainers to test the vision of officers prior to a taser course. I asked Anna when she had given the trainers the machine. I arrange the calibration of all our medical equipment and I was concerned that it had not been calibrated. Anna confirmed the date and it turned out that she had given them a machine that had not been calibrated. Anna was happy the trainers would do it so she didn't have to, but they were only visually shown how to work the machine and perform the test once by [Colleague 1]."*

The panel noted that Colleague 4's evidence was untested during the hearing. However, the panel considered that this was consistent with other evidence it has heard in relation to Mrs Williams approach.

The panel determined that, on the balance of probabilities, it is more likely than not that Mrs Williams did provide the Keystone machine to colleagues when the machine had not been calibrated and/or the colleagues had not been trained on the machine. It therefore finds this charge proved.

Charge 11

11. Failed to implement an updated and comprehensive Mental Health Welfare screening matrix, in that you:
    a. Refused to collaborate with the Mental Health and Welfare Lead Practitioner,
    b. Were obstructive in respect of any process change,

These charges are found proved.

In reaching this decision, the panel took into account the Force's job description for the "*Occupational Health Manager*" post. It noted that the job description does not make specific reference to a mental health welfare screening matrix obligation. However, it noted that it does state:

> *"Lead responsibility for the clinical aspects of Occupational Health and the promotion, maintenance and improvement of physical and mental well being of all members of staff […]*
>
> *[…]*
> *To oversee, or where applicable, assist the Occupational Health Nurse(s), in providing all aspects of health supervision of staff […]"*

The panel found that the job description established a duty in that, whilst there is no specific reference to a specific 'mental health welfare screening matrix' it covers a wide range of responsibilities which centred around promoting, maintaining and improving the wellbeing of staff.

Further, the panel noted that Mrs Williams was instructed by her line manager to implement an updated and comprehensive Mental Health Welfare screening matrix and therefore this in itself established a duty for her to fulfil this.

The panel had regard to the written statement of Witness 1. She stated:

> *"Anna also refused to implement the updated and comprehensive Mental Health Welfare screening matrix which was agreed by North Wales Police for implementation on 3rd June 2019. The old screening questionnaire was not evidence based in line with the College of Policing nor comprehensive enough for all policing roles included which resulted in an inability to give assurance to the psychological health of the staff. Anna's failure to implement the new matrix would not have allowed consideration for susceptibility to the vicarious trauma from the*

high-risk organisational roles that the staff can experience daily. Anna refused to collaborate with the Mental Health and Welfare Lead Practitioner and was obstructive regarding any process change even though it was not her area of expertise. Her refusal made it impossible to correlate trends of psychological wellbeing across the organisation in relevant departments and identify any staff member experiencing a traumatic response or disorder which means evidence based therapy and support could not be provided. This could potentially lead to further deterioration of the patient's psychological health and the public's safety if an operational officer. The old Welfare Screening Programme and new Welfare Screening Programme are exhibited as Exhibit [Witness 1]/12 and Exhibit [Witness 1]/13 respectively."

The panel found that Witness 1's live evidence was consistent with her witness statement.

Based on all the evidence before it, the panel determined that, Mrs Williams did fail to implement an updated and comprehensive Mental Health Welfare screening matrix in that she refused to collaborate with the Mental Health and Welfare Lead Practitioner and was obstructive in respect of any process change. It therefore finds these charges proved.

Charge 12

12. Failed to act on the notes taken by Colleague 4 at Health and Wellbeing meetings, stating to Colleague 4
    a. That you "couldn't care less" or words to that effect,
    b. "If it all goes tits up, then they've only got themselves to blame" or words to that effect,

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Colleague 4. She stated:

"When Anna was not at work, I would attend the monthly Health and Wellbeing board meetings. This was so OHU was kept in the loop with business. I would take notes and then report the minutes of the meeting to Anna and let her know about changes the board wanted to implement for the OHU but Anna was never interested and didn't action anything. For example, the board wanted to implement a wellbeing team or group within the OHU, but when I told Anna she said she "couldn't care less" and "if it all goes tits up, then they've only got themselves to blame"."

The panel determined that Mrs Williams would have been required to act on the notes taken by Colleague 4 at the health and wellbeing meetings given what is set out in the job description.

The panel found that the evidence of Colleague 4 is more likely than not to be true. It found that based on the documentary evidence before it, Mrs Williams did fail to act on the notes taken by Colleague 4. It determined that on the balance of probabilities, it is more likely than not that she stated that she "*couldn't care less*" and "*If it all goes tits up, then they've only got themselves to blame*" or words to that effect, to Colleague 4. The panel therefore finds these charges proved.

Charge 13a, 13b, 13c and 13d

13. Failed to adequately support staff, in that you:

    a. Failed to include in Colleague 4's PDR that they had been working above their grade, despite requests to do so,
    b. Spoke to Colleague 4 in a rude and/or dismissive manner,
    c. Failed to support Colleague 4 when she was spoken to in a rude and/or dismissive manner by Colleague 1,

d. Assigned a disproportionate number of appointments per remote clinic to Colleague 5 [C5], in that you:
    i. Assigned Colleague 5 more appointments than yourself,
    ii. Did not give Colleague 5 travel and administration time,
    iii. Refused to assist Colleague 5 when informed that they were struggling with their workload,

These charges are found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it.

In relation to charge 13a, the panel was not satisfied that there was evidence before it to determine that Colleague 4 was in fact working above her pay grade. It therefore was not satisfied that there was a failure on Mrs Williams part in not documenting this in her PDR, nor was it satisfied that there was a duty on Mrs Williams to include in the PDR that Colleague 4 was working above her pay grade.

In relation to charges 13b and 13c, the panel was not satisfied that there is sufficient evidence to determine that Mrs Williams spoke to Colleague 4 in a rude or dismissive manner or that she failed to support Colleague 4 when she was spoken to in a rude or dismissive manner by Colleague 1. The panel noted that there was not any evidence to show that Mrs Williams intervened in relation to the conversations between Colleague 1 and Colleague 4. However, the panel determined that there was no evidence before it which establishes that there would have been a duty on Mrs Williams to intervene or that intervention was necessary by her. The panel noted that Colleague 4's statement was admitted as hearsay so in that regard it was limited and further the panel found that there was a lack of corroborative evidence in support of this charge.

In relation to charge 13d, the panel noted that there was not any data or documentary evidence to demonstrate the number of appointments which were allocated. The panel found that the evidence in relation to this charge was not corroborated by any other

documentary or live evidence. It therefore was not satisfied that there is sufficient evidence to prove that Mrs Williams assigned a disproportionate number of appointments per remote clinic to Colleague 5 in that she assigned Colleague 5 more appointments than herself, did not give Colleague 5 travel and administration time and refused to assist Colleague 5 when informed that they were struggling with their workload.

The panel noted that in respect of these charges, it had regard to the written statement of Colleague 4 which was admitted as hearsay evidence. It noted that it was not able to test the contents of the statement and that the evidence in relation to the above charges was not corroborated by any other documentary or live evidence. It therefore finds these charges not proved.

Charges 13e and 13f

13. Failed to adequately support staff, in that you:
    e. Advised an unknown member of staff to take a career break due to a mental health issue instead of taking a period of absence and/or referring them to the mental health team,
    f. Failed to escalate Colleague 6's [C6] ill health to the Occupational Heath Consultant physician

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 as well as the documentary evidence.

In relation to charge 13e, the panel noted that it had regard to Witness 1's statement which stated:

"Whilst there does not appear to be any specific instances of harm suffered by patients because of Anna's conduct, there have been some poor decisions which

could have resulted in harm. Since Anna was dismissed, certain cases have come to light which should have been escalated to the Consultant Occupational Health Physician. [PRIVATE].”

The panel noted that Witness 1’s evidence during the hearing was clear and consistent with her documentary evidence. [PRIVATE]. Further, when she was asked whether there was a referral procedure or protocol when a mental health nurse was employed, and a mental health unit was established, she confirmed that there was. The panel noted that it did not have sight of the documentation which outlined any procedures or protocols. However, the panel found that there was a failure on Mrs Williams part [PRIVATE].

The panel found that based on the evidence before it, on the balance of probabilities, it is more likely than not, that Mrs Williams advised an unknown member of staff to take a career break due to a mental health issue instead of taking a period of absence and/or referring them to the mental health team.

In relation to charge 13f, the panel had regard to Witness 1’s written statement which stated:

“Another staff member [Colleague 6], had numerous lengthy repeat appointments in the OHU with Anna. [PRIVATE].”

The panel heard from Witness 1 during the hearing who gave evidence which was clear and consistent with her documentary evidence.

[PRIVATE]. The panel found that within these records there is no mention of Colleague 6’s ill health being escalated to the Occupational Heath Consultant physician.

The panel therefore found that, based on the evidence before it, Mrs Williams did fail to escalate Colleague 6’s [C6] ill health to the Occupational Heath Consultant physician. It therefore finds this charge proved.

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 Mrs Williams' 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, Mrs Williams' fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Segovia referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Segovia invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2018)' (the Code) in making its decision.

Mr Segovia informed the panel that whilst the concerns in this case may span over a period of time which pre-dates 2018, the Code of 2018 is the relevant one to be looking at given the only difference between the 2018 and 2015 Code is that the 2018 Code address nursing associates.

Mr Segovia identified the specific, relevant standards where Mrs Williams' actions amounted to misconduct.

Mr Segovia submitted that the conduct must be serious to amount to professional misconduct. He submitted that in this case, there appears to be a very broad scenario where Mrs Williams whilst she was a registered nurse, was acting as the manager of the OHU at the Force. He submitted that the key issues in this case are a series of very serious, and prolonged failures by Mrs Williams to manage the OHU in a way that did not present a risk to members of staff, which included emergency workers, and the wider public.

Mr Segovia categorised the failures as failures to undertake appropriate staff training and ensure competence, failures to undertake personal development with staff, failures to implement systems and procedures including documentation, records and audits, failures to implement a mental health welfare screening matrix and a failure to act in the best interests of Colleague 6.

Mr Segovia submitted that the panel may conclude that Mrs Williams fundamental failings do fall well below the professional standards expected of her as a registrant in her role as the manager of the OHU.

Submissions on impairment

Mr Segovia 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 Segovia invited the panel to consider whether Mrs Williams is able to practise as a nurse kindly, safely and professionally. He invited the panel to consider whether there is a present risk to members of the public and also to consider the need to uphold proper professional standards and public confidence in the profession.

In relation to the risk of harm, Mr Segovia drew the panels attention to Mrs Williams' failures in respect of the spirometry testing, blood pressure monitoring, clinical policy documents, staff medicals and calibration of equipment. He submitted that some of these failures directly impact on how the police officers would be carrying out their role with the public and therefore Mrs Williams actions not only presented a risk to the employees of the Force, but also to the public.

In relation to insight, Mr Segovia referred the panel to the evidence of Witness 1 which stated:

> *"Anna had no appetite to change and no insight into her behaviour and attitude. She lacked insight into governance and risk and did not acknowledge that the OHU requires policies, procedures and staff training and development to ensure it is safe and well led. Had I not been appointed the OHU would have continued to be unsafe and a high risk to the Force, the staff members and potentially to the public's safety.*
> *[…] However, Anna's attitude, behaviour, dishonesty, and lack of accountability combined with her refusal to engage and cooperate with resolving the issues and improving the OHU which left the department at high risk and unsafe left me with no choice but to refer her to the NMC with the support of the North Wales Police."*

Mr Segovia invited the panel to take the view that the contents of Witness 1's statement are true. He submitted that this is a case where there was a pattern of failures and breaches of the code of conduct. He submitted that Mrs Williams has breached fundamental tenets of the profession in terms of professionalism, leadership and most unfortunately, has brought her own reputation into disrepute. He submitted that the wider and unfortunate implication is that the reputation of the profession is somewhat diminished and brought into disrepute by the actions or inactions of Mrs Williams.

Mr Segovia submitted that considering the level of insight shown is a very helpful method of judging whether Mrs Williams presents a future risk. However, he submitted that there is nothing before the panel which demonstrates whether Mrs Williams has insight into her failures. He further stated that there is no evidence of remediation and therefore there is a high risk of repetition, particularly because this is a case where the concerns are attitudinal and behavioural in nature.

In closing, he invited the panel to consider whether Mrs Williams is a nurse who can practise safely, kindly and professionally and on that basis consider whether a finding of impairment is necessary in this case.

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), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decisions and reasons on which stage to consider Mrs Williams' application for Agreed Removal from the register

At the close of receiving legal advice on misconduct and impairment, Mr Segovia informed the panel that upon receiving the panels decision on facts, Mrs Williams' UNISON representative has sent in an application for agreed removal from the register. He brought the application to the attention of the panel before it retired to make its decision in relation

to misconduct and impairment as it is a matter for the panel to decide at what stage it considers the application and make its recommendations to the Registrar.

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

The panel considered the NMC's guidance on procedure when there is an application for agreed removal whilst a fitness to practice substantive hearing is ongoing which stated:

> *"The panel will consider how best to minimise the disruption caused to the hearing. This will usually mean waiting until the end of the finding of facts or impairment stage of the hearing, unless there is an urgent reason for the application to be considered earlier."*

The panel took the view that it would be appropriate to make a decision in relation to misconduct and impairment before considering the application for agreed removal and making any recommendations. It considered the nature of the facts found proved in this case and that there are wide ranging matters for the panel's consideration including a dishonesty matter. The panel found that a decision in relation to misconduct and impairment may assist the Assistant Registrar when they consider the agreed removal application. Further, it decided that not to proceed with this stage of the hearing would in effect be abandoning the process which would not serve the public interest. In addition, the panel did not have any information before it to determine that there is an urgent reason for the application to be considered before a decision was made on misconduct and impairment.

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 Mrs Williams' actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Williams' actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

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

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

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

8 Work cooperatively

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

10 Keep clear and accurate records relevant to your practice

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

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

10.5 take all steps to make sure that all records are kept securely

10.6 collect, treat and store all data and research findings appropriately

11 Be accountable for your decisions to delegate tasks and duties to other people

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

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

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

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

20 Uphold the reputation of your profession at all times

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

However, the panel was of the view that Mrs Williams failures were wide ranging including a failure to support her staff, ensuring policies, training and competencies were in place, ensuring documentation, records and audits were being kept, ensuring 1:1's were undertaken and ensuring calibration of equipment. Further it noted that the concerns also relate to failure to make appropriate clinical decisions.

In respect of the dishonesty, the panel considered that Mrs Williams was acting in a senior position as a manager of the OHU and would have been expected to lead by example and set the proper standards of conduct. Further, the panel noted that the dishonesty spanned over a period of time and that for a significant period the 1:1's were not being completed yet Mrs Williams informed the Head of Medical Services and Wellbeing that they had been completed. The panel found that the 1:1's were in place to serve a purpose which was aimed at staff development and to cover any areas of potential concern and so there was a risk in that if there were areas of concern within a staff members practice, this would

have been left unaddressed. The panel noted that, whilst there is no indication that the dishonesty would have resulted in personal gain for Mrs Williams, there appears to be indication of issues which are attitudinal in nature as Mrs Willliams neglected her responsibilities and mislead her manager on a number of occasions over a period of time.

The panel found that individually and collectively the charges found proved are sufficiently serious to amount to misconduct. The panel determined that Mrs Williams actions demonstrate a serious departure from the code and breaches of the fundamental tenets of the profession. The panel found that Mrs Williams' actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Williams' 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 be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

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

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

The panel found that all four limbs of the "test" are engaged.

The panel finds that a patient was put at risk harm as a result of Mrs Williams' misconduct, specifically in relation to Colleague 6 who was suffering from ill-health and required escalation. Further, the panel found that by not ensuring the required training and competencies were completed, this could have resulted in Police officers (including police drivers, taser users, firearms officers) engaging directly with members of the public when not competent or medically fit for duty. The panel found that this presented a risk to the

officers and to the wider public. The panel found that Mrs Williams is liable in the future to put patients at a risk of harm. The panel found that Mrs Williams' 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.

Regarding insight, the panel considered that it did not have a reflective piece or other evidence which demonstrated that Mrs Williams has an understanding of how her actions were wrong and how they had the potential to put the patients and the public at a risk of harm. Mrs Williams has not demonstrated an understanding of how this impacted negatively on the reputation of the nursing profession. The panel has not had any information before it which demonstrates that Mrs Williams understands what was expected of her as the manager of the OHU and how she should have managed her responsibilities differently. Further, Mrs Williams has provided no evidence that she has reflected on how her dishonesty would affect public confidence in the profession.

Whilst the panel noted that concerns relating to dishonesty are more difficult to remediate, it was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Williams has taken steps to strengthen her professional practice. The panel noted that Mrs Williams' failures are widespread in that they relate to both clinical and managerial aspects of her role as the manager of the OHU. The panel did not have any evidence of steps taken by Mrs Williams to address her failures such as relevant training or any remediation in respect of any of the areas of concern.

In light of the lack of insight, lack of steps taken to address the failings and remediation, the panel determined that there is a significant risk of repetition.

The panel concluded, based on all the reasons above, that Mrs Williams has not demonstrated that she is able to practise as a nurse kindly, safely and professionally. The

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

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

The panel determined that a finding of impairment on public interest grounds is required as public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Williams' fitness to practise impaired on the grounds of public interest.

The panel had regard to Mrs Williams' application form for agreed removal which was signed by her UNISON representative on her behalf which states:

> *"Do you admit:*
> *[…]*
> *That your fitness to practise is impaired?"*

The panel noted that in response to this question, the box indicating 'yes' was ticked.

Having regard to all of the above, the panel was satisfied that Mrs Williams' fitness to practise is currently impaired.

Agreed Removal Application and Recommendation

Mr Segovia addressed the panel on Mrs Williams' application for Agreed Removal. He submitted that the panel is obliged to make a recommendation to the Assistant Registrar whether that be a recommendation to grant the application or to deny it.

Mr Segovia referred the panel to its findings in relation to misconduct and impairment. He addressed the panel on its findings in relation to the lack of insight and lack of any steps taken by Mrs Williams to address the failings and the lack of evidence of remediation.

Mr Segovia acknowledged that as part of Mrs Williams' application for Agreed Removal, she has accepted current impairment but drew the panels attention to the matter that Mrs Williams' has not explained why she deems her fitness to practise to be impaired.

Mr Segovia told the panel that the NMC's position in relation to the panel's recommendation is neutral, but he invited the panel to carefully consider the matter. He acknowledged that he is not addressing the panel on sanction at this stage but the NMC's position is that Mrs Williams' actions are fundamentally incompatible with remaining on the register and that there is a realistic prospect of a striking off order being imposed in this case. However, he reiterated that he does not make the submission that the panel recommendations should be to deny the application.

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

The panel considered the documentation received in respect of Mrs Williams' application for Agreed Removal together with the submissions from Mr Segovia.

[PRIVATE].

The panel noted that in the Notice of Hearing, the NMC informed Mrs Williams that its sanction bid is that of a striking off order. The panel took into account that it has not made a determination in respect of the sanction stage and is yet to make any final decision. However, in view of the seriousness of the conduct individually and collectively, it considered that there is the potential that it would be open to the panel to conclude that Mrs Williams' conduct is fundamentally incompatible with her remaining on the register.

In the panels view, the public protection and wider public interest concerns would not be sufficiently met by an Agreed Removal from the register, and in the circumstances, its recommendation to the Registrar is not to allow the application.

Agreed Removal application refused

The panel had regard to the Agreed Removal decision letter dated 19 October 2023. The Assistant Registrar stated:

> *"I've decided not to agree the application for removal from the register based on the assessment of the relevant criteria.*
>
> *[…]*
>
> *Mrs Williams' actions put patients at risk of harm and were an abuse of her role as a manager.*
>
> *Mrs Williams hasn't demonstrated any insight into why her actions were wrong, how they could have put patients and the public at risk of harm and how they impacted negatively on the reputation of the nursing profession.*
>
> *The FtPC stated that it would be open to them to conclude that Mrs Williams' conduct is fundamentally incompatible with her remaining on the register. They have recommended that I don't agree the application to remove Mrs Williams from the register.*
>
> *The facts found proved by the FtPC raise fundamental questions about Mrs Williams' professionalism. In my view they are so serious that they're likely to result in the FtPC making a striking-off order.*
>
> *[…]*

Assistant Registrar's decision

In all the circumstances I conclude that it's not in the public interest to agree to Mrs Williams' removal from the register."

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Williams' name off the register. The effect of this order is that the NMC register will show that Mrs Williams has been struck-off the register.

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

Submissions on sanction

Mr Segovia informed the panel that in the Notice of Hearing, the NMC had advised Mrs Williams that it would seek the imposition of a striking off order if it found Mrs Williams' fitness to practise currently impaired.

Mr Segovia submitted that having found Mrs Williams current fitness to practise is impaired, the panel must decide what sanction, if any of course to impose. He submitted that the panel may consider that this is a case where a striking off order may well be appropriate.

Mr Segovia addressed the panel on what the NMC deemed to be aggravating and mitigating features in this case. He submitted that this is a serious case relating to serious failures and dishonesty. He reminded the panel that the concerns do not relate to events which occurred in an isolated incident or a single day and that instead the failures took place over a long period of time. Mr Segovia highlighted that the panel has already

identified that Mrs Williams has not demonstrated insight or remediation. He submitted that the NMC takes the view that there was an abuse of the management position Mrs Williams held in many ways and highlighted the presence of some attitudinal concerns.

Mr Segovia submitted that the panel does not have evidence of any mitigating features by way of any evidence of insight or remediation. He submitted that whether there are any mitigating features present in this case is a matter for the panel's consideration.

Mr Segovia invited the panel to consider the issue of professionalism. He submitted that Mrs Williams' actions raise very serious and fundamental questions about her professionalism. He referred to the SG which sets out a number of questions for the panel's considerations when determining whether a striking off order is the appropriate sanction. He submitted that Mrs Williams has been found to have been dishonest, some colleagues were treated poorly as a result of her actions and there were fundamental failures by her to implement changes to deal with concerns that were being raised and to ensure proper training.

Mr Segovia submitted that the NMC's position is that in this case, the only appropriate sanction to deal with the real and continuing risk to the public, as well as to ensure that public confidence is not undermined, is the striking off order.

Mr Segovia reiterated that this is a case where attitudinal issues are present and there is a lack of insight and remediation. He submitted that, in the circumstances, a striking off order is the appropriate and proportionate sanction to impose.

In closing, Mr Segovia informed the panel that there is no previous regulatory history for Miss Williams to bring to the attention of the panel. However, he submitted that this should have no bearing on what sanction is imposed because of the public protection issues identified.

Decision and reasons on sanction

Having found Mrs Williams' 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:

- Misconduct which occurred over a prolonged period
- Conduct which placed colleagues including Police Officers and the public at a risk of harm
- Lack of insight into failings
- Lack of evidence of remediation
- Abuse of a position of trust

The panel was not satisfied that it has had any evidence of mitigating features in 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, and the public protection issues identified, an order that does not restrict Mrs Williams' 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 Mrs Williams' misconduct was not at the lower end of the spectrum and that a caution order would be

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

The panel next considered whether placing conditions of practice on Mrs Williams' registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and the failure of Mrs Williams to reflect on her practice and engage with the process. The misconduct identified in this case was not something that can be addressed through retraining alone. The panel also took into account that Mrs Williams' lack of insight and lack of any steps she has taken to address the failings in this case suggests that she would not be willing to comply with any conditions. The panel also noted that Mrs Williams is not currently practising as a nurse and has indicated that she wishes to continue employment in a non-nursing capacity. Furthermore, the panel concluded that the placing of conditions on Mrs Williams' registration would not adequately address the seriousness of this case and would not protect the public.

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

The panel found that none of the factors above apply to the circumstances of this case.

The panel found that the nature and extent of Mrs Wiliams misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of an experienced registered nurse. In addition, the panel noted that Mrs Williams was acting in a managerial role where she would be expected to set the standards for others. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Williams' actions are fundamentally incompatible with Mrs Williams remaining on the register. In light of the circumstances of this case, the panel concluded that a suspension order would not satisfy the wider public interest.

In the light of all the reasons above, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Mrs Williams' actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Wiliams' actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mrs Williams in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Segovia. He submitted that an interim suspension order is required for a period of 18 months for public protection and that it is in the wider public interest. He submitted that this was required to cover the 28-day appeal period and any period during which an appeal may be dealt with.

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 striking off order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the period during which an appeal might be made and the period for which it may be heard.

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

That concludes this determination.