Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Simon Wiklund, Head of Legal, Professional Standards Authority
Kisha Punchihewa, Head of Legal, Professional Standards Authority

In attendance
David Hopkins, Legal Advisor, 39 Essex Chambers

Observers
Rachael Martin, Scrutiny Team Coordinator, Professional Standards Authority
Rebecca Senior, Lawyer, Professional Standards Authority
Kate Fawcett, Senior Scrutiny Officer, Professional Standards Authority

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 5 November 2019.

6. **The relevant decision**

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 12 September 2019.

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 12 September 2019
- The Authority’s Detailed Case Review
- Transcripts of the hearing dated 10-14 June 2019 and 9-12 September 2019
- Counsel's Note
- Case Examiners’ Bundle
- Exhibits
- The NMC’s Code of Conduct
- The Authority’s Section 29 Case Meeting Manual

7.2 The Members and the Legal Advisor were provided with a copy of a referral letter from the NMC to the Authority.

---

\(^1\) CRHP v Ruscillo [2004] EWCA Civ 1356
8. Background

8.1 The Registrant was employed as a nurse at a private hospital (‘the hospital’) at the time of the alleged misconduct. The allegations concern the Registrant’s conduct in dishonestly making several retrospective amendments to the observation charts and nursing notes of Patient A. Although the amendments were accurate, they were not recorded as retrospective.

8.2 Patient A was admitted to the hospital for an elective right total hip replacement. The Registrant was responsible for Patient A’s care along with another nurse (Ms 3). Both cases were dealt with separately by the NMC with Ms 3 receiving a warning.

8.3 A few days after his admission Patient A presented with symptoms of a chest infection. His condition deteriorated and a decision was made to transfer him to an NHS hospital. Patient A suffered a cardiac arrest the same day he was transferred and died a few days later.

8.4 Patient A’s transfer to an NHS hospital was subject to a Root Cause Analysis (RCA) undertaken by the hospital and led by the Clinical Services Manager. A review of the theatre and ward documentation was undertaken, and it was identified that the National Early Warning Scores (NEWS) chart for Patient A had additional ‘over writes.’ There were also NEWS scores present on the chart which were not present when the documentation was initially reviewed 11 days previously.

8.5 Suspicion fell on the Registrant and Ms 3 who were subsequently interviewed. During the interviews, the Registrant and Ms 3 admitted that the amendments were made two days after Patient A had died when they were working on a nightshift together and came across Patient A’s notes in the nursing office.

8.6 In a handwritten statement the Registrant admitted the amendments were made to give clarity to the care given and to emphasis that which was already noted. The Registrant also stated that the purpose of making the retrospective entries was, “To make it clearer to read for the investigation, so I would see what had been written accurately for my statement. To highlight what had been done to aid the investigation” (page 52 NMC bundle).

8.7 The RCA recorded a finding that the NEWS chart and certain nursing notes for Patient A differed from the photocopied version of the medical notes sent with Patient A on his transfer to the NHS hospital. The report also recorded that, “Two nurses were questioned; both acknowledged they altered the original version of the medical records held at BMI Beaumont Hospital when they heard the patient had died” (page 25 NMC bundle).

8.8 An inquest into Patient A’s death took place on 13 March 2018 recording the cause of death as multiple organ failures, sepsis, hospital acquired pneumonia and ischaemic heart disease. Several matters of concern were identified by the coroner, including the altering of the notes by the Registrant and Ms 3. The main points to note from the Registrant’s evidence which she gave on oath as well as confirm her witness statement was correct were that she was not aware that an investigation in relation to Patient A’s transfer nor was she aware of his death when she made the retrospective entries.
8.9 The coroner made a referral to the NMC in relation to several concerns including the altering of the notes by the Registrant and Ms 3.

8.10 The NMC advanced its case on the basis that the Registrant knew that Patient A had died and/or knew that an investigation into his death had commenced or was likely to take place at the time when the retrospective entries were made.

8.11 At the hearing the Panel could not be satisfied that the Registrant knew there would be an investigation or that Patient A had died and that this was her motivation for making the retrospective amendments.

8.12 However, under cross examination on day 4 the Registrant admitted that she knew there was going to be an investigation regarding Patient A's transfer. This admission appeared to confirm her motivation for changing the records, as she knew her work would be scrutinised and her record keeping had been deficient. The Registrant accepted that in doing so, she acted dishonestly.

8.13 On day 6 of the hearing the NMC sought to amend the charges though the issue was first canvassed on day 4. It would also appear that a copy of the proposed amendments was given to the defence on day 4 from the transcript. The proposed amendment included an allegation that the Registrant had acted dishonestly in making the retrospective amendments in addition to being aware that patient A had died she was aware that an investigation into his death had commenced or was likely to take place and was aware that one or more investigations arising from Patient A’s transfer to another hospital had commenced or was likely to take place.

8.14 The application to amend the charges was not made until nearly three months later following a short adjournment. The Panel rejected the application on the basis that it would be ‘inherently unfair’ to allow such ‘substantial amendments’ late in the day.

8.15 Consequently, the allegation of dishonesty fell away as the Panel were not satisfied on the balance of probabilities that the Registrant knew of Patient A’s death when she made retrospective entries in Patient A’s notes.

8.16 Subsequently the Panel did not make a finding of misconduct in relation to the charges proved by admission. The case was closed, and no further action taken.

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:

*The Panel’s decision not to allow the amendment of charges*

9.3 The Members considered whether it was reasonable for the Panel not to allow an amendment of the charges. The Members were primarily concerned that the consideration of the protection of the public or the wider public interest is not obviously at the forefront of the Panel’s decision. The Panel’s decision to reject the application to amend the charges was on the basis that it would be “unfair”
to the Registrant, but the Panel did not address how that unfairness could have been dealt with. The Panel also failed to acknowledge when considering amending the charges that the Registrant had been on notice of a potential change of the allegations for some time, given that on day 4 immediately following the Registrant’s evidence the matter of amending the charges was first raised. The hearing then adjourned for 12 weeks. When the hearing resumed the defence had already formed a basis on which the amendments were opposed. The Members concluded that the Panel failed to take this into account when assessing fairness and whether there would be injustice to the Registrant.

9.4 The Members concluded that the Panel’s assessment of “injustice to the Registrant” was overly narrow and that there was a failure to consider the public interest in amending the charges given the Registrant’s admission in her evidence of dishonesty. Consequently, the Panel’s decision making on this matter fell into error.

The original charges

9.5 The Members considered whether there was sufficient material before the NMC case examiners on which the NMC could have framed a charge that the retrospective entries were made dishonestly without reference to the Registrant’s knowledge of whether Patient A had died.

9.6 The Members identified sufficient evidence at the investigation stage to have allowed a wider set of allegations to have been drafted. In particular, the issue of motivation could have been alleged more clearly in order to capture the mischief in the Registrant making retrospective entries with the knowledge that at some point they would be scrutinised. The Members noted that the most serious charge of dishonesty had been alleged but considered that the failure to include a wider set of allegations to fully capture the misconduct constituted a procedural irregularity.

Conclusion on insufficiency for public protection

9.7 The Members were concerned both with the Panel’s decision not to allow the amendment to the allegations and the failure to bring a wider range of charges in this case. The Members also concluded that insufficient consideration was given to the public interest by the Panel in the refusal to amend the charges. Nevertheless, the Members were not satisfied that had the Panel allowed the amendment to the charges and a wider range of charges been considered, that this would necessarily have resulted in more serious findings. In all the circumstances, therefore, the Members did not consider the outcome 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 C should be communicated to the Regulator.

[Signature]

10/12/19

Alan Clamp (Chair)  Dated