Section 29 Case Meeting

13 April 2023

15-16 New Bridge Street, Blackfriars, London EC4V 6AG

professional standards authority

Julie Isherwood

Members present
Marcus Longley (in the Chair), Board Member, Professional Standards Authority
Remi Gberbo, Lawyer, Professional Standards Authority
Simon Wiklund, Head of Legal, Professional Standards Authority

In attendance
Michael Standing, Counsel, 39 Essex Chambers

Observers
Caroline Corby, Chair, Professional Standards Authority
Rachael Martin, Scrutiny Team Coordinator, Professional Standards Authority
Rebecca Senior-Carroll, Lawyer, Professional Standards Authority

This meeting was held remotely

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's Panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public
- to maintain public confidence in the profession concerned, and

- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the Panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of Justice of England and Wales and the statutory time limit for an appeal would expire on 20 April 2023.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 13 February 2023.

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the Panel dated 13 February 2023
- The Authority's Detailed Case Review
- Transcripts of the hearing dated 6-13 February 2023
- Counsel's Note dated 11 April 2023
- Exhibits
- Case Examiner's Master Bundle
- The NMC's Indicative Sanctions Guidance
- The Authority's Section 29 Case Meeting Manual.

7.2 The Members and the Legal Advisor were provided with a copy of a response from the NMC to the Authority's Notification of Section 29 Meeting. The

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

Members considered the response having received legal advice and after they reached a conclusion on the sufficiency on the outcome.

8. Background

8.1 At the material time the Registrant was working as a community staff nurse at the Lancashire and South Cumbria NHS Foundation Trust ('the Trust'). The Registrant had been employed with the Trust since November 2013.

8.2 Patient 1 had complex needs, including chronic kidney disease, dysphagia, pneumonia, rheumatoid arthritis, nocturia, gastritis and pulmonary fibrosis. She required regular observations, as well as close monitoring of bloods and medication and was at risk of pressure ulceration.

8.3 The Registrant had visited Patient 1 at home on 8 January 2021 to undertake a reassessment, however rather than undertaking completing the assessments as required, she had copied observations undertaken in a previous assessment by a different nurse a year earlier and passed this off as her own. The concerns came to light when Patient 1's daughter complained to the Trust.

8.4 The charges considered by the Panel were that the Registrant failed to take baseline observations for Patient 1, failed to inspect the skin for pressure sores and failed to update Patient 1's care plan. It was also alleged that the Registrant copied the information from a community nursing assessment dated 3 January 2020 and used this to complete her assessment dated 8 January 2021 and failed to record that she had not undertaken this assessment with Patient 1. This was alleged to be dishonest.

8.5 The Registrant had admitted not completing the basic observations or assessments as required for Patient 1 and that she had copied previous assessments but had denied being dishonest. The Registrant had explained that she did not know that she was required to undertake baseline observations and that she had copied the assessment because Patient 1's daughter had said that there had been no changes in the past year. The Panel found the allegation of dishonesty proved.

8.6 The Registrant had previously been referred to the NMC by the Trust in 2016 regarding poor clinical care, failing to assess a patient for a pressure sore and subsequently dishonestly amending records to give the impression that appropriate treatment had been given when a safeguarding alert had been made. An interim conditions of practice order ("ICoP") was imposed in April 2018 and remained in place when the concerns giving rise to this referral took place.

8.7 At the conclusion of this case, the Panel acknowledged that the misconduct in both cases was similar. It found impairment on public protection and public interest grounds, noting that the Registrant had insight and developing insight in relation to the proven dishonesty.

8.8 The Panel imposed a conditions of practice order for three years with a review.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members discussed the following concerns about the decision:

Previous FtP case

9.3 The Members considered whether the Panel had afforded sufficient weight to the previous case, noting that this was a very similar incident of dishonesty which was relevant to the Panel's consideration of the risk of repetition and its assessment of the Registrant's attitude.

9.4 Although the actual terms of the interim conditions had not been placed before the Panel, it had been aware of the previous incident, and that the events which gave rise to the current charges occurred while the Registrant was subject to an ICoP order.

9.5 The Members considered that only limited weight could be attached to the existence of the ICoP at the time of the events in question given that the Registrant's practice was restricted to a limited degree, requiring her to only work with the Trust and meet with her line manager at least once a week and develop a Personal Development Plan with her line manager regarding record keeping.

9.6 The Members concluded that the Panel had taken this into account in its assessment of the seriousness of the misconduct and in its assessment of the risk of repetition.

9.7 The Members were therefore satisfied that there had not been a failure by the Panel at either the impairment or sanction stage to give appropriate weight to the fact that this was a repeated incident of dishonesty and were also satisfied that the Panel had given adequate weight to the fact that the dishonesty occurred during a period when the ICoP were in place.

Dishonesty

9.8 The Members considered that the Panel was not wrong to conclude that the dishonesty was at the lower end of the spectrum of seriousness. Although serious in terms of the potential risk to the patient concerned, Members considered that the concerns regarding candour and wilful dishonest misrepresentation of care provided in the 2016 incident were not present in this case and further, that the Registrant had admitted copying the assessments when challenged.

9.9 The Members felt therefore that the Panel was not wrong to conclude that the misconduct was not at the top end of the spectrum of seriousness.

Insight

9.10 The Members noted that the Registrant had disputed the allegation of dishonesty. This was a course of action that was open to her, and it did not necessarily follow that the Registrant had no insight.

9.11 In her reflective statement the Registrant had referred, albeit not directly, to understanding that trust had been broken and that she was on course to rebuilding this trust. The Registrant had also acknowledged that she had not acted in accordance with the NMC's code. The Members considered that this was evidence of the Registrant's attempt to address that she had been dishonest.

9.12 Although the Members were satisfied that there was evidence upon which the Panel could conclude that the Registrant had 'developing insight', the reasoning for the Panel's finding had been lacking in detail. The substance of the finding however was not considered to be incorrect.

The Registrant's Attitude

9.13 The Members took the view that in order for the sanction decision to be more easily understood, the Panel ought to have addressed its assessment of whether there were attitudinal failings in a lot more detail particularly in a case involving a repeated incident of dishonesty. However, the Panel failed to address attitudinal failings adequately.

9.14 The Members considered whether the Panel had sufficiently explained its findings as to why the dishonesty had occurred. Having rejected the Registrant's suggestion that a lack of support was a factor, and having stated that it considered that the dishonesty was not a careless act, the Panel's determination almost led to the inevitable conclusion that this was a willful act, which if so, gave rise to concerns regarding the Registrant's attitude. The Members were of the view that there had been a failure by the Panel to explain its findings on this issue; having dismissed potential alternative explanations there was a requirement for the Panel to explain its conclusions clearly.

9.15 The Members noted the Panel's view that the Registrant had sought to deflect blame on to others but considered that there were relevant contextual factors arising from the Registrant's working circumstances at the time. There had been an acknowledgment by her employer that her supervision had been intermittent and that her line manager had changed was supposed to be weekly supervision to once a month. The Members could therefore understand how this could result in a Registrant losing confidence and struggling on a professional basis. The Registrant appeared to be explaining the issues arising in her work at the time and the Members were satisfied that the Panel had captured this in its assessment that the Registrant had developing insight.

9.16 The Members noted the Registrant's stance that at the material time was she thought what she was helping the Community Outreach team by volunteering to undertake an assessment when it was short staffed, and the Members had some sympathy that she had been well-intentioned.

9.17 The Members noted the Panel's finding that there was a risk that the Registrant would act in this way again. The Members considered whether the Panel's determination that conditions of practice order adequately explained how it considered that the risk of repetition which it had identified would be addressed adequately. Although the Members were satisfied that the conditions requiring the development of a personal development plan addressing the duty of candour and record keeping and the requirement that the Registrant work only

under supervision for 3 years represented an adequate safeguard to minimize the likelihood of a recurrence, the Panel could have provided a more comprehensive explanation as to how this addressed the risk of repetition it had identified.

9.18 The Members concluded that this was an example of poor explanation rather than a clear failure by the Panel to address relevant issues arising.

Aggravating and mitigating factors

9.19 The Members considered whether the apparently unstable supervision of the Registrant's practice was a relevant factor given that this was not said to have been the cause of the dishonesty. The Members considered that the Panel was entitled to take wider context into account, and the Registrant's evidence that she had been struggling and clearly needed support was relevant to its assessment.

9.20 The Members considered that given that this was a borderline case, the Panel ought to have provided more by way of explanation as to the weight it had attached to the various aggravating and mitigating factors identified and how these influenced its sanction decision. In the circumstances of this case, it was clear that the Registrant was currently working well and had positive testimonial evidence and there were no concerns about her clinical practice.

Sanction

9.21 The Members considered that the primary concern in this case was the Registrant's dishonesty in a clinical context which was addressed by the condition requiring the Registrant to create a personal development plan addressing candour and accuracy in record keeping. The Members were mindful that the Registrant complied with the ICoP and therefore it was difficult to conclude that the conditions imposed were insufficient.

9.22 The sanction decision ought to have made reference to the factors that led to the conclusion that a conditions of practice order was the most appropriate and proportionate outcome.

9.23 The Panel's assessment of seriousness was rational and having concluded that the Registrant had developing insight in relation to the findings of dishonesty, the decision to impose a conditions of practice order in the terms it did was open to it on the evidence before it.

9.24 However, as this was a case involving acts of dishonesty, in respect of which the Sanctions Guidance indicated a very serious sanction would be appropriate, the Panel ought to have provided sufficient detail in its determination to make clear that it had engaged fully with the SG. The Members recognised that whilst the Panel was required to exercise its independent judgment and was not bound to impose the sanction outcome envisioned in the SG, it was required to explain very clearly its reasons for departing from it.

Conclusion on insufficiency for public protection

9.25 The Members were concerned with the Panel's lack of clarity and detailed reasons, particularly regarding the findings on insight and attitudinal issues and

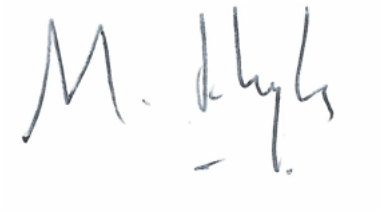
how it arrived at the decision to impose conditions. Nevertheless, they considered that the decision to impose conditions was within the bounds of what they would expect to protect the public and not a decision which no reasonable Panel could have made. In all the circumstances, therefore, it was not insufficient for public protection.

10. Referral to court

10.1 Having concluded that the Panel's Determination was not insufficient for public protection, the Members were not required to consider whether they should exercise the Authority's power under Section 29 to refer the case to the relevant court.

11. Learning points

11.1 The Members agreed that the learning points set out at Appendix B should be communicated to the Regulator.



12/05/23

Marcus Longley (Chair) **Dated**

12. Annex A – Definitions

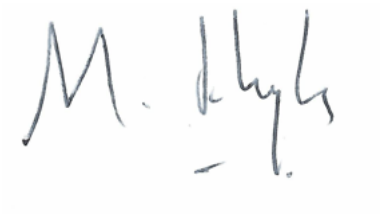
12.1 In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	A Fitness to Practise Committee of the NMC
The Registrant	Julie Isherwood
The Regulator	The NMC
NMC	Nursing & Midwifery Council
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on 13 February 2023
The Court	The High Court of Justice of England and Wales
The SG	Regulator's Sanctions Guidance

Annex B – Learning Points

12.2 The Members agreed that the following issues should be raised with the NMC:

- In many areas of the decision the Panel's reasons were lacking in clarity and detail. Further explanation would have assisted the public reading the decision in understanding the findings made and how the Panel reached the decision it did on sanction.
- We were concerned that the Panel was not made aware of the particular terms of the ICoP Order imposed in 2018. While we did not consider this information to have made a material difference to the overall outcome, all relevant information ought to have been made available to the Panel, particularly given that the NMC made submissions for a strike off in this case.
- There was a significant delay in this case coming before a Panel and this could have had an impact on the proceedings. Additionally, we had concerns that it took two years for the NMC to obtain an interim order, which in our view defeats the object of the imposition of interim restrictions.
- We were concerned to note the non-compliance with the interim conditions. In particular, the employer unilaterally deciding not to hold supervision meetings as frequently as required. While we appreciate that this is not a matter for the regulator to resolve, we felt it necessary to express our concerns.



12/05/23

Marcus Longley (Chair) **Dated**