Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Thursday, 25 April 2024

Virtual Hearing

Name of Registrant:	Julie Warmington
NMC PIN	11A0134E
Part(s) of the register:	Registered Nurse- Sub Part 1 RNA: Adult Nurse, level 1 (10 January 2011) Recordable qualifications: V300: Nurse independent / supplementary prescriber (3 December 2018)
Relevant Location:	Lancashire
Type of case:	Misconduct
Panel members:	Adrian Smith (Chair, Lay member) Dorothy Keates (Registrant member) Linda Redford (Lay member)
Legal Assessor:	Tim Bradbury
Hearings Coordinator:	Samantha Aguilar
Nursing and Midwifery Council:	Represented by James Wilson, Case Presenter
Mrs Warmington:	Present and represented by Anna Chestnutt, instructed by the Royal College of Nursing (NMC)
Order being reviewed:	Suspension order (6 months)
Fitness to practise:	Not Impaired
Outcome:	**Order to lapse upon expiry in accordance with Article 30 (1), namely on 4 June 2024.**

Decision and reasons on review of the substantive order

The panel decided to allow the order to lapse upon expiry in accordance with Article 30 (1) of the Nursing and Midwifery Order 2001 ('the Order') on 4 June 2024.

This is the first review of a substantive suspension order originally imposed for a period of 6 months by a Fitness to Practise Committee panel on 2 November 2023.

The current order is due to expire at the end of 4 June 2024.

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

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

'That you, a registered nurse:

1. *On 10 November 2016:*

a) *Did not tell Patient A to come back if his symptoms worsened;* **[FOUND PROVED BY WAY OF ADMISSION]**

b) *Did not develop a care plan for Patient A;* **[FOUND PROVED BY WAY OF ADMISSION]**

c) *Did not arrange a* [PRIVATE] *for Patient A;* **[FOUND PROVED BY WAY OF ADMISSION]**

d) […]

2. *On 24 November 2016:*

a) *Did not see Patient A in person;* **[FOUND PROVED BY WAY OF ADMISSION]**

b) *Did not escalate to a* [PRIVATE]*.* **[FOUND PROVED BY WAY OF ADMISSION]**

3. *On 5 January 2017:*

a) *Did not carry out any observations on Patient A or arrange for another nurse to see him;* **[FOUND PROVED BY WAY OF ADMISSION]**
b) *Did not escalate to a* [PRIVATE]*.* **[FOUND PROVED BY WAY OF ADMISSION]**

4. *On 10 January 2017:*
a) *Did not ensure that observations were carried out;* **[FOUND PROVED]**
b) *Did not arrange for Patient A to be seen by a* [PRIVATE]*;* **[FOUND PROVED]**
c) *Refused to attend Patient A's cell later in the day.* **[FOUND PROVED]**

5. *On 11 January 2017:*
a) […]
b) *Failed to take the emergency bag.* **[FOUND PROVED BY WAY OF ADMISSION]**

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.* **[FOUND PROVED in relation to 4a and 4c]**

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

The original panel determined the following with regard to impairment:

'The panel 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 undertaken 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. 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. Further, 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.'

The original panel determined the following with regard to sanction:

'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*
- *Potential serious financial hardship*

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.*

[…]

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.'

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction. Additionally, the panel had regard to the NMC guidance which states, *'the question that will help decide whether a professional's fitness to practise is impaired is: Can the nurse, midwife, or nursing associate practise safely, kindly and professionally? If the answer to this question is yes, then the likelihood is the professional's fitness to practise is not impaired'.* In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle and the documents provided on your behalf by your legal representative.

The panel took into account Mr Wilson's submissions. Mr Wilson submitted that the charges arose out of your professional relationship with Patient A. He submitted that you had contact with Patient A between 10 November 2016 and 11 January 2017. He provided the panel with a summary of the charges and the chronology of the case. He submitted that the reason the charges arose are because Patient A sadly died of peritonitis caused by a perforated duodenum on 11 January 2017, which is when you last had contact with him.

Mr Wilson drew the panel's attention to the charges found proved. He reminded the panel that another nurse and doctor were also involved in Patient A's care, so it was not solely your actions which led to Patient A's death. However, he submitted that from the NMC's point of view, the panel found that your misconduct breached the fundamental tenets of the nursing profession and brought the reputation of the profession into disrepute.

Mr Wilson submitted that in respect of Charge 6 in relation to 4a and 4c, the original panel found that the patient was placed at risk of unwarranted harm as a result of your misconduct. Mr Wilson submitted that in terms of insight, you did not at the time reflect on your failings roundly and did not recognise how your failures impacted on the outcome for Patient A and what that would mean to the public confidence. Mr Wilson submitted that it was on this basis that the panel determined that as a result of the lack of full insight, there remains a risk of repetition and you were therefore impaired on the grounds of public protection. He also submitted that the original panel found you impaired on public interest grounds.

Mr Wilson reminded the panel that the previous panel suggested that a future reviewing panel may be assisted by a reflective piece which properly addresses your misconduct, 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. He informed the panel that the NMC made no positive submission either way, because it is a matter for the panel to consider at this stage.

Mr Wilson addressed the Impairment Bundle (containing 88 pages) provided on your behalf for this hearing. He submitted that this bundle was before the original panel. Despite this, that panel still made its decision that you were impaired and concluded that there remained a risk of repetition.

The panel also had regard to Ms Chestnutt's submissions on your behalf. Ms Chestnutt submitted that you admitted the majority of the Charges. However, in regard to Charge 6, an alternative was put before the original panel, and that panel was entitled to conclude that you either contributed to the death of Patient A or that your action or inaction created the loss of a chance for survival. She informed the panel that the first proposition was far more serious than the second, and the original panel took care to point out that nothing you had done or failed to do contributed to the death of Patient A. Ms Chestnutt submitted that in fact, it was only two charges that relate specifically to 10 January 2017, namely the day before Patient A died that created the loss of a chance of Patient A's survival, which is a nuanced but important difference. The evidence reflected that Prison Officers attended Patient A's cell to check on his welfare and called you to conduct a clinical examination on him. For reasons you gave during your oral evidence at the substantive hearing, you refused to treat Patient A. Ms Chestnutt submitted that it was your refusal, and in the original panel's view, your failure to ensure adequate clinical follow up with a nurse colleague or a [PRIVATE], which gave rise to the charges. Ms Chestnutt submitted that it was those specific events that created the loss of a chance of survival and that it is on that basis in which an element of Charge 6 was found proven. She submitted that this was the less serious proposition.

Ms Chestnutt submitted that the original panel's findings were intended to mark the seriousness of the misconduct and imposed a 6-month suspension order as opposed to the initial invitation from the NMC at the time which was for a 12-month suspension order. She submitted that the original panel took into account that you immediately left custodial nursing following the death of Patient A, you then moved to a primary care setting and became a nurse practitioner. The impairment bundle (containing 88 pages) reflected that you were a *'standout member of that medical community'*, *'well-liked'* and *'respected both clinically and personally'* and that there had been at that point a seven-year gap between the death of Patient A and the panel's decision on sanction.

Ms Chestnutt submitted that the crux of the matter was perhaps your lack of insight into the events surrounding Patient A's death, and that is something that you have reflected upon carefully. She drew the panel's attention to your reflective piece, which Ms Chestnutt submitted is focused and well considered. She submitted that the tone in your reflective piece is in keeping with someone who has provided care to a person who has sadly died in an untimely manner. You felt *'devastated'* by your part in Patient A's death. You have demonstrated in your reflection, and acknowledged the importance of your shortfalls in documentation and communication at the time of the incident and the impact on Patient A and why this is important. Ms Chestnutt told the panel that you acknowledged that there could have been a different outcome for Patient A, and that you offered a thoughtful and sensitive reflective piece as to what you have been able to accept, what you have learned and what you can continue to learn moving forward.

Ms Chestnutt told the panel that the suspension order has been nothing short of devastating for [PRIVATE]. [PRIVATE]. Nonetheless, you have been able to complete courses in communication, conflict management and documentation and record keeping, which were specific to the competencies relevant to the events surrounding Patient A's death.

Ms Chestnutt submitted that whilst not only working as [PRIVATE], you have also been providing care to [PRIVATE] which reflects the level of care and compassion that you show on a daily basis. Ms Chestnutt submitted that this is a testament to the sort of care professional that you truly are.

Ms Chestnutt invited the panel to consider the length imposed by the original panel, which was six months and intended to mark the seriousness of these matters. She invited the panel to allow the suspension to lapse when it expires and to reflect the fact that you had been a well-respected and competent nurse who had been practising without issues at the point of your suspension, and that you have provided a well-considered reflective piece which demonstrates your insight.

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

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

The panel considered whether your fitness to practise remains impaired.

The panel noted that the original panel found that you have not yet '*developed sufficient insight into your failings'*. At this hearing, the panel noted that you had made admissions to Charges 1a, 1b, 1c, 2a, 2b, 3a, 3b and 5b. It considered the seriousness of the Charges found proved and carefully acknowledged that it was not solely your actions or inactions which led to the passing of Patient A.

In its consideration of whether you have taken steps to strengthen your practice, the panel took into account that prior to the substantive suspension order, you had been practising as a registered nurse for almost seven years since Patient A's death, and no concerns had been raised about your practice. It also had sight of the Impairment Bundle (containing 88 pages) which was before the original panel which contained nine testimonials and a number of training certificates which included a Level 3 Adult Immediate Life Support Certificate (completed 22 January 2018), Resuscitation: Adult Basic Life Support Certificate (completed 13 February 2022) and PSTS/Conflict Management online training module certificate (completed 12 February 2023).

The panel considered whether you are currently impaired on public protection grounds. It took into account your most recent training certificates:

- Communication, completed on 17 March 2024.
- CSTF-PSTS/Conflict Management online, completed on 17 March 2024.
- Documentation and Record Keeping, completed on 17 March 2024.

The panel also had regard to the positive testimonials that you provided for the benefit of this review:

- *'Known Julie* [PRIVATE] […] [PRIVATE] *[…] need help with my daily routine. Since 2023 Julie has taken over my daily routine* [sic] [PRIVATE].

  I am aware of the NMC Charges against Julie and feel if she does not get [her] *PIN back it will be a loss to the NHS'*, undated testimonial written by [PRIVATE].

- *'I am aware of the details of the NMC charges against Ms Warmington.*

  I have always found Ms Warmington to be a helpful, hard working individual. She has always seemed to go out of her way to help patients and has come across as a kind caring, individual. She has always been helpful when I have asked her to do things and she appears to be an intelligent, motivated, logical individual who always seem to put patients first. Over our time together I have not seen anything that would make me feel that she is unsafe in any way.' Dated 27 February 2024, written by an Associate GP at [PRIVATE].

- *'Julie is a highly respected nurse, which is evident having mentored and worked alongside her for several years.*

  Her ability to deliver high quality patient care is evident, Julie's professional approach is admirable, she demonstrates a highly motivated, intelligent, and meticulous approach which has no doubt benefited patients and the wider care facility.

  Julie demonstrates high levels of critical decision making alongside high levels of accuracy and competence. Julie's curiosity and enthusiasm for her vocation is clearly evident. Julie demonstrates keen thought and foresight in her questions and her documentation is concise and detailed.

Julie would be a valued asset to any medical practice; no doubt the service would be greatly enhanced by the inclusion of such an outstanding individual.

Given Julies [sic] *on going case re NMC, it is acknowledged the allegations made against her. This in my opinion does not change any reference statement I have made about her practice.'* Dated 2 October 2023, and written by a colleague.

The panel also acknowledged your reflective piece dated 25 April 2024 and noted your reflection since your suspension on 4 November 2023. It was of the view that you have sufficiently reflected on how your misconduct may have brought the nursing profession into disrepute and resulted in risk of harm to the public:

'I had not conducted my practice to the high standards of the NMC code and public expectations. Identifying areas of my shortcomings and interactions with patient A whilst I have detailed below.

1) *Escalation and de-Escalation techniques*
2) *Obtaining current and existing medical history*
3) *Documentation and communication*

[…]

In addition, recognition of the NMC code to maintain public confidence within the nursing profession, delivering a high standard of care, alongside protecting the public and their wider interest remains a high priority within my practice.

[…]

Demonstrating insight into my interactions with patient A, I recognise that if I had:

- *completed or considered the above actions (thereby better de-escalation skills and attempts)*
- *escalated to other staff members within health care and*
- *documented correctly and communicated more effectively*

The above actions would have provided a higher and more accurate level of care delivered to patient A and therefore different outcomes become a probability.

[…]

Understanding now, that by demonstrating all my improvements to practice, regret and acknowledgement of my interactions and care I had undertaken with patient A was not demonstrated through my previous reflection. Providing details of events, for greater understanding, and changes I had introduced and undertaken, was not demonstrating insight. I hope this reflection demonstrates my acknowledgement, regret and insight.'

Having carefully considered your reflective piece, the panel concluded that you have demonstrated an enhanced insight into what happened and your part in it. The panel accepted that nursing in a prison environment is extremely complex and challenging. However, you have been able to show that you have addressed the issues and demonstrated sufficient remorse into the incidents that unfolded.

The panel also took into account your dedication for the nursing profession and your wish to return to nursing. The panel heard from Ms Chestnutt that despite your financial difficulties in trying to keep up to date with your nursing practice, you have done what you can in the circumstances. You stated in your reflective piece:

'It's a great honour to be a nurse and to be given the chance to help patients when they need it the most or at their most vulnerable. I've always been honoured within my work and would appreciate the opportunity to support patients again in the future.'

In light of the above, the panel determined that you are not liable to repeat matters of the kind found proved, having reflected deeply on these events. You have undertaken the relevant training and practised as a nurse without concerns since the death of Patient A, and prior to your substantive suspension order. The panel therefore decided that a finding of continuing impairment is not necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel decided that the sanction of suspension for 6 months is sufficient to meet the public interest. The panel therefore determined that, in this case, a finding of continuing impairment on public interest grounds is not required.

For these reasons, the panel finds that, although your practice was impaired at the time of the incidents, given all of the above, your fitness to practise is not currently impaired.

In accordance with Article 30(1), the substantive suspension order will lapse upon expiry, namely the end of 4 June 2024.

This will be confirmed to you in writing.

That concludes this determination.