

**Conduct & Competence Committee
Substantive Hearing
on
18th March 2013 to 22nd March 2013
And 25th March 2013 to 28th March 2013
And 2nd April 2013
At
61 Aldwych, London
WC2B 4AE
And
22nd July 2013 to 26th July 2013
And
4th November 2013 to 7th November 2013
At
20 Old Bailey, London
EC4M 7AN**

Registrant:	Janice Margret Harry
NMC PIN:	70I1747E
Part(s) of the register:	Registered Nurse- Sub Part 1 Adult Nursing- November 1973
Type of Case:	Misconduct
Area of Registered Address:	England
Panel Members:	Judith Worthington (Chair/Registrant Member) Monica Daley (Lay Member) Angela Stones (Lay member)
Legal assessor:	Megan Topliss
Panel Secretary:	Andrew Brown
NURSING AND MIDWIFERY COUNCIL:	Mr William Davis, instructed by NMC Regulatory Legal Team
Ms Harry:	Present and represented by Mr Kevin O'Donovan
Facts Admitted:	None
Facts proved:	1a(i), 1a(ii), 1a(iii), 1b(i), 2a (in respect of 1a(i), 1a(ii) 1a(iii) and 1b(i), 2b (in respect of 1a(ii)), 4a(i), 4a(ii), 4a(iii), 4a(iv), 4d, 4e(ii), 5b(i),

Facts not proved:	1b(ii), 1b(iii), 3a, 3b, 4b(i), 4b(ii), 4c, 4e(i), 5a, 5b(ii) 5c(i), 6(i), 6(ii), 7a, 7b, 7c.
Impairment:	Impaired
Sanction:	Caution Order, 5 years
Interim order directed:	NA

Details of Charge as read:

That you, whilst employed by Mid Staffordshire NHS Foundation Trust and its predecessor the Mid Staffordshire General Hospitals NHS Trust (“the Trust”) as Director of Nursing and Quality Assurance and/or Director of Clinical Standards and Chief Nurse and/or Director of Infection Prevention and Control:

1. Did not ensure that adequate nursing services were provided in the following areas:
 - (a) number of staff on the following ward(s):
 - (i) between around 2002 and January 2006, Ward 10D
 - (ii) between around 1998 and 2006, Accident and Emergency department (“A&E”)
 - (iii) between September 2005 and June 2006, Emergency Assessment Unit (“EAU”)
 - (b) mix of staff skills and/or competencies on the following ward(s):
 - (i) between around 2002 and January 2006, Ward 10D
 - (ii) between around 1998 and 2006, A&E
 - (iii) between September 2005 and June 2006, EAU
2. By your actions set out at paragraph 1 above, you allowed a situation(s) to arise and/or continue whereby patients were exposed to the following:
 - (a) Risk
 - (b) danger
3. On unknown dates, did not deal with incident forms in an appropriate manner, in that you:
 - (a) said to Clinical Nurse Manager, Ms 1, when she handed incident forms to you “don’t bring me problems bring the answer”, or words to that effect
 - (b) on at least one occasion handed an incident form, in relation to staffing problems, back to Ms 1 without looking at it
4. Did not ensure that nursing services were delivered to an appropriate standard, in the following areas:

- (a) record keeping on the following ward(s):
 - (i) between around 1998 and June 2006, Ward 6
 - (ii) between around 2003 and June 2006, Ward 8
 - (iii) between around 2002 and January 2006, Ward 10D
 - (iv) between around September 2004 and June 2006, EAU
 - (b) hygiene and cleanliness on the following ward(s):
 - (i) between around 2002 and January 2006, Ward 10D
 - (ii) between around September 2004 and June 2006, EAU
 - (c) between around September 2004 and January 2006, administration of medication on Ward 10E
 - (d) between around September 2004 and June 2006, provision of nutrition and fluid on the EAU
 - (e) maintenance of patient dignity and/or privacy on the following ward(s):
 - (i) between around 2002 and January 2006, Ward 10
 - (ii) between around September 2004 and June 2006, EAU
5. On various unknown dates, you failed to communicate with nursing staff in an appropriate manner, in that you:
- (a) shouted
 - (b) used inappropriate language on various occasions including:
 - (i) saying to Ward Sister, Ms 4, about another member of staff that “she is a waste of space” or words to that effect
 - (ii) telling staff off and saying “that’s not good enough, get it done”, or words to that effect
 - (c) disregarded staff concerns on various occasions including:
 - (i) at a bed meeting when Ward Manager, Ms 2, informed you, based on her clinical knowledge, that in her opinion, a patient was not well enough to be sent home, you ‘tore shreds off’ Ms 2 and disregarded her concerns
6. In around 2001, you contacted Ward Manager, Ms 3 and demanded that the available beds on Ward 11 be used, more particularly:
- (i) your manner and/or tone of voice was inappropriate
 - (ii) you reduced Ms 3 to tears
7. During the period of reconfiguration of services you provided inaccurate information, in that:

- (a) In April 2006, you advised the Trust Board that the impact of the proposed cost savings would not be detrimental to patient safety and/or care
- (b) On 24 April 2006, you informed the Hospital Management Board that the proposal to change the ratio of qualified to unqualified staff from 60/40 to 50/50 or even 40/60, would not impact on the numbers of staff and standards of care
- (c) On an unknown date, you provided reassurance to the Trust Board that nursing vacancies were being filled when you knew, or ought to have known that recruitment at the Trust was an ongoing issue

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

Issue as to Charges:

Before continuing with the witness, Ms 5, the panel sought clarification from the case presenter, Mr Davis, as to how the NMC puts its case in relation to the Charges and the sites within the Trust.

Mr Davis clarified that Charges 1 to 6 relate to the Stafford Hospital, but in so far as Charge 7 is concerned, insofar as there was some evidence relating to Cannock Hospital that was included within the Trust.

Mr O'Donovan said that there was an issue of grave concern as to the lack of particularity as to that Charge. He told the panel that he had attended the hearing to meet allegations concerning Mrs Harry's employment at Stafford Hospital, not at Cannock Hospital. He said that the first mention of Cannock was in the evidence of Ms 5 and that if it was to be persisted with, the registrant was entitled to full particulars of that allegation. He said that if the NMC wished to pursue issues at Cannock Hospital, it should be introduced as a separate charge.

Mr Davis further submitted that there was limited evidence about Cannock Hospital, which was limited to what Ms 5 had said in her evidence and was part of the reconfiguration. He submitted that the evidence was so narrow that essentially there was no prejudice. Mr Davis did not seek to amend the Charge; the evidence did not take Mr O'Donovan by surprise as it was mentioned in paragraph 27 of Ms 5's witness statement. He submitted that it was difficult to see what prejudice there was.

The panel had regard to the submissions of Mr O'Donovan on your behalf and to those of Mr Davis on behalf of the NMC. It accepted the advice of the legal assessor. The legal assessor advised that the Charge stem referred to the Mid Staffordshire NHS Foundation Trust and its predecessor the Mid Staffordshire General Hospitals NHS Trust and that Charge 7 referred to advising the Trust Board. She reminded the panel to consider whether there was any prejudice and, if necessary, to give Mrs Harry further time, or the opportunity to have witnesses recalled to be asked further questions.

The panel noted that the primary focus of the allegations was the Stafford Hospital. However, the panel is satisfied that the stem of the charges concerned the Mid Staffordshire NHS Foundation Trust, which incorporated Cannock Hospital and that as

Director of Nursing and Quality Assurance and/or Director of Clinical Standards and Chief Nurse and/or Director of Infection Prevention and Control; the registrant had responsibility for all of the Hospitals across the Trust. The panel noted that no specific prejudice to Mrs Harry's case had been set out. If further time is required or witnesses need to be recalled, the panel would facilitate that.

Admissibility of Evidence:

During the evidence in chief of Ms 6, Mr O'Donovan, objected to Mr Davis asking Ms 6 about the circumstances under which Mrs Harry left the Trust.

Mr O'Donovan submitted that this was not relevant. He further submitted that this was prejudicial to Mrs Harry, as she had signed an agreement upon leaving the Trust, and therefore could not offer a full explanation to the panel as to the circumstances under which she left. He told the panel that Mrs Harry had not left for disciplinary reasons.

Mr Davis submitted that the question was relevant as the panel had heard different views on Mrs Harry's departure from the witnesses so far.

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

The panel concluded that this question was not relevant and decided to limit the evidence to relate to the period of time when Mrs Harry was employed by the Trust as this is the relevant period in the charges. As such the panel decided not to allow Mr Davis to pursue this line of questioning.

Admissibility of Evidence:

Mr Davis indicated that he intended to adduce evidence from Ms 6 regarding the review of nursing staffing levels and skill mix at the Trust carried out between October and December 2007, after Ms Harry had left the Trust.

Mr O'Donovan objected to Mr Davis calling evidence in respect of the period after Ms Harry had left the Trust. Mrs Harry left on or around 9 June 2006. Mr O'Donovan submitted that the panel did not have information regarding the conduct or purpose of the report. The panel had no information about the conclusion of the report. He submitted that, therefore, the relevance of the report was obscure. Mr O'Donovan submitted that this evidence was entirely irrelevant to events when Mrs Harry was at the Trust. Mr O'Donovan submitted that as the review took place over a period from October to December 2007, there could have been sudden changes in staffing levels within this time.

Mr Davis submitted that establishment figures do not change abruptly. Mr Davis reminded the panel that what weight to attach to any evidence was a matter for the panel's own judgement. Mr Davis submitted that a review, by its very nature, takes place retrospectively.

The panel had regard to the submissions of Mr O'Donovan and those of Mr Davis.

It accepted the advice of the legal assessor.

The panel was of the view that this evidence was potentially relevant. As this was a review, it may identify issues that were present at the time that Mrs Harry was employed at the Trust. The panel therefore decided to allow Mr Davis to adduce this evidence. However, in fairness to Mrs Harry, the panel concluded that Mr O'Donovan should be provided with the report and should have time to consider it prior to it being put before the panel.

Mr Davis' application for an adjournment to allow time to contact a witness:

Mr Davis made an application to be allowed until this afternoon to make further contact with Ms 1 in order to arrange for her to give evidence either by video-link or telephone. He submitted that the reason this time period was necessary was because Ms 1 was in Florida, and therefore, five or six hours behind the UK. This means contact would not be possible until at least 1pm UK time, which is 8am in Florida.

He told the panel that Ms 1 was a key witness in this case, as she was the Clinical Ward Manager of A&E throughout the period covered in the charges. He submitted that Ms 1's evidence was in support of Charges 1a(ii), 1b(ii) and 3 and that she was the only witness able to give direct evidence regarding these matters. He informed the panel that there was a consistent theme with the Board witnesses that A&E was a source of problems. Mr Davis drew the panel's attention to the email communication between Ms 1 and the NMC between 25 February 2013 and 26 March 2013. He submitted that the initial exchange of emails demonstrated that she was not unwilling to give evidence, but was more concerned about the logistics and that a further period of time may allow the NMC to reassure her about giving evidence. He told the panel that the NMC accepted that she was a witness who ought to be available to be cross-examined and that Ms 1 had provided the NMC with the telephone number of a friend in Florida. He detailed to the panel the manner in which Ms 1's evidence could be adduced, in order to shorten the length of the telephone contact. He reminded the panel that it is incumbent on the NMC to attempt to have any witness give oral evidence.

Mr O'Donovan opposed this application. He submitted that it was inconceivable that Ms 1 does not have a telephone number of her own. He invited the panel to infer from Ms 1's failure to provide a direct telephone number that she was unwilling to cooperate with the NMC. He drew the panel's attention to Ms 1's email to the NMC on 14 March 2013, which he submitted was plainly evasive. Mr O'Donovan submitted that nothing has been adduced to suggest that were the panel to allow this adjournment, there would be any positive result.

The panel had regard to the submissions of Mr Davis and those of Mr O'Donovan. It accepted the advice of the legal assessor.

The panel noted that Ms 1 was a key witness to Charges 1 and 3. It also noted her senior position and the length of her employment at the Trust. Further, the panel noted that as Ms 1 has been retired from the Trust in 2006, her views would less likely to be influenced by changes to the Hospital since her retirement. The panel accepted that Ms 1 was in recent contact with the NMC and had not indicated that she was unwilling to give evidence. It was satisfied that there is a likelihood of the NMC making contact with Ms 1 today and, given her importance to the case, the panel allows the NMC time to make further contact with Ms 1 today. The panel therefore will adjourn until tomorrow at 9.30am. The panel reminds the NMC of the need for detailed, clear and direct

communication with Ms 1 in order to make its position clear. The panel further would ask the NMC to ascertain when in April Ms 1 will return to the UK.

Decision to adjourn:

Mr Davis and Mr O'Donovan made a joint application to adjourn the hearing on 28 March 2013. They submitted that although there was one day remaining in the listing of this case, namely Tuesday 3 April 2013, the hearing should adjourn today, as it would be undesirable for Mrs Harry to begin giving evidence then, she would be unable to complete that evidence, and therefore she would have to remain under oath until the hearing resumed. They submitted that this would be undesirable.

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

The panel accepted the joint submissions of Mr Davis and Mr O'Donovan. It decided to adjourn this hearing to be resumed for five days on 22 July 2013.

Mr Davis's Rule 28 application to amend the charges:

Mr Davis made an application to amend a number of the charges under Rule 28 of the NMC *Fitness to Practise Rules*.

He invited the panel to amend the stem of the Charges to read:

"That you, whilst employed by the Mid Staffordshire General Hospitals NHS Trust ("the Trust")..."

Mr Davis submitted that without this amendment, the charge was inaccurate. He drew the panel's attention to your indication that you had at no time been employed by Mid Staffordshire NHS Foundation Trust and submitted that this was in fact the case. He submitted that this amendment would cause no injustice to you and did not alter the gravamen of the charges.

Mr Davis also invited the panel to amend Charge 1a(iii) to read:

"Between September 2005 and June 2006, Emergency Assessment Unit ("EAU")"

Mr Davis submitted that this would more accurately reflect the evidence that the panel had heard. He said that this amendment did not affect the gravamen of the charge, or cause any unfairness to you.

Mr O'Donovan made no objection to the proposed amendments, and invited the panel to allow them.

The panel accepted the advice of the legal assessor.

The panel was of the view that these amendments served to clarify the charges and did not cause any prejudice to you. It noted that there was no objection from you as to the amendments being made. The panel therefore decided to allow these amendments to the charges.

Decision and Reasons:

At the outset it is important to remind all parties and the public that this panel is independent. Its members are not employed by the NMC but are independent professionals brought in to sit on the panel. They are advised by the legal assessor who is an independent barrister in private practice.

The panel had regard to all of the oral and documentary evidence in this case. That evidence comprised four nurses at ward manager level and two former members of the Trust Board. It specifically did not include the Francis Inquiry Report. It heard the submissions of Mr Davis on behalf of the NMC and those of your representative, Mr O'Donovan. It had careful regard to Mr O'Donovan's written submissions, which he provided to the panel at this stage. It accepted the advice of the legal assessor. The legal assessor advised the panel in a number of respects. This included advice that they should decide the case only on the evidence placed before it, and that the Francis Inquiry Report was not a document adduced before it. She cautioned the panel against allowing itself to be influenced by any media interest or reporting and advised it not to seek supplementary material.

The panel has reminded itself that the burden is on the NMC to prove the facts as set out in the charge and that to find the facts proved the panel must be satisfied on the balance of probabilities. This means that for any fact or event to be found proved the panel must be satisfied that it is more likely than not to have occurred.

At the outset of the hearing, Mr O'Donovan indicated that you did not admit any of the charges. He said that you were not of the view that your fitness to practise is currently impaired.

The panel heard oral evidence from a number of witnesses, these were:

- Ms 2, the ward manager of Ward 10D
- Ms 5, a former non-executive director of the Trust's Board
- Ms 6, Chair of the Trust from mid-October 2004.
- Ms 3, the unit manager for the Emergency Assessment Unit ("EAU").
- Ms 4, initially the part time ward manager for Ward 6 and 8 and from 2005 to 2008 the full time manager of Ward 8.
- Ms 1, a former Clinical Nurse Manager in Accident and Emergency ("A&E") at the Trust.

You were employed by Mid Staffordshire General Hospitals NHS Trust ("the Trust") from 1998- 2006, variously as Director of Nursing and Quality Assurance, Director of Clinical Standards and Chief Nurse, and Director of Infection Prevention and Control.

The Trust was split across two hospital sites, Mid-Staffordshire General Hospital and Cannock Hospital which although 10 miles apart, functioned as one unit. There were 20 Wards across the Trust and a staff of approximately 800 nurses supported by approximately 1,500 Healthcare Support Workers.

You commenced working at the Trust in 1998, as Director of Nursing and Quality. In this role you carried out the role of nursing leadership, but also had responsibilities for

nursing development, education and training; research and development; clinical audit and clinical risk across the Trust. You were employed at a period of change in the Trust.

In 2000, following the appointment of a new Chairman, your job description and title changed to Director of Clinical Standards and effectively, Chief Nurse. This involved additional responsibilities and additionally you were responsible for research and development across the Trust. In 2006, when a Chief Operating Officer was appointed to the Trust, your job title formally changed to that of Chief Nurse.

Late in 2005, as well as your other roles, you undertook the role of acting Chief Operating Officer, this related to the day to day management of the Hospital. You later also became Director of Infection and Prevention Control in addition to your role of Director of Clinical Standards and Chief Nurse, until you left the Trust in June 2006.

It is alleged that during your employment, as Director of Nursing, you did not ensure adequate nursing numbers, skill mix or standards on various wards when it was your duty and responsibility to do so. You also allegedly dealt with more junior staff in an inappropriate way and misled the Board in respect of staffing. This forms the subject of the charges.

In summary, Mr Davis invited the panel to consider precisely what your role and responsibilities were at the Trust. In respect of Charges 1, 2 and 4, Mr Davis said that it was for the NMC to establish that you had responsibility for the provision of adequate nursing services, and then to prove that you failed in these responsibilities.

He reminded the panel of your role as Head of Clinical Standards. Mr Davis said that throughout the hearing, you had sought to distance yourself from frontline nursing management, suggesting that yours was purely a strategic role.

Mr Davis submitted, however, that you were ultimately responsible for ensuring that nursing was delivered to the proper standards across the Trust, even if you were not directly involved in line management of individual nurses. Mr Davis submitted that this was a leadership responsibility, borne out by your various job descriptions.

Mr Davis invited the panel to consider your evidence in respect of your responsibilities in your role as Chief Operating Officer for both of the hospitals in the Trust from 2005. He submitted that in the latter stages of your employment at the Trust, you did have direct control over the operational running of the hospitals in the Trust, in your capacity as Chief Operating Officer. He said that this was particularly relevant when considering the charges connected with EAU, in which you had had a high level of involvement.

Mr Davis submitted that the NMC did not seek to blame you directly for all issues at the Trust. He accepted that it is inevitable in an organisation the size of the Trust, that individual nurses would make errors. He submitted, however, that you were responsible for systemic failures in the nursing provisions at the Trust, meaning that errors and failings were more frequent, as nurses were unable to provide the appropriate level of care to patients within the environment which you managed.

Mr Davis accepted that there was no doubt that at various times during the period of your employment the Trust had faced financial difficulties.

He submitted that there were at times unacceptable and dangerously low staffing levels at the trust.

Mr Davis submitted that it was abundantly clear that you had an aggressive, unapproachable manner with nursing staff. He reminded the panel of your evidence that few of the issues at the Trust were brought to your attention and submitted that this was because nurses felt that they could not raise their concerns with you.

Mr Davis then considered each of the charges in turn.

Mr Davis invited the panel to find all of the allegations proved on the balance of probabilities, with the exception of Charge 1b(ii) which he said that the NMC wished to withdraw, due to lack of evidence.

Mr O'Donovan, on your behalf, made oral submissions, and provided the panel with a copy of written submissions, which it read in full prior to its deliberation.

Mr O'Donovan reminded the panel that the allegation against you is not that you are directly and personally responsible for failings at the Trust, but that there were serious failings in your management role. He submitted that the NMC must therefore prove that there was a complete failure on your part. He said that this was setting the bar quite high and, indeed, so high, that it would be highly unlikely that the NMC could prove its case.

Mr O'Donovan reminded the panel that you had joined the NHS at the age of 20, and retired at the age of 57. He said that you had provided an invaluable service to the NHS and that you had attended this NMC hearing to defend your professional reputation. Mr O'Donovan invited the panel to bear in mind your long, unblemished career, when considering your credibility as a witness and the likelihood of the allegations against you being made out.

Mr O'Donovan said that the evidence brought by the NMC in this case was remarkably flimsy, given the gravitas of the allegations against you.

Mr O'Donovan submitted that the NMC had provided only limited evidence from senior medical staff, and indeed from Senior Nursing Staff as to the impact of your alleged failings on patients and their care. Mr O'Donovan also highlighted the absence of evidence from other executive directors from other directorates, particularly those that directly impacted upon yours such as Finance and Human Resources. He said that the nurses from whom the panel had heard represented only a tiny minority of the nurses, and indeed of the staff in general, at the Trust.

Mr O'Donovan submitted that your evidence was reliable, clear and direct. He said that you had not evaded questions, either from Mr Davis or the panel.

Mr O'Donovan then went on to address the panel in respect of each of the Charges individually.

The panel heard and accepted the advice of the Legal Assessor.

Overall, the panel found the NMC's witnesses to be credible. It was of the view that Ms 2's evidence although credible, was occasionally subjective and not specific. The panel

found Ms 5 to be a fair, measured witness, who provided constructive criticism of your practice. Ms 5 was clear when she did not know something. Ms 6 provided a good overview of the situation within the Board and your role within it, but was unable to assist with the general running of the Hospitals. The panel was of the view that Ms 3's evidence was credible, but did not provide specific details. The panel noted that Ms 4 had had a close working relationship with you, and was, therefore, perhaps more objective.

The oral evidence of Ms 1 was provided via telephone. The panel found her evidence to be reliable and credible. The panel bore in mind, however, that it had not had the opportunity to assess Ms 1's demeanour when considering what weight to place on her evidence.

The panel also heard oral evidence from you, Ms Harry. It found your evidence to be generally credible. However, it was of the view that your responses were occasionally formulaic.

It considered each of the Charges in turn.

Charge 1:

1. *Did not ensure that adequate nursing services were provided in the following areas:*

a) *number of staff on the following ward(s):*

- i. *between around 2002 and January 2006, Ward 10D*
- ii. *between around 1998 and 2006, Accident and Emergency department ("A&E")*
- iii. *between September 2005 and June 2006, Emergency Assessment Unit ("EAU")*

b) *mix of staff skills and/or competencies on the following ward(s):*

- i. *between around 2002 and January 2006, Ward 10D*
- ii. *between around 1998 and 2006, A&E*
- iii. *between September 2005 and June 2006, EAU*

It is alleged that during your employment you did not ensure that adequate nursing services were provided in respect of the number of nursing staff and mix of skills and/or competencies on various wards at various times. These were Wards 10D, between 2002 and January 2006; the Accident and Emergency department ("A&E") between around 1998 and 2006; and the Emergency Assessment Unit ("EAU") between September 2005 and June 2006.

Ms 2 worked as the Senior Staff Nurse on the Ward 10D between 2002 and January 2006. She told the panel that no management time was dedicated to Ward 10D. Ms 2 was of the view that staffing on the Ward was "awful". She said that during the night shift there was one Registered Nurse and one Healthcare Assistant and that frequently there was only one Registered Nurse and no Healthcare Assistant on the night shift resulting in occasions where one nurse was expected to care for 17 patients.

Ms 2 told the panel that during the day shift there were often just two Registered Nurses and one Healthcare Assistant on the Ward. She told the panel that she was so concerned by low staffing levels that she would come into work on her days off.

Ms 2 said that there were often no Bank staff available to immediately cover sickness or maternity leave as the process for making an application for Bank Staff was ineffective, and took too long, requiring four separate signatures that by the time the application was complete, the staff were no longer required. Ms 3 also said that the application process for Bank staff took too long to be effective. You said that the process for applying for Bank staff was not ineffective, but required the Ward Managers to complete the relevant paperwork in good time, to cover any vacancies. You said that this was frequently not done.

In respect of substantive vacancies, you said that these also required paperwork to be completed in good time, to allow the Trust to advertise the vacancies. You said that there were issues with the completion of this paperwork and, indeed, paperwork in general on these Wards. You did not give any example of steps you had taken to improve this situation. You also told the panel that you chaired the Trust's Vacancy Scrutiny Committee which would consider appointments to all vacancies.

Ms 1, who was Clinical Nurse Manager of A&E, gave evidence in respect of staffing levels on A&E between 1998 and 2006. She said that the staffing levels required for the A&E were difficult to predict, given the nature of A&E. She said that the situation did not improve throughout the period in which she managed A&E. Ms 1 estimated that the A&E department required *"half of the amount of staff that we had again"*. During her oral evidence, Ms 1 retracted the comment in her statement that there were issues with skills mix on A&E and stated that there were in fact no such issues with skill mix, she just would have liked more staff.

You told the panel that by its very nature, the A&E department could become extremely busy, particularly in winter. You said that, further to this, A&E staff and management often do not feel connected to the rest of the organisation, leading them to believe that they are the busiest department when often, this was not the case. You accepted, however, that there had been issues in staffing levels on A&E, but said that this was largely in respect of consultants rather than nurses.

You said that the EAU had been set up, in part, to reduce the pressure on the A&E department. This was corroborated by the evidence of Ms 3. You said that this was effective, and allowed the A&E department to meet its targets. You said that you were able to establish the EAU without additional cost, a result of the Trust *"mothballing"* a number of wards at Cannock Hospital.

Ms 3 told the panel that upon opening in 2004, the EAU was well staffed, and continued to be so for 12 months. She said, however, that in 2005 the Trust lost a large number of staff and struggled to fill the vacancies. Ms 3 said that from September 2005, staffing levels on the EAU were inadequate. You said that you had been heavily involved in setting up EAU, and that you had a clear recollection of how it was run. You said that the staffing levels on the EAU had remained consistently adequate as the Programme Board which set up the EAU never agreed to any staff reductions whether by medical or any other staff.

The approach the panel took to Charge 1 was as follows:

- 1) Whether the staffing levels or skill mixes on each ward were adequate;
- 2) Whether the provision of adequate numbers or skill mixes was the responsibility of Ms Harry in her role as Director of Nursing/ Chief Nurse and;
- 3) Whether Ms Harry by omission or commission failed to provide adequate numbers or skill mixes which includes what she knew or ought to have known and also what it was in her power or control to provide.

The panel first considered whether the staffing levels on each of these wards were adequate.

The panel had not been provided with, but would have been assisted by details of the objective establishment figures for each of the respective wards in the Charge. Without this, the panel did its best on the available subjective evidence of the individual nurses who had worked on the wards at the time.

The panel had regard to the evidence of Ms 2 in respect of staffing levels on Ward 10D at this time. The panel lacked information about the levels of dependency of the patients on this ward. Ms 2 believed, and the panel accepted her evidence on this, that her ability to care for patients adequately was compromised. Ms 2 said that on occasion during night shifts there were 17 patients with one trained nurse and one Healthcare Assistant, but that it was often the case that the Healthcare Assistant was not there. Ms 2 said that during the day shift there were two Registered Nurses and one Healthcare Assistant. She said that as a result, nurses often did not have enough time to document the care they gave and could be delayed in providing care.

The panel therefore concluded that this meant that the ability to provide adequate nursing care on Ward 10D was compromised and this was due to inadequate staffing numbers.

In respect of staffing levels on A&E, the panel had regard to the evidence of Ms 1. Ms 1 said in her statement that staffing levels were inadequate and she maintained this in her evidence in chief. Although Ms 1 conceded, in response to cross examination, that staffing levels were adequate at times, more often than not they had to make the best of the levels of staff they had, including pulling the Triage Nurse into A&E, leaving Triage uncovered. The role of the triage is to initially assess patients and to prioritise treatment according to need. Ms 1 said that she felt that more staff would have been useful, in allowing nurses to spend more time with their patients.

The panel therefore concluded that A&E would have been able to provide a better level of service had there been more staff and that low staffing levels were frequently the subject of discussion between Ms 1 and senior managers, including you. The panel concluded that you would, therefore, have been aware of that staff levels on A&E were inadequate.

With regard to the staffing levels on the EAU, the panel noted Ms 2's evidence that staffing levels were adequate, until the EAU was handed over to the Medical Directorate. During her oral evidence, Ms 2 said that the level of complaints in relation

to very basic nursing care was high. The panel noted Ms 2's comment that managing the EAU was like "*constant fire-fighting*", with staff being sent home at quiet times in order that they could be recalled when the Unit was particularly busy

The panel also had regard to the evidence of Ms 3 in respect of this charge. Ms 3 gave a detailed account of staffing levels in EAU, she described this as a 48 bedded-unit and on one side of the Unit two nurses were expected to look after 27 patients with two Healthcare Assistants.

The panel therefore concluded that staffing levels on the EAU were inadequate.

The panel having found that there were inadequate staffing numbers on Ward 10D then went on to consider the appropriate skill mix. An example given by Ms 2 was that during a night shift, there were 17 patients with one trained nurse and one healthcare assistant, but it was often the case that the healthcare assistant was not there. The panel finds that in the absence of adequate staffing, that in this case this would more likely than not also lead consequently to an inadequate skill mix and competencies.

It was conceded by Mr Davis, during his closing submissions on facts, that Ms 1 had said that her statement was incorrect where it said that there was an inadequate skill mix on A&E, and thus there was no evidence to support Charge 1b(ii).

The panel therefore found Charge 1b(ii) not proved.

The panel then considered the skill mix on EAU. The panel noted Ms 3's answer to the panel's direct question as to her view of the skill mix on EAU, to which she responded that the skill mix on the EAU was adequate. The panel had regard to your evidence that you had overseen the training up of advanced nurse practitioners for the EAU and that some of the Healthcare Assistants were encouraged to undertake higher level NVQs in care giving. In the absence of any alternative evidence setting out the number and skills of staff within the establishment on a day to day basis, the panel in considering that the NMC must always prove its case, could not be satisfied that the skill mix on EAU was inadequate.

The panel then went on to consider whether the staffing levels on the Ward 10D, A&E and the EAU were your responsibility. The panel had regard to the notes of the Board meetings of January 2005 and June 2005 at which vacancies were discussed. It is recorded in those minutes, which the panel has seen, that you told the Board that staffing levels were abnormally low "*and that this was taking its toll on patient care, but that the situation was being monitored.*" At the Board meeting of May 2006, there were questions from the public regarding staffing levels. In your evidence you did not challenge the accuracy of those Board minutes. Further, the panel noted Ms 2's specific example of an incident whereby she had attempted to refuse an additional patient as she believed that she had insufficient staff to provide adequate care. The panel was of the view that this issue would have been discussed in bed meetings which you chaired on a regular basis.

The panel therefore concluded that you knew, or ought to have known about staffing issues generally at the Hospitals, and on Ward 10D, A&E and the EAU in particular. Your comment that the "*situation is being monitored*", indicates to the panel that it is more likely than not that you had a degree of influence over staffing levels and would

have been in the position to ensure higher numbers of staff were made available to Ward 10D, A&E and the EAU. Your evidence was that staffing levels were adequate. You said that you did not specifically line manage ward nurses and that issues of staff levels and skill mix were a matter for the management of the directorates. However, the panel is of the view, from the evidence before it that concerns about the staffing levels were discussed at the bed meetings and in individual discussions with colleagues. The panel also heard evidence that you would sometimes assist in A&E, in moving patients and therefore you would have been aware of the low staffing levels from your own observations which you later reported to the Board. The panel further note that you had a particular interest in the EAU as you had been instrumental in setting it up and you continued to visit it, even after its management had been handed over to the Medical Directorate. You therefore should have been aware of the issues with staffing levels on the EAU.

The panel therefore finds that you as Director of Nursing/Chief Nurse had the responsibility to ensure adequate staffing levels and skill mixes within the Hospital and that as Director of Nursing/Chief Nurse you ought to have known that staffing levels on Ward 10D, A&E and EAU and the skill mix on Ward 10D were inadequate. As such you should have addressed the situation to provide adequate nursing services in those areas.

The panel therefore found Charges 1a(i) 1a(ii) 1a(iii) and 1b(i) proved and Charges 1b(ii) and 1b(iii) not proved.

Charge 2:

2. By your actions set out at paragraph 1 above, you allowed a situation(s) to arise and/or continue whereby patients were exposed to the following:

a) Risk

In respect of Ward 10D, Ms 2 said that the low staffing levels adversely impacted on the nurses' delivery of care and attention to patients, in particular in respect of documentation. She said that as staff were often required to care for so many patients at once, they did not have time to complete documentation promptly, therefore placing patients at risk of harm. Ms 2 said that the nurses on Ward 10D were unable to provide the appropriate level of care as they frequently had to go without breaks to cover the shift and were overtired whilst carrying out their duties. Ms 2 told the panel that on one occasion she had attempted to refuse two patients being brought onto Ward 10D, as she had serious concerns that there were insufficient staff to provide care for them, she said, however, that you had insisted on their being placed on the ward.

The panel noted the evidence of Ms 2, that frequently one nurse was expected to care for 17 patients. She said she thought this impacted on the level of care and attention provided to patients; in particular it affected the ability to complete documentation which presented a risk as delays in completing documentation may result in not providing care when it is required. The panel therefore concluded that this put patients at risk of harm.

In respect of Ward 10D, by failing to ensure both adequate staffing levels and skills and competency mixes on these wards, you exposed patients to risk.

In regard to A&E, the panel bore in mind its finding that staffing levels were low. Ms 1 identified that patients were put at risk when, as a result of low staffing levels, the Triage Nurse was required to work within the department, leaving patients in the waiting room without Triage facilities.

Ms 3 said that following the drop in staffing levels on the EAU, standards of care fell, presenting a significant risk to patients. Ms 3 said that you would have been aware of these issues, as on occasion, you had acted as a porter, bringing patients from A&E to the EAU. Ms 1 confirmed and you accepted that you did act as a porter when A&E was busy, to transfer patients to wards.

The panel noted that Ms 3 described the EAU as having “*an extremely roaming geography*” and formed the view that the layout of this unit, with several bays over a large area, made monitoring the patients on this unit particularly challenging. The panel inferred that inadequate staffing levels had the potential to place patients at risk and that, on such a unit, this would be emphasised.

The panel therefore found Charge 2a proved in respect of Charges 1a(i), 1a(ii), 1a(iii) and 1b(i).

b) Danger

The panel took the view that as there was a separate charge alleging danger, this was not the same as risk of harm and that to prove this charge, the NMC would have to show that patients were placed in actual danger by low staffing numbers and/or skill mixes. Whilst the panel recognised that both Ms 2 and Ms 3 were concerned with the risks to patients by low staffing levels, neither provided specific details of where that risk had escalated into actual danger.

However, in respect of A&E, the panel noted specific detail of Ms 1 that following the withdrawal of the Triage nurse “*we were depending on the receptionist [...] which I thought was dangerous.*”

The panel therefore found Charge 2b in respect of 1a(ii) proved.

3. On unknown dates, did not deal with incident forms in an appropriate manner, in that you:

a) said to Clinical Nurse Manager, Ms 1, when she handed incident forms to you “don’t bring me problems bring the answer”, or words to that effect

The panel heard that incident forms were always completed in respect of any patient who had breached the four hour target for turnaround in A&E. These would then be discussed at the bed meetings, and the forms handed to either you or your deputy.

Ms 1 said that there had been times when she had handed incident report forms to you, and that you had said to her “*don’t bring me problems, bring the answer*”, or words to that effect. Ms 1 said you frequently used this phrase, and that was the end of the matter. You did not recall the specific incident referred to in the charge, but accepted that this was a phrase you used particularly with Ms 1. You said it did in many ways summarise your management style. You said that nurses should be able to think for

themselves, and should learn independence, without always needing to resort to more senior staff members.

The panel noted your acceptance that you may well have said this to Ms 1 and that it was a phrase that you regularly used. Ms 1 confirmed that this was a phrase you frequently used.

The panel therefore concluded that it was more likely than not that you said this.

The panel then considered whether this was appropriate. The panel noted that Ms 1 said that she did not find your comment to be offensive or inappropriate. In her evidence, Ms 6 said that this was, in her view, indicative of good management style.

The panel concluded that saying this to Ms 1 in this particular context, was not inappropriate.

The panel therefore found Charge 3a not proved.

b) on at least one occasion handed an incident form, in relation to staffing problems, back to Ms 1 without looking at it

The panel noted your acceptance that you returned the incident form to Ms 1. The panel accepted your explanation, however, that you had done so in order for Ms 1 to resubmit the incident form following the relevant process. The panel noted Ms 1's evidence that whilst the incident form was handed back, this was after she had nevertheless read the contents to you.

The panel therefore concluded that whilst it was more likely than not that you did return an incident form to Ms 1 without looking at it, the panel accepted, on the evidence of Ms 1 that you had been provided with the information verbally. As such, on this occasion, this did not amount to dealing with this incident form in an inappropriate manner.

Accordingly, the panel found Charge 3b not proved.

4. Did not ensure that nursing services were delivered to an appropriate standard, in the following areas:

a) record keeping on the following ward(s):

- i. between around 1998 and June 2006, Ward 6*
- ii. between around 2003 and June 2006, Ward 8*
- iii. between around 2002 and January 2006, Ward 10D*
- iv. between around September 2004 and June 2006, EAU*

Ms 2 said that the nurses on Ward 10D were frequently too busy directly providing care, to complete adequate records. In respect of Wards 6 and 8, Ms 4 gave evidence that record keeping was appalling, and was not a priority. Ms 4 said that had record keeping audits been undertaken, record keeping issues would have been apparent to you.

You said that record keeping audits were completed at Ward level across the Trust and that efforts were made and initiatives in place to ensure the appropriate standards of record keeping.

The panel had regard to the evidence of Ms 4, in respect of record keeping on Ward 6. Ms 4 said that record keeping on Wards 6 and 8 was *“shocking. Members of staff did not keep accurate records and some did not document at all”*. During her evidence, Ms 4 maintained that there had been no record keeping audits at ward level on these wards, but that she was aware of them being undertaken on other wards. Ms 4 said that regular record keeping audits were now undertaken on Ward 6 since approximately 2007.

The panel accepted the evidence of Ms 4 in respect of Wards 6 and 8, as she had direct experience of managing the nursing staff on these wards, and would have been involved in the implementation of any record keeping audits and as such, there was an inappropriate standard of record keeping.

In respect of Ward 10D, the panel noted Ms 2’s comment in response to panel questions, that nursing staff were aware of the NMC’s standards for record keeping and it was their own responsibility to meet these. However, she said that there had been no *“drives or challenges”* to ensure that the appropriate standards of documentation were met. Ms 2 said that nurses were aware that their record keeping was not at the appropriate standard, and that medical staff frequently raised concerns regarding record keeping. Ms 2 was not aware of audits or any feedback regarding documentation.

In respect of record keeping on EAU, the panel had regard to the evidence of Ms 2, she said that she was not aware of any audits of how records were kept. She said that staff on the EAU knew they were in a situation where they were cutting corners on documentation, and that she was constantly trying to encourage her staff to increase the level of documentation. Ms 3 confirmed this during cross examination saying that record keeping on EAU was *“hit and miss”*; she said that there had been some *“pathway audits”* which substantiated that the documentation was not adequate. In her witness statement, Ms 3 said that record keeping was not consistent as staff were busy and there was also a high turnover of staff.

The panel was of the view that, as Registered Nurses, Ms 4, Ms 2 and Ms 3 would have been aware of the appropriate standards for record keeping, as set out in the NMC’s guidelines and were therefore able to give cogent evidence that record keeping was not of the appropriate standard on Wards 6 and 8, 10D and the EAU at the relevant times.

The panel then considered whether you had a responsibility to ensure that record keeping was at the appropriate standard on these wards. The panel was of the view that, as the Trust’s Director of Nursing/Chief Nurse, you had a responsibility to ensure that such an important area of nursing as record keeping was being completed to the appropriate standard. Further, you were the Trust’s Director of Clinical Standards.

The panel was of the view that record keeping was a clinical standard of which you would have had direct control and concluded, therefore, that it was your duty to ensure that it was met. As head of Clinical Standards, you would have received the results of any record keeping audits. The panel was of the view that it was your duty, as head of the Clinical Standards Directorate, to monitor record keeping and other clinical

standards and feed them back to the directorates. The panel concluded that the systems in place for monitoring record keeping were your overall responsibility, however, they were ineffective. The panel had regard to the job description for your role as head of Clinical Standards, including “ensuring that clinical standards are set, monitored and evaluated for nursing [...] as agreed with the Chief Executive.”

You said that you were assured by external quality monitors regarding record keeping, however, the panel was of the view that this amounted to an over-reliance on external monitoring and that this was insufficient to meet your responsibilities.

Accordingly, the panel found Charge 4a(i), 4a(ii), 4a(iii) 4a(iv) proved.

4b. hygiene and cleanliness on the following ward(s):

- (i) between around 2002 and January 2006, Ward 10D*
- (ii) between around September 2004 and June 2006, EAU*

Ms 2 said there were frequently issues with hygiene on the EAU. She said that when completing drug rounds on Ward 10D, nurses frequently encountered patients who had been incontinent, but that they did not have sufficient time to address this, due to low staffing levels. Ms 3 said that on the EAU there were issues surrounding the high turnover of patients in beds and that whilst the bed linen was changed, the old linen was often not taken directly to be laundered.

You said that to the best of your knowledge at the time, the wards were hygienic and safe. You said that you regularly walked around the wards and that there was a specific matron in charge of hygiene and cleanliness and that they had not reported any incidents back to you. You said that the matron was in charge of hygiene but that she dealt with any issues in this area through the director of facilities.

You disputed Ms 3’s evidence that the EAU became unhygienic. You said that the EAU had been designed as one of the cleanest parts of the Hospital. By way of example, you said that the floor-cleaning technology was the most up to date and effective across the Trust, but as it was a dry system, you occasionally received complaints that the floor was simply being dry mopped, when this was not the case. Whilst you disputed that EAU had poor standards of hygiene, you accepted that it was an “untidy” unit, as there was a high throughput of patients and a large amount of equipment, which could often be left out.

The panel noted that the minutes recorded that the Trust had received an external award for its level of hygiene.

The panel had regard to the evidence of Ms 2 in respect of Ward 10D, that standards of cleanliness and hygiene were generally acceptable, but that due to low staffing levels and “outbreaks of *Clostridium Difficile*”, this was often difficult to maintain. The panel were not provided with any evidence of whether there was a direct link between the *Clostridium Difficile* and the standards of hygiene at the time.

In respect of hygiene and cleanliness on EAU, the panel had regard to Ms 3's evidence. Ms 3 said that standards were generally high, but there were occasionally complaints regarding hygiene and cleanliness on the Unit, in particular dirty bed linen being left on the floor beside patients' beds.

The panel was of the view that whilst there appears to have been occasions of poor hygiene, with bed linen on the floor, this was an issue at ward level and not sufficient to prove that you did not ensure an appropriate level of hygiene and cleanliness on Wards 10D and the EAU at this time. The panel was of the view that these instances would have been the responsibility, in the first instance of the Ward Sister or manager.

The panel therefore found Charges 4b(i) and 4b(ii) not proved.

c) between around September 2004 and January 2006, administration of medication on Ward 10E

The panel had regard to the evidence of Ms 2 that medications were not administered in a timely fashion on Ward 10D and 10E. Ms 2, in her oral evidence, gave a specific example as to the difficulty in administering insulin in a timely fashion on Ward 10E. She said there was no mechanism in place to ensure that patients would have their insulin. Ms 2 said that such a system was now in place. Ms 2 said that insulin needed to be provided fifteen minutes before meals, with such a staffing ratio it would be difficult to do this in a timely fashion.

The panel concluded that there may well have been issues with administration of medication, arising from staff shortages. However, it did not have sufficient evidence to conclude that these arose specifically on Ward 10E. Ms 2 gave evidence of 17 patients, with up to 14 of those on insulin and the panel thought it was more likely than not she was talking of Ward 10D, where she worked prior to working on Ward 10E.

Accordingly, the panel found Charge 4c not proved.

(d) between around September 2004 and June 2006, provision of nutrition and fluid on the EAU

It is further alleged that between around September 2004 and January 2006, you did not ensure adequate nutrition and fluid provision on EAU. The panel heard that, according to Trust policy, patients received menu based nutrition. Ms 3 said, however, that as the turnaround was so high on the EAU and there was such pressure for beds throughout the Trust, patients' food was often delivered to the wrong person or not at all. Ms 3 said that this often resulted in diabetic patients not receiving diabetic menus. You accepted that nutrition could be a challenge on the EAU, where patients frequently moved about, and were not intended to stay for more than three days.

The panel noted the evidence of Ms 2 and Ms 3, that patients on the EAU were provided with "menu-based nutrition", but that as patients frequently moved beds and did not remain on the unit for long periods, this was not always effective. Ms 2 said that "in terms of nutrition in the EAU it was very difficult to get the correct food to the correct patient". The panel also noted Ms 2's indication that diabetic menus were not always given to diabetic patients.

The panel noted the evidence it had heard that this was a large unit with approximately 50 patients and a “*complex geography*” and concluded that it would, therefore have been difficult to ensure that the right patients got the right food. This was confirmed by you, in your comment that patients often did not get the meals they had ordered, due to the high level of patient flow. Ms 3 told the panel that nurses on the EAU made every effort to ensure that patients received “*some form of nutrition.*”

The panel therefore concluded that nurses did face difficulty in delivering nutrition to patients on the Unit, due to the nature of the unit, the high patient and, indeed, staff turnover, and the low staffing levels. Although there was evidence that all patients received “*some form of nutrition*”, the panel concluded that this was in fact inadequate. The panel noted that EAU was under your directorate and therefore you were directly responsible for ensuring that systems were put in place for nutrition to be delivered to an appropriate standard at the time it was under your responsibility and also once it had been transferred to the Medical Directorate.

The panel therefore found this Charge 4d proved.

(e) maintenance of patient dignity and/or privacy on the following ward(s):

(i) between around 2002 and January 2006, Ward 10

(ii) between around September 2004 and June 2006, EAU

You told the panel that when you arrived at the Trust, there had been issues around patient dignity and privacy. You said that you had worked hard to address these. You said that you were committed to working toward separate toilet and bath facilities. You acknowledged that it would have been preferable to have single-sex wards, but said that this was not always possible due to the Hospitals’ infrastructure. You said that the Board had agreed that if there was to be any structural development, all newly built wards would be single-sex. Prior to this, however, you said that you were committed to single-sex bays being used on mixed-sex wards. You said that following concerns regarding patient dignity, pyjama bottoms were introduced for elderly female patients. You did accept, however, that there had been ongoing issues with patient dignity.

In respect of patient privacy, you said that you had asked for white boards featuring patients’ names to be removed on the wards. You said that vigilance was key to ensuring patient dignity and privacy.

The panel had regard to the evidence of Ms 2 that staff tried hard to maintain the privacy, and dignity on wards 10D and 10E. As such, the panel concluded that whilst there may have been difficulty in maintaining patient dignity and privacy, however, it did not have sufficient evidence to conclude that privacy and dignity was not adequately maintained on Ward 10.

The panel therefore found Charge 4e(i) not proved.

In respect of the EAU, the panel noted the evidence of Ms 3 that privacy and dignity were not upheld on the EAU, with male patients opposite female patients and patients who were alert and orientated together with those who were confused. An example of how patients were mixed was given by Ms 2, who described how an alcoholic patient was next to a patient who had recently suffered a miscarriage.

The panel noted the evidence, corroborated by you, that there was a drive, from 2004, at the Trust for all wards became single-sex. It further noted that as you had been involved in the establishment and development of the EAU, and therefore that you should have given consideration to this, in maintaining patient dignity and privacy at that time and thereafter.

The panel therefore found Charge 4e(ii) proved.

5. *On various unknown dates, you failed to communicate with nursing staff in an appropriate manner, in that you:*
 - a) *Shouted*

During your time at the Trust there were issues with the availability of beds. In order to address this, you held regular bed meetings, as often as once a day for approximately 20 minutes. The bed meetings were attended by around 15 to 20 members of staff, these were Ward managers or their representatives and bed nurses. All of the witnesses and indeed, you described these meetings as pressurised and tense, as it was often difficult to locate beds, and often ward managers felt that they did not have sufficient staff, time or facilities to accept another patient.

As you were the Trust's Director of Nursing/Chief Nurse, you also chaired regular senior nurse meetings, attended by ward managers either monthly or bi-monthly. You said that these meetings were less pressurised than the bed meetings and were of a reasonably formal nature, with an agenda and speakers. You also attended Board meetings in your capacity as a Board member, and frequently held staff briefings with nursing staff, following Board meetings.

It is alleged that on various unknown dates, you failed to communicate with nursing staff in an appropriate manner. You said that you had never sworn at members of staff. None of the witnesses suggested that you had. Ms 4 said however that whilst she found you "*approachable and very supportive*" in her capacity as a bed manager, she "*would describe [you] as a bully at times*". She said that in her capacity as a Grade F Ward Sister, she found you "*unsupportive, unapproachable and unprofessional with other members of staff*". She said that the way in which you spoke to some members of staff was inappropriate, "*telling people off*" and raising your voice in an aggressive manner. Ms 4 also said that you had an inappropriate manner with staff members. She said that you were not a voice for nurses at the Trust. Despite this, Ms 4 said that she got on with you.

You said that you did not speak to staff inappropriately, and described your manner with more junior members of staff as "*firm but fair*". You said that you were direct in the way you spoke, but accepted that some individuals may find this to be aggressive. You told the panel that you had attended external training with a communication coach, in order to address any issues there may have been with your communication with other staff. You said that when you walked on the wards, the nurses would scatter, but that you believed that this was because they were often standing around the nursing station and it was your direction that they should be attending to patients.

It is alleged that on various unknown occasions you shouted at staff. Ms 2 said that she saw you "*tear into staff*" at bed meetings. Ms 2 said that you had never shouted or

raised your voice at her but that she had seen you do it to other individuals. Ms 2 said that she was not able to recall specifically which members of staff this had been. You asserted that you had only raised your voice once during your time at the Trust, but that that had been to a Board member; you said that you had never shouted at a member of staff.

The panel noted Ms 2's response to a question from the panel regarding whether you had shouted; Ms 2 said that she did not recall you shouting, and that the issue was "*more related to tone*". The panel also had regard to the evidence of Ms 4, who said that when telling people off, you would "*raise your voice in an aggressive manner*"; however, the panel was of the view that this did not of itself constitute "*shouting*". The panel noted that neither Ms 4, Ms 1 nor Ms 3 provided direct evidence of you shouting. All of the witnesses said, and the panel accepts, that you had a sharp tone and manner with staff, who, at times, were upset by this.

The panel found Charge 5a not proved.

b) used inappropriate language on various occasions including:

- i. saying to Ward Sister, Ms 4, about another member of staff that "she is a waste of space" or words to that effect*

It is also alleged that you used inappropriate language including saying to Ms 4, of another member of staff; "*she is a waste of space*", or words to that effect. Ms 4 said that in her capacity as a Grade F Ward Manager, you would often talk to her about other members of staff. She recalled you using this phrase when a member of staff walked past. You said that you did not recall this incident, but that this was a comment you used frequently, in jest, within your own team. You said that you would not have used this phrase seriously.

The panel had regard to Ms 4's evidence that a member of staff passed you and her, and she said that you said they were "*a waste of space*"; Ms 4 said that she did not "*recall whether [you] used any inappropriate language.*" As such, the panel concluded that Ms 4 did not think that your comment was inappropriate. You accepted that you did use this phrase frequently within your own directorate, but did not remember this particular incident.

The panel acknowledged that Ms 4 did not find the language used in making this comment inappropriate. However, it concluded that given the context of this incident, where you were the most senior nurse in the Hospital talking to a more junior member of staff about another staff member it was inappropriate language and not to be expected from the Director of Nursing/Chief Nurse.

The panel therefore found this Charge 5b(i) proved.

b. used inappropriate language

- ii. telling staff off and saying "that's not good enough, get it done", or words to that effect*

It is further alleged that you would tell staff off and say *“that’s not good enough, get it done.”* Ms 2 said that she had witnessed you saying this to other members of nursing staff.

The panel noted the evidence of Ms 4 in respect of this charge. The panel concluded that it was more likely than not that this was a phrase you used, and that it reflected your management style as discussed in your evidence.

The panel was of the view, however, that this phrase in itself does not necessarily amount to inappropriate language and that there could be occasions when it would be appropriate for a manager to use this to a member of staff.

The panel therefore found Charge 5b(ii) not proved.

c) disregarded staff concerns on various occasions including:

- i. at a bed meeting when Ward Manager Ms 2 you, based on her clinical knowledge, that in her opinion, a patient was not well enough to be sent home, you ‘tore shreds off’ Ms 2 and disregarded her concerns*

It is also alleged that you disregarded staff concerns on various occasions. These were at a bed meeting, when it is alleged that you *“tore shreds off”* Ms 2, when she informed you, based on her clinical opinion, that a patient was not well enough to be sent home. Ms 2 said that you disregarded her concerns, and that after you had spoken to her in an aggressive manner, she *“felt her cheeks burning”*, she said that the way in which you spoke to her not only made her feel uncomfortable, but also others present at the meeting.

The panel had regard to Ms 2’s account of this incident. Ms 2 said that she was distressed and *“felt her cheeks burning”* and also that she felt that her concerns regarding the patient were being disregarded. Ms 2 was unable to remember the particulars of her concerns.

The panel concluded that there had been an incident involving a difference of opinion between you and Ms 2 regarding the discharge of a patient, which Ms 2 no doubt found distressing. However, the panel concluded that it did not have sufficient information as to what the colloquialism *“tore shreds off”* amounted to and whilst the panel accepted that Ms 2 may have been upset, this was not sufficient to prove this charge.

Accordingly, the panel found Charge 5c(i) not proved.

- 6. In around 2001, you contacted Ward Manager Ms 3 and demanded that the available beds on Ward 11 be used, more particularly:*
 - i. your manner and/or tone of voice was inappropriate*

In around 2001, you contacted Ms 3 by telephone and demanded that the available beds on Ward 11 be used. It is alleged that your manner and/or the tone of your voice during this call was inappropriate. Ms 3 told the panel that whilst she worked on Ward 11, she had had limited contact with you. She said that around 2001, a bed manager telephoned her and demanded that she use all the available beds in her ward. Ms 3 said she had told the bed manager that she could not take additional patients, as she

did not have sufficient staff on the ward. She said that the bed manager rejected her concerns, and the issue was escalated to you. Ms 3 said that you telephoned her and demanded that she use the beds, Ms 3 told the panel that this made her feel undermined. She said that she was reduced to tears by you and had to terminate the call. You had no recollection of the call, or of having reduced Ms 3 to tears.

The panel had regard to Ms 3's account of this incident. Ms 3 said that she felt undermined by your call. In her witness statement, she did not make any reference to your tone during this call nor did she give any evidence of either your manner or the tone used in making the call, beyond that it was a "demand". The panel noted the evidence that it has heard the case regarding your manner and tone when speaking to staff generally and concluded that it was possible that you used an inappropriate manner and tone of voice when speaking to Ms 3. However, it did not have sufficient evidence to conclude on the balance of probabilities that you did so in this instance.

The panel therefore found Charge 6(i) not proved.

ii. you reduced Ms 3 to tears

The panel accepted Ms 3's indication that she had to terminate the call because she was crying. You had no recollection of this. The panel was of the view that as Ms 3 terminated the call when she felt she was going to cry, you may not have known this. Further, the panel noted that at the time of the call, Ms 3 had already had a difficult conversation with a bed manager, regarding the same issue. In response to cross examination, Ms 3 said that she was beginning to feel upset generally following the first telephone call, as she did not feel that she was being listened to. Ms 3 was under particular pressure at this time, over the issue of bed management. The panel was of the view that the term "reduce to tears" meant a conscious effort to make an individual cry, as such, the panel would have to be satisfied that it was you who caused Ms 3 to cry rather than it being a consequence of all the facts pertaining at the time. The panel was not satisfied, on the evidence, that you did cause Ms 3 to cry. The panel concluded, therefore, that whilst Ms 3 may have cried following the telephone call, it did not have sufficient evidence to conclude, on the balance of probabilities, that it was you who reduced her to tears.

The panel therefore found Charge 6(ii) not proved.

7. During the period of reconfiguration of services you provided inaccurate information, in that:

a. In April 2006, you advised the Trust Board that the impact of the proposed cost savings would not be detrimental to patient safety and/or care

It is alleged that during the period of reconfiguration of services, you provided inaccurate information to the Trust Board. The panel heard that from April 2006, the Trust was undergoing reconfiguration, arising from a government requirement to cut expenditure. It is alleged that in April 2006, you advised the Trust Board that the impact of cost savings would not be detrimental to patient safety and/or care. Ms 6 said that, with hindsight, your advice was incorrect.

The panel had regard to Ms 6's evidence in her witness statement that she recalled you having given advice to the Board in respect of the impact of proposed cost savings on patient safety and/or care. Ms 6 said, in that same statement however, that this would have been documented in the minutes of the Board's meetings in April. The panel carefully looked through the minutes of the Board for 6 and 24 April, the only two sets of Board meeting minutes provided to the panel for that month, but could find no record within them of you discussing this matter at either of those meetings. The panel observed that overall the nature of the Board minutes was limited and sparse and afforded very little recorded information or detail about what would have been discussed at the meetings. Indeed, the only mention of this issue at Board meetings is by Mr 7, the Chair of the Trust Board. In the absence of supporting, contemporaneous minutes, the panel did not feel it could properly rely on the assertion of Ms 6 in her witness statement made on 19 August 2011, some five years after the Board meetings in April 2006.

The panel therefore concluded that there was insufficient evidence before it to find this charge proved.

Accordingly, the panel found Charge 7a not proved.

- b. On 24 April 2006, you informed the Hospital Management Board that the proposal to change the ratio of qualified to unqualified staff from 60/40 to 50/50 or even 40/60, would not impact on the numbers of staff and standards of care*

It is further alleged that you informed the Hospital Management Board that the proposal to change the ratio of qualified to unqualified staff from 60:40 to 50:50 or even 40:60, would not impact on the numbers of staff and standards of care. You said that it was important to note that different areas of the practice required different ratios of qualified and unqualified staff; you also said that it was not necessary for Registered Nurses to undertake all nursing duties.

The panel had regard to the minutes of the Board meeting of 24 April 2006. It appears that skill mix was discussed at Board meetings, however there was no evidence that it was discussed by you, on this particular occasion. The minutes do not record any information provided by you to the Board to the effect that any proposal to change ratios of qualified and unqualified nurse "would not impact on the numbers of staff and standards of care".

The panel therefore found Charge 7b not proved.

- c. On an unknown date, you provided reassurance to the Trust Board that nursing vacancies were being filled when you knew, or ought to have known that recruitment at the Trust was an ongoing issue.*

It is also alleged that on an unknown date, you advised the Board that nursing vacancies were being filled when you knew, or ought to have known that recruitment was an ongoing issue at the Trust. Ms 5 told the panel that you did advise the Board that nursing vacancies were being filled. You said that you were aware that recruitment was an ongoing issue at the Trust, but this was, in the most part, in the Medical

Directorate. You said that you had not been aware of significant numbers of unfilled nursing vacancies within the Trust.

The panel took into account your evidence that you had been striving to recruit staff; in particular you implemented the recruitment of a cohort of about 60 Indian nurses. Also, the panel was unable to conclude, given the uncertainty in relation to the figures provided by the Finance and Human Resources Directorates that any information you did provide about recruitment was inaccurate.

The panel therefore found Charge 7c not proved.

Decision on Misconduct and Impairment:

Having found a number of the facts proved, the panel went on to consider the questions of misconduct and impairment.

The panel considered the submissions of Mr Davis on behalf of the NMC and the submissions of Mr O'Donovan on your behalf. The panel heard and accepted the advice of the legal assessor. It had regard to all of the oral and documentary evidence adduced in the case.

The panel has borne in mind that this is a two stage process. It must first consider whether your actions set out in the charges found proved amount to misconduct, and if so, whether as a result of that misconduct, your fitness to practise is currently impaired.

The panel noted that your impairment should be judged by reference to your suitability to remain on the register without restriction, and that misconduct can be defined as conduct which falls far short of that which can reasonably be expected of a registered nurse.

Mr Davis, on behalf of the NMC, drew attention to the definition of misconduct as set out in the case of *Roylance v. GMC* and provided copies of the case to the panel. Mr Davis also drew attention to the analogies between your case and the case of *Roylance*. Dr Roylance was a Chief Executive in an NHS Trust and you were a Director of Nursing/Chief Nurse. Mr Davis told the panel of the ruling in that case that as a General Practitioner, Dr Roylance still had the general obligation to care for the sick, and that duty did not disappear when he took on the appointment of Chief Executive, but continued to coexist with it.

In respect of Charge 1, Mr Davis submitted that the panel's finding of fact were that as Director of Nursing/Chief Nurse, you had a responsibility to ensure adequate staffing levels and skill mixes on the specific wards at the Trust; that you were, or ought to have been aware of the issues with staffing levels and skill mix on the wards detailed in the charges; that as a Director of Nursing/Chief Nurse, you were in a position to intervene to ensure adequate staffing levels and skill mixes and that your failure to do so amounted to a failure to provide adequate nursing care. He submitted that your acts and/or omissions fell short of the required standards.

In respect of Charges 4a, d and e(ii) Mr Davis relied on the panel's findings that you were responsible for ensuring that systems for auditing record keeping at the Trust were in place. However, they were ineffective. He submitted that in your capacity of Head of

Clinical Standards you had a duty not only to ensure effective, accurate record keeping across the Trust, but to ensure that this was appropriately and adequately monitored given that record keeping is such an important part of nursing. Similarly, he submitted that you had a responsibility to ensure the adequate provision of nutrition and fluid on the EAU and to maintain patient dignity throughout the Trust.

Mr Davis submitted that each of these failings indicates that you have fallen short by omission or commission of the required standards. He drew attention to the relevant NMC Codes, which were in place at the time of the incidents. These were the UKCC *Code of Professional Conduct* (1992), the NMC *Code of Professional Conduct* (2002) and *The code: Standards of conduct, performance and ethics for nurses and midwives* (2004). He drew attention to the paragraphs of these codes of which he submitted you were in breach.

In respect of Charge 5b(i), Mr Davis submitted that this was a different type of allegation. He reminded the panel of its finding that this was inappropriate and not to be expected of a Director of Nursing/Chief Nurse.

Mr Davis submitted that your misconduct was of a serious nature. Mr Davis reminded the panel of its finding at Charge 2a, that each of your failings set out at Charge 1 placed patients at risk. He further reminded the panel of its finding at Charge 2b that your actions set out at Charge 1a(ii), failing to ensure adequate numbers of nursing staff on A&E, exposed patients to danger. Mr Davis submitted that you had allowed systemic failures to continue at the Trust, to the detriment of the care provided to patients, and that therefore, your actions had amounted to serious misconduct.

In respect of impairment, Mr Davis drew attention to the formulation for misconduct set out by Dame Janet Smith in the 5th Shipman report and that paragraphs a to c were engaged. He submitted that you had in the past placed patients at unwarranted risk of harm. He further submitted that through the systemic failures at the Trust, for which you were responsible, you brought the nursing profession into disrepute, by placing nurses under your overall management in a position where they could not provide adequate or appropriate care to patients. He submitted that you had also brought the nursing profession into disrepute through your inappropriate comments about a more junior member of staff. Mr Davis submitted that by failing to ensure that adequate nursing care was provided to the patients at the Trust, who were indirectly under your care, you had breached a fundamental tenet of the nursing profession; in failing to work with others to protect the health and wellbeing of those in your care.

Mr Davis said that when considering your current fitness to practise, the panel should consider the level of insight you have shown and submitted that this was very little. Mr Davis told the panel that you, in evidence, did not accept that the failure to provide adequate nursing services was your fault and so was not a failing in your professional responsibility as a Registered Nurse. Therefore, you lacked insight into the full extent of your failings. He submitted that this was not a case in which the issue of remediation was particularly pertinent, given that the majority of the allegations relate to managerial issues rather than directly to your clinical practice. Mr Davis reminded the panel that you are currently retired and have said that you do not intend to return to nursing.

Mr Davis drew the panel's attention to the case of *CHRE v. NMC and Grant* (2011) EWHC 927 (Admin). He invited the panel to consider whether your misconduct was of

so serious a nature that the need to uphold proper standards and public confidence in the nursing profession and the NMC as its regulator would be undermined were a finding of impairment not to be made.

Mr O'Donovan invited the panel to find that your actions did not amount to misconduct. He submitted, however, that were the panel to find that your actions amounted to misconduct, it should not then conclude that your fitness to practise is currently impaired.

Mr O'Donovan invited the panel to consider the incidents within their overall context. He reminded the panel that the Trust was split over two hospital sites with 20 wards, and employed approximately 800 nurses and 1500 support workers. Mr O'Donovan submitted that the matters that the panel found proved related to a small number of wards and said that this did not evidence a Trust-wide failure on your part. Mr O'Donovan submitted that the panel's findings were not indicative of overall systemic failures. Mr O'Donovan invited the panel to consider that Ward 10D, A&E and EAU and also Wards 6 and 8, were among approximately 20 others at the Trust in respect of which the panel had heard no evidence of any issues. He submitted that the EAU was a new unit, and submitted that, as such, it required a period of "*bedding in*", but was not particularly great in the overall scheme. He disputed the NMC's case that the findings indicate systemic failure on your part.

In respect of A&E, Mr O'Donovan reminded the panel of the pressures that A&E departments across the UK were under at the time of the incidents. He submitted that Ward 10D was a problematic medical ward.

Mr O'Donovan reminded the panel that there was no suggestion that there was any personal, callous disregard towards patients on your part.

Mr O'Donovan submitted that the facts found by the panel could not amount to a finding of misconduct. Mr O'Donovan submitted that whilst it was the case that you had a responsibility to respond to nursing issues at the Trust, the panel had not found that you had ignored any direct evidence of any information you received in respect of these issues. Mr O'Donovan drew the panel's attention to its finding that "*you knew or ought to have known*" of the issues from your interactions with staff and hands on experience. He submitted that you had perhaps demonstrated an unfortunate lack of judgment or over reliance on information from other nurses at the Trust.

In respect of Charge 5a, Mr O'Donovan accepted that your use of language had been inappropriate but submitted that there was a large distance between making an "*ill judged aside*" and serious misconduct.

In respect of impairment, Mr O'Donovan informed the panel that prior to the incidents, you had had a lengthy, unblemished career as a Registered Nurse in the NHS. He submitted that yours had been a career of some distinction. Mr O'Donovan told the panel that upon leaving the Trust, you had undertaken various other senior posts within the NHS for three years until your retirement in 2009. He said that during your time in these various roles, there had been no issues raised with your practice or management. Mr O'Donovan told the panel that since your retirement you now live off your pension and engage in voluntary work. He submitted that since 2009, you had had nothing to do with nursing. Mr O'Donovan therefore invited the panel to question what the relevance of a finding of impairment was in order to uphold public confidence in the nursing

profession, in the case of a nurse who is no longer working, in respect of incidents some years old, the latest of which was in 2006.

The legal assessor referred the panel to the case of *Roylance, Doughty, Grant* and the formulation of Dame Janet Smith for impairment in the 5th Shipman Report. The panel accepted the advice of the legal assessor.

The panel first considered whether your actions set out in the charges amounted to misconduct. The panel had regard to the case of *Roylance*. The panel had been concerned by your evidence that, in your view, the word "Nurse" in your job title as Chief Nurse was "misleading" and that the role was in fact more of a management role than a nursing role. The panel was of the view that, rather, you had been appointed Chief Nurse precisely because you were a Registered Nurse. It was your experience and expertise as a nurse as well as your skills as a general manager/administrator that were required for the post. You were expected in this role to act as the foremost nurse at the Trust; ensuring a high level of nursing provision and acting as an example to and a voice for other nurses at the Trust. In this respect, the panel had regard to the evidence of Ms 4 that you "were not a voice for nursing at the Trust".

The panel bore in mind its finding that you ought to have been aware that there were inadequate staffing levels and skill mixes on certain wards at the Trust. It had no evidence that you had brought these issues to the attention of the Board beyond a note in the minutes dated 1 September 2005, that you said that "it was abnormal for Trust to carry this amount of nursing vacancies and it was taking its toll on the organisation but the situation was being monitored." The panel accepted that the Trust was under severe financial pressure at the time of the incidents, however, it was nonetheless of the view that you had a responsibility to raise these issues comprehensively with the Board and take steps to ensure the adequate provision of nursing services across the Trust. The panel concluded that you had failed to do so. Although the failings occurred on four wards this potentially affected the health and safety of a significant number of patients as EAU was a 48 bedded ward with a rapid turnover.

The panel noted that you had established the EAU in order to alleviate pressure on the A&E department and to ensure that patients were dealt with within the 4 hour target. The panel accepts that breaches of this target had financial implications for the Trust. However, the EAU was a particularly difficult ward with a high throughput of poorly patients. The panel was of the view that notwithstanding that it had no evidence that there were issues on other wards, you had a responsibility as Director of Nursing/Chief Nurse to ensure the adequate provision of nursing care across the Trust, in all wards, because that is what safeguards patients. However, you lost sight of this and became focussed on meeting targets and training up nurses.

The panel bore in mind its findings that your failure to ensure adequate staffing levels and skill mix on a number of wards placed patients generally at risk of harm and further its finding that your failure to ensure adequate staffing on A&E specifically placed patients in danger.

In respect of ensuring nursing standards being delivered to an appropriate standard, this is what almost inevitably flows from not having enough staff: record keeping is not maintained, the standard of nutrition is affected and the ability to maintain patient

privacy and dignity is an issue. Staff do not have the time to undertake all these basic aspects of nursing care.

The panel had regard to the various codes that were in place at the time of the incidents. It concluded that you were in breach of the following passages of the NMC *Code of Professional Conduct* (2002):

“1.2 As a registered nurse, midwife or health visitor, you must:

- _ protect and support the health of individual patients and clients*
- _ protect and support the health of the wider community*
- _ act in such a way that justifies the trust and confidence the public have in you*
- _ uphold and enhance the good reputation of the professions.”*

“8.4 When working as a manager, you have a duty toward patients and clients, colleagues, the wider community and the organisation in which you and your colleagues work. When facing professional dilemmas, your first consideration in all activities must be the interests and safety of patients and clients.”

The panel therefore concluded that your actions amounted to misconduct. Having previously found that as Director of Nursing/Chief Nurse you had the responsibility for, and should have been aware of the issues on the wards, the panel concluded that your conduct fell far short of that which was expected of a Registered Nurse, and, indeed a Registered Nurse in such a senior position of trust as you were.

The panel then considered whether, as a result of your misconduct, your fitness to practise is currently impaired.

The panel accepted that, at the time of the incidents, you, as Director of Nursing/Chief Nurse, and the Trust as a whole were under significant financial pressure and turmoil. However, the panel was concerned that you had lost sight of what was required of you in your role. The panel was of the view that you had failed to focus on ensuring the adequate provision of “*frontline*” nursing services, instead being distracted by training, targets and other matters. The panel considered you to be a very senior manager and an intelligent woman, but the panel was concerned that you had effectively closed your mind to your direct operational responsibilities and had limited yourself to the strategic role. However, as Director of Nursing/Chief Nurse you had the professional responsibility for every nurse in the Trust. The panel is satisfied that in your role, many of these issues were raised with you, however, you were not accepting them as issues, nor stating any case to the Board of needing more staff to meet adequate nursing levels and standards.

The panel had regard to the formulation for impairment provided by Dame Janet Smith in the 5th Shipman report:

‘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 and/or is liable in the future to breach one of the fundamental tenets of the profession
d...'

The panel concluded that you had in the past placed patients at risk of harm. It noted its findings that your failure to ensure adequate staffing levels and skill mixes on a number of wards had placed patients at risk of harm and further, its finding that your failure to ensure adequate staffing levels on A&E had placed patients in danger. The panel bore in mind that you had not placed patients at risk directly, through failings in your clinical practice, but indirectly, through your failing to ensure adequate nursing provision at the Trust. The panel was of the view that as Director of Nursing/Chief Nurse, you had a responsibility to ensure staffing levels and skill mixes were adequate on all wards across the Trust, in order to provide the appropriate level of nursing care to patients, and to avoid placing them at unwarranted risk of harm. The panel accepted that you were under a high degree of pressure at the Trust at the time, in particular financial pressure, but was of the view that it was nevertheless your responsibility to be an advocate to ensure adequate nursing provision.

The panel then considered whether you would be liable to place patients at risk of harm in future. The panel was of the view that you had demonstrated no insight into your failings; because even at these proceedings you have not accepted that there were inadequate numbers of staff or that you had any responsibility for the numbers of staff and how they delivered care to patients. Although you have retired and are no longer practising as a nurse, the panel nevertheless had to consider the position were you to return to nursing. On account of your lack of insight, the panel could not rule out that you would again act in such a manner as to place patients at risk of harm, were similar circumstances to arise.

The panel was of the view that you had, in the past, brought the nursing profession into disrepute. As Director of Nursing/Chief Nurse, you had a professional responsibility to the nurses and to the provision of nursing care at the Trust, and that you had failed in this role. The panel bore in mind the evidence that various nurses had raised concerns with you regarding staffing levels and skill mixes on the wards, as well as the provision of nutrition and the maintenance of patient dignity. However, the panel had no evidence of you acting on these concerns or escalating them appropriately. The panel bore in mind its finding that you allowed these failures to occur within four wards and continue whilst in your role as Director of Nursing/Chief Nurse. Further, the panel had regard to the evidence of Ms 4 that you "*were not a voice for nurses*" at the Trust. The panel also bore in mind its finding that you had breached the important paragraphs 1.2 and 8.4 of the NMC's codes.

The panel was therefore of the view that at the time of these incidents your fitness to practise was impaired. Whilst the panel had regard to the posts that you subsequently held, it derived little assistance from this because of the lack of testimonials which would have assisted in assessing your current attitude. However, notwithstanding the passage of time that has elapsed, the panel concluded that your fitness to practise is currently impaired for the reasons given.

The panel had regard to the public interest. The panel was of the view that the public had the right to expect that a Director of Nursing/Chief Nurse would prioritise the provision of quality "*frontline*" nursing services, even accepting the financial constraints

faced by the Trust at the time. The panel therefore concluded that there was also a public interest in a finding of impairment in this case, in order to uphold proper standards in the nursing profession and to maintain public confidence in the profession. Accordingly, the panel found that your fitness to practise is currently impaired by reason of your misconduct.

Decision on Sanction:

In reaching its decision on sanction, the panel has considered the submissions of Mr Davis, on behalf of the NMC, and those of Mr O'Donovan, on your behalf. It had regard to all of the evidence adduced in this case. It has accepted the advice of the legal assessor.

The panel has applied the principles of fairness and proportionality, weighing the public interest with your own interests and taking into account any mitigating and aggravating factors in the case. The public interest includes the protection of members of the public and, in particular, patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour within the profession. The panel has taken account of the current *Indicative Sanctions Guidance*, bearing in mind that the decision on sanction is one for its own independent judgement.

The panel recognises that the purpose of sanction is not to be punitive, although a it may have a punitive effect.

Mr Davis reminded the panel of the public interest in declaring and upholding proper standards of performance and maintaining confidence in the nursing profession. He drew the panel's attention to Paragraph 16 of the *Indicative Sanctions Guidance*, which states:

- “16 *A number of judgments have identified and confirmed that the public interest includes amongst other things:*
- 16.1 protection of patients and others*
 - 16.2 maintenance of public confidence in the professions and the regulatory body*
 - 16.3 declaring and upholding proper standards of conduct and behaviour”*

He drew attention to the aggravating features of this case, in particular, the panel's finding that your failure to ensure adequate staffing levels on particular wards placed patients at risk of harm and that your failure to ensure adequate staffing levels on A&E placed patients in danger. Mr Davis reminded the panel that these errors occurred over a long period of time and therefore would have impacted upon numerous patients, not least because A&E and the EAU were among the most pressurised wards at the Trust. He further reminded the panel of its finding that you had an overarching responsibility to ensure the provision of proper nursing services across the Trust. Mr Davis acknowledged as a mitigating factor the fact that the Trust was under considerable financial pressure at the time of the incidents.

Mr O'Donovan reminded the panel that you retired in September 2009 from all paid work, including nursing and healthcare work. He submitted that it was therefore in excess of four years since any act or omission of yours could have affected anyone else's health or wellbeing and neither would you be liable to do so in future, given that you do not intend to return to nursing or, indeed, any paid work. Mr O'Donovan invited

the panel to consider that this matter has been “*burdening you*” since approximately July 2010. He invited the panel to consider the detrimental impact that any sanction would have on your personal life. Mr O’Donovan told the panel that throughout these proceedings you had been “*harassed*” by the press, to the extent that it has adversely impacted your health.

Mr O’Donovan reminded the panel that it was not its duty to “*punish*” you and that its primary role was the protection of the public. He reminded the panel of the need for proportionality and invited the panel to consider the guidance given at paragraphs 19, 20 and 21 of the *Indicative Sanctions Guidance*:

- “19 *In determining what sanction, if any, should be imposed, panels must act proportionately, which will involve balancing the interests of the public against those of the registrant.*
- 20 *The requirement for panels to give act proportionately arises from Article 8 of the ECHR. Article 8 provides for the right to respect for private and family life, and will be applicable in almost every case where a panel is considering imposing a significant sanction against a nurse or midwife¹².*
- 21 *Accordingly, any interference with the nurse or midwife’s ability to practise must be no more than necessary to satisfy the public interest, which includes the protection of the public. It must strike a fair balance between the rights of the nurse or midwife and the public interest.”*

Mr O’Donovan invited the panel to consider that its decision in this case is “*groundbreaking*” in as far as it has indicated that the NMC’s reach stretches from the Ward to the Boardroom. He submitted that the NMC therefore had already sent out a clear message to the profession and the public. Mr O’Donovan said that the panel had made this message sufficiently clear through its finding of impairment against you. Mr O’Donovan reminded the panel that part of its duty is not to bring the NMC into disrepute and in upholding this duty, the panel had to act proportionately. He submitted that in the particular circumstances of this case, there was a real risk that the public may feel that any sanction it imposed was done so merely to be “*vindictive*”. Mr O’Donovan submitted that, in all the circumstances, and on the facts found proved, this is a case in which no further action is appropriate and proportionate.

Mr O’Donovan submitted that were the panel of the view that taking no further action was not appropriate, it should not consider a Striking-Off Order simply because the other sanctions available to it did not appear to fit.

The panel accepted the advice of the legal assessor. This included cautioning the panel against allowing itself to be influenced by anything it may have heard, read or seen elsewhere about the Mid-Staffordshire Trust, or any general adverse public opinion about the Trust as a whole.

The panel had regard to the aggravating and mitigating factors in this case.

In respect of aggravating factors, the panel bore in mind your seniority at the Trust and its earlier finding that you had failed to act “*as a voice for nurses*” at the Trust. The panel also recognised its finding at the impairment stage of your lack of insight continued throughout these proceedings. That is that there were inadequate numbers of staff and skill mixes or that you had any responsibility for the numbers of staff and how they delivered care to patients. The panel noted that you have not acknowledged the impact your failings may have had on patients and other members of staff at the Trust, and the reputation of the nursing profession. However, the panel was of the view that this lack of insight was more as a result of how you perceived your role as being a strategic one, divorced from an operational one, reflecting your thinking and understanding of your

role at the time in question. Although the panel rejected this and was of the view that a Director of Nursing/Chief Nurse cannot separate those two roles, the panel also recognises that there were other personnel in managerial roles who also had responsibilities for staffing issues including recruitment and achieving clinical standards. In terms of mitigation, the panel accepted that, at the time of the incidents, the Trust was under considerable financial pressure and there was pressure on you from a dysfunctional Board. The panel was of the view that it was as a result of this and other pressures that you lost focus on frontline nursing, and instead focussed on targets, training and other matters. The panel concluded that whilst this was a failing on your part, it accepted that the panel has been able to form this judgment with the benefit of hindsight. Some seven years have since elapsed in which the organisation in which you worked has come under considerable scrutiny.

The panel noted your lengthy, successful career in nursing, prior to the incidents. The panel accepted that you had given considerable time and effort in developing the training and development of nurses, including introducing advanced nurse practitioners. Further, the panel noted that there had been no issues raised with your practise in the senior posts you held after you had left the Trust.

The panel recognised that your reputation will have been irrevocably damaged by these proceedings which, for you, at the pinnacle of your profession will not have been inconsiderable. The panel also accepts that these proceedings have been lengthy, the initial referral to the NMC being made back in 2010 and this will have been a considerable strain upon you.

The panel considered the sanctions available to it in ascending order, beginning with the least punitive.

The panel first considered taking no further action. It noted its finding that you had by your actions allowed a situation to arise and/or continue whereby patients were exposed to risk and danger, albeit indirectly through your failings in a managerial position. Further it noted that you had brought the nursing profession into disrepute through failing to act as a voice for nurses at the Trust. Further, the panel bore in mind your lack of insight into your misconduct. The panel therefore concluded that taking no further action in this case would not appropriately reflect the seriousness of your failings, or maintain public confidence in the nursing profession and the NMC as its regulator.

The panel then considered a Caution Order. The panel expressly noted that whilst it had found that your failings had exposed patients to risk and, in the case of the low staffing levels on A&E, to danger, this had not arisen from any failings in your practice directly, neither had the NMC presented any evidence before the panel of actual patient harm resulting from your actions. The panel noted that there had been no suggestion of failings in your clinical practice and that you had had a long, distinguished and otherwise unblemished, career as a nurse. Although the panel found you were not a "*voice for nurses*", it recognised that you were committed in your managerial role in supporting the Board in trying to meet government-set targets, thereby not incurring financial penalties whilst operating within a very difficult financial climate. The panel also noted that you strove to develop the skills of the nursing staff generally. The panel therefore concluded that there was no requirement to restrict your practise in order to ensure public protection.

The panel then considered whether a Caution Order would satisfy the public interest in upholding proper standards in the nursing profession and maintaining public confidence in the profession and the NMC as its regulator. The panel bore in mind your seniority at the Trust. The panel was of the view that a Caution Order would not only mark the

seriousness and unacceptability of your misconduct, but also send a clear message to the nursing profession, and in particular, those in senior positions of the importance of maintaining focus on the provision of “*frontline*” nursing services and that it was important that the public understood that this was a message to the nursing profession. The panel therefore concluded that a Caution Order was the most appropriate order which would be proportionate in balancing the panel’s duty both to protect the public and your own interest.

Having decided to impose a Caution Order, the panel went on to consider why the next most restrictive sanction, a Conditions of Practice Order was not appropriate. The panel noted that there were no issues with your clinical practice that could be addressed by a Conditions of Practice Order. The panel therefore concluded that a Conditions of Practice Order would not be appropriate in this case.

The panel therefore decided to impose a Caution Order for the maximum period of 5 years, in order to mark your conduct as unacceptable and signal that this must not be repeated, thereby declaring and upholding proper standards in the nursing profession and maintaining public confidence in the profession and the NMC as its regulator. That concludes this determination and the NMC proceedings against you.