Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 6 - Tuesday 13 July 2021 and Monday 17 – Wednesday 19 January 2022

Virtual Hearing

Name of registrant:	Mrs Veronica Ogechi Ihenanacho
NMC PIN:	06A1210E
Part(s) of the register:	Registered Nurse Adult Nursing – 26 September 2006
Area of registered address:	Essex
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, Lay member) Dr Natasha Duke (Registrant member) Richard Bayly (Lay member)
Legal Assessor:	Tracy Ayling QC (6 – 13 July 2021) Michael Levy (17-19 January 2022)
Hearing Coordinator:	Parys Lanlehin-Dobson (6 - 13 July 2021, 17 - 18 January 2022) Graeme King (19 January 2022)
Nursing and Midwifery Council:	Represented by David Claydon, Case Presenter
Mrs Ihenanacho:	Present and unrepresented
Facts proved:	Charges 2, 3, 4, 5, 6, 7 and 8
Facts not proved:	Charges 9, 10 and 11
No case to answer:	Charge 1
Fitness to practise:	Impaired
Sanction:	**Striking off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse, while working at Royal London Hospital on 1 October 2017:

1. At approximately 12pm, having noted that Patient A's blood glucose reading was 4mmol/L did not stop the insulin infusion and/or record that you had stopped the insulin infusion **(No case to answer)**

2. Did not ensure that the following blood glucose readings for Patient A were recorded: **(Proved in its entirety)**

   (a) 2.8 mmol/L at 12:08;
   (b) 3.2 mmol/L at 12:53;
   (c) 6.9 mmol/L at 13:30;
   (d) 9.9 mmol/L at 15:35;

3. Recorded inaccurate blood glucose readings in Patient A's Variable Rate Intravenous Insulin Infusion Administration Chart ('chart') of: **(Proved in its entirety)**

   (a) 12.3 mmol/L at 10:05;
   (b) 6.0 mmol/L at 11:20;
   (c) 4.0 mmol/L at 12:00;
   (d) 5.8 mmol/L at 13:20;
   (e) 6.2 mmol/L at 14:10;
   (f) 6.4 mmol/L at 15:00;
   (g) 7.0 mmol/L at 16:05;

4. Your actions in charge 3 above were dishonest, in that you recorded blood glucose readings on one or more occasions, which had not been taken **(Proved)**

5. Did not escalate the blood glucose readings at charge 2(a) and/or (b) above, which indicated a hypoglycaemic episode **(Proved)**

6. Did not adjust or record that you had adjusted the insulin sliding scale at any stage, as required **(Proved)**

7. Recorded that a blood glucose reading of 11.1 mmol/L had been taken at 17:15 when it had not **(Proved)**

8. Your actions in charge 7 above were dishonest, in that you recorded that a blood glucose reading had been taken at 17:15 when you knew that was not the case **(Proved)**

9. Recorded that the insulin rate was running at 4ml per hour at 17:15 when it was running at 1ml per hour **(Not proved)**

10. Your actions in charge 9 above were dishonest, in that you recorded that the insulin rate was running at 4ml per hour when you knew that was not the case **(Not proved)**

11. Recorded the times 18:00 and 19:20 on Patient A's chart, which: **(Not proved in its entirety)**

    (a) Were pre-populated;

    (b) Were incorrect as subsequent blood glucose checks were required at regular one hour intervals.

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

Decision and reasons on application for hearing to be held in private

During the hearing, it became apparent that there would be reference to your health and the health of a witness involved in this case. As such Mr Claydon, on behalf of the Nursing and Midwifery Council (NMC) applied to hold such parts as related to health, in private. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You indicated that you supported the application to the extent that any reference to your health and the health of any third parties should be heard in private.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to your health and the health of a witness the panel determined to hold such parts as related to health, in private.

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

The panel heard an application made by Mr Claydon under Rule 31 to allow the written statements of Witness A and Witness G into evidence. Both were not present at this hearing and, whilst the NMC had made efforts to ensure that these witnesses were present, Witness A was unable to attend as she is no longer in the country. Witness G could not attend the hearing [PRIVATE].

Mr Claydon informed the panel that the NMC was unable to reach Witness A in respect of this hearing and it was believed that she was out of the country, having returned to [PRIVATE]. He submitted that all reasonable attempts to contact Witness A had been made but to no avail. Mr Claydon invited the panel to admit the written statement of Witness A as evidence.

Mr Claydon told the panel that on the morning of this hearing he had made contact with Witness G to confirm his attendance. He told the panel that Witness G [PRIVATE]. Mr Claydon invited the panel to admit the signed and dated witness statement of Witness G as evidence.

You told the panel that you supported this application.

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

The panel gave the application in regard to the statements of Witness A and Witness G serious consideration.

The panel considered whether you would be disadvantaged by the change in the NMC's position from reliance upon the live testimony of Witness A. It was of the view that the evidence of Witness A was highly relevant and the sole and decisive evidence in respect of charge 1. Further it considered that the absence of Witness A would prevent you from cross-examining her and the panel from asking her questions.

The panel has taken into account the matters above and the circumstances in which the statement was made, in that it was taken at the time, and the reasons why the witness

was unavailable for cross examination. In the interest of fairness to you the panel determined to reject the application to admit the witness statement of Witness A.

The panel went on to consider the second application to admit the witness statement of Witness G. The panel considered that you would be placed at a disadvantage as Witness G's absence would prevent you from cross-examining him and the panel from asking him questions. However the panel determined that the evidence of Witness G was not the sole and decisive evidence relating to any of the charges in this case. The panel was of the view that Witness G's witness statement was helpful in providing an overview and context of the culture on the ward which in turn assisted your case. The panel has taken into account the circumstances in which the statement was made, in that it was taken at the time, and the reasons why Witness G was unavailable for cross-examination. The panel therefore decided to allow the application and Witness G's witness statement to be read into the record and considered as evidence.

Decision and reasons on application of no case to answer in relation to charges 1 and 11

Having determined that the evidence of Witness A relates directly to charge 1 and having decided her statement was inadmissible the panel had concerns about the lack of evidence before the panel to assist in its decision on the facts pertaining to charge 1 and whether there was a case to answer.

The panel invited submissions from Mr Claydon. He submitted that he had no positive submissions in respect of charge 1 and whether there was a case to answer was a matter for the panel.

In respect of charge 11, Mr Claydon submitted that the panel should consider the written and oral evidence of Witness D and Witness B who told the panel that the times of 18:00 and 19:20 had been prepopulated on Patient A's chart. The panel should consider that

there is sufficient evidence before it to support the charge and all the witnesses have affirmed that the charts were prepopulated.

The panel took account of the submissions made by Mr Claydon and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that, properly directing itself on the law and the burden and standard of proof, it could find the facts proved and whether you had a case to answer.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 1 proved on the basis that the sole and decisive evidence in relation to this charge is inadmissible.

The panel determined there had been sufficient evidence to support the remaining charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer in respect of charge 11. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Assessment of witnesses

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness B: At time of the incident Witness B was working as a Junior Charge

	Nurse and was the nurse in charge of the ward on that shift.
• Witness C:	Witness C at the time of the incident worked as the line manager to Witness E. Witness C was not present on the ward at the time of the incident but was working on the ward the next day on 2 October 2017.
• Witness D:	Witness D is a registered nurse and was employed as a junior sister. At the time of the incident they were working on the ward and were also the nurse in charge.
• Witness E:	Witness E is a registered nurse, was working as a senior nurse for Neurosciences and Stroke and your line manager. They were not present at the time of incident.
• Witness F:	Witness F was at the time of the incident working as a Health Care Assistant (HCA) on the ward assisting you.

The panel also heard live evidence from you.

The panel considered the evidence of the witnesses and assessed their evidence as follows:

Witness B:

The panel was of the view that Witness B was a credible and reliable witness. They were clear when they could not recall some of the evidence.

Witness C:

The panel considered Witness C to be a credible and helpful witness. The panel accepted that the passage of time had an impact on their recall but the panel was satisfied that they did their best to assist the panel. They were not present during the incidents and were only able to provide evidence relating to their meeting.

Witness D:

The panel also considered Witness D to be a credible and reliable witness. They were clear about what they could not recall. They also corrected themselves a number of times when they thought they were speculating, so was considered as fair to you.

Witness E:

The panel considered Witness E to be clear, credible and confident during their live evidence. They told the panel that they should have taken notes at the meeting following the incident.

Witness F:

The panel considered Witness F to be a reliable and credible witness. They reflected whilst giving their evidence and clarified when they were unsure about things. Their recollection of the events was somewhat different in their oral and written evidence.

You:

The panel did not find you to be a credible or reliable witness and did not accept the account you gave. You focused on your inability to perform the sliding scale machinery and deflected blame onto others. The panel noted that you continually said *"I cannot remember*", "*I didn't know what I was doing*" and *"I was confused"* when you were asked difficult questions.

Background

You commenced employment as a registered nurse at the Barts Health NHS Trust ('the Trust'), Royal London Hospital on 15 August 2016.

The ward is a hyper acute stroke unit with the capacity to take 26 stroke patients. Patients are usually submitted to the ward from A and E. The ward is divided into bays and side rooms and you were allocated side rooms 21 to 26, who were rehab patients. Patients in the bays are cardiac monitored patients and the patients in the side rooms are the more stable and are rehab patients who do not require cardiac monitoring.

The evidence was that on 1 October 2017, you were allocated to side rooms 21 to 26. This was a management decision because you were not trained in cardiac monitoring. You started your shift with five patients which increased to six during the shift. One patient was receiving end of life care. Witness B indicated that this was a normal and usual workload. You were allocated Witness A to assist you as well as HCA's Witness F and Witness G.

On 1 October 2017 you were working a 12.5 hour day shift on the ward. A number of staff took the blood glucose readings that were recorded on a glucometer for Patient A and reported these readings to you for inputting into the patient's diabetic chart.

Upon later checking Patient A's glucometer printout, it is alleged that the blood glucose readings you had entered on the diabetic chart were false. In addition the times of future blood glucose readings (but not the blood glucose results) had already been pre-populated in the patient's diabetic chart.

Upon investigation, it is also alleged that you did not manage Patient A's blood glucose levels effectively with the sliding scale insulin and as a result Patient A experienced hypoglycaemic episodes. Consequently the senior nurses transferred the care of all your patients to other nurses for the remainder of that shift, as they believed their safety may be compromised if you were to continue to care for them.

Witness E reported the concerns to her line manager, Witness C. Witness C and Witness E held a meeting with you and you were asked to provide your written version of events. You were suspended with immediate effect and an investigation commenced.

On 10 December 2017 you handed in your resignation from the Trust in order to retire.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Claydon and those made by you.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will

be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel first considered whether or not you had an obligation to perform the duties as alleged. It determined that you were required to look after rehab patients in beds 21-26, including Patient A, and that your workload on the shift on 1 October 2017 whilst heavy, was not onerous. You had the assistance of two HCA's and a floating nurse.

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

Charge 2)

That you, a registered nurse, while working at Royal London Hospital on 1 October 2017:

2. Did not ensure that the following blood glucose readings for Patient A were recorded:

a) 2.8 mmol/L at 12:08;
b) 3.2 mmol/L at 12:53;
c) 6.9 mmol/L at 13:30;
d) 9.9 mmol/L at 15:35;

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the printout of all the readings that were stored in the glucometer from the shift in question. The glucometer printout shows the ID numbers of staff members along with the reading and the time that they were taken. The four blood glucose readings that form this charge were taken by staff members other than you.

Further the panel had regard to the verbal and written evidence from Witness B, Witness F and Witness G. The panel noted that there were differing accounts as to whether HCAs or nurses recorded the blood glucose readings on Patient A's diabetic chart. However the panel accepted that it was your responsibility as the nurse allocated to this patient to ensure that the blood glucose readings were recorded on the patient's diabetic chart and they were not.

Charge 3)

That you, a registered nurse, while working at Royal London Hospital on 1 October 2017:

3. Recorded inaccurate blood glucose readings in Patient A's Variable Rate Intravenous Insulin Infusion Administration Chart ('chart') of:

a) 12.3 mmol/L at 10:05;
b) 6.0 mmol/L at 11:20;
c) 4.0 mmol/L at 12:00;
d) 5.8 mmol/L at 13:20;
e) 6.2 mmol/L at 14:10;
f) 6.4 mmol/L at 15:00;
g) 7.0 mmol/L at 16:05;

This charge is found proved in its entirety.

The panel took into account the oral and written evidence of Witness B and Witness C who both informed the panel of the necessary procedures that were required when blood glucose readings were taken and recorded.

In reaching this decision, the panel had regard to Patient A's diabetic chart and the electronic blood glucose printout for Patient A on 1 October 2017. These documents show readings were recorded by you on to Patient A's diabetic chart, however examination of the blood glucose machines indicated that these readings were inaccurate as they did not occur. No tests were carried out by you at all on 1 October 2017.

Charge 4)

4. Your actions in charge 3 above were dishonest, in that you recorded blood glucose readings on one or more occasions, which had not been taken

This charge is found proved.

In reaching this decision the panel had regard to your written and oral evidence.

The panel considered whether or not there was an alternative explanation for the recording of blood glucose readings when they had not been taken. It considered your evidence that you were stressed and overworked that day. It rejected your evidence in this respect for a number of reasons. Whilst the panel accepted that you might have felt stressed, it did not accept that this was an alternative explanation for not taking seven blood glucose readings, and falsely recording that you had taken them.

The panel determined that it was your obligation as the nurse with responsibility for the patient to make sure those accurate recordings were made. The cumulative effect of the number of occasions you failed to perform readings and falsified the blood glucose readings on the diabetic chart drove the panel to the conclusion that there was no viable alternative explanation other that you were dishonest.

Charge 5)

5. Did not escalate the blood glucose readings at charge 2(a) and/or (b) above, which indicated a hypoglycaemic episode

This charge is found proved.

The panel had regard to the written evidence of Witness B and Witness C, who both confirm that if you had taken action by stopping the sliding scale and consulting a doctor/ nurse in charge, then you would have recorded this in Patient A's notes. You did not.

The panel heard and saw documentary evidence confirming that you were trained on diabetes and the use of insulin and therefore it would have been your professional duty as a registered nurse to escalate the readings to a senior colleague.

Witness B referred the panel to the nursing notes in the bundle and told the panel that there is no record of you taking action or escalating the readings. Further he told the panel that you did not inform him, as the nurse in charge, of Patient A's hypoglycaemia.

The panel noted the difference between your written submissions in which you stated that you had restarted the 5% dextrose intravenously however your oral evidence to the panel was that you could not remember anything that happened as you were *"so stressed"* and busy.

The panel took the view that in light of the lack of supporting evidence of any action taken by you, it was on the balance of probabilities that the blood glucose readings at 2a and 2b were not escalated.

Charge 6)

6. Did not adjust or record that you had adjusted the insulin sliding scale at any stage, as required

This charge is found proved.

The panel heard evidence from various witnesses that the use of the sliding scale insulin is a basic requirement on this ward. Whilst you have explained that you were "*uncomfortable*" and unable to use it, there is no evidence that you asked either Witness B or Witness D for assistance in looking after the sliding scale insulin for this patient.

The panel had regard to the policy regarding the use of sliding scales apparatus that provides explicit instructions on the doses of insulin to be used. The panel noted that there was no documentary evidence to indicate that you made adjustments or recorded any information pertaining to the sliding scale.

The diabetes policy available to you clearly indicated the steps required to either adjust or record the sliding scale insulin. The panel concluded that even with a lack of knowledge as indicated by you, the policy advised you to alert the nurse in charge/doctor or undertake some adjustment or recording in respect of the sliding scale insulin. You did not do this nor did you record that you had not received support and were unable to do so.

The panel was of the view that as the nurse responsible for Patient A, even if you did not feel competent in using the sliding scales, you should have recorded that concern in writing. Whilst you gave evidence that you complained to Witness D, this is not corroborated as the witnesses says this was not raised. The panel therefore preferred the evidence of Witness D, in that you did not raise any concerns about your use of the sliding scale.

Charge 7)

7. Recorded that a blood glucose reading of 11.1 mmol/L had been taken at 17:15 when it had not

This charge is found proved.

The panel had regard to the glucometer printout which shows that there was no reading taken at 17:15.

Further the panel took into account the written evidence of Witness B. He had been informed that you were on a break at 17:15 making it impossible for you to have recorded the reading.

Based on the evidence before it, both oral and written the panel determined that you recorded the blood glucose reading had been taken at 17:15 when it had not.

Charge 8)

8. Your actions in charge 7 above were dishonest, in that you recorded that a blood glucose reading had been taken at 17:15 when you knew that was not the case

This charge is found proved.

In reaching its decision the panel considered the same evidence and made its decision for the same reasons as set out in charge 4. The panel considered whether or not there was an alternative explanation for the recording of a blood glucose reading at 17:15 when it had not been taken. It considered your evidence that you were stressed and overworked that day. It rejected your evidence in this respect for a number of reasons. Whilst the panel accepted that you might have felt stressed, it did not accept that this was an alternative

explanation for not taking a blood glucose reading at 17:15, and falsely recording that you had.

The panel determined that it was your obligation as the nurse with responsibility for the patient to make sure that accurate recordings were made. The cumulative effect of the number of occasions you failed to perform readings and falsified the blood glucose readings on the diabetic chart drove the panel to the conclusion that there was no viable alternative explanation other than that you were dishonest.

Charge 9)

> 9. Recorded that the insulin rate was running at 4ml per hour at 17:15 when it was running at 1ml per hour

This charge is found not proved.

In reaching its decision the panel had regard to Patient A's diabetes chart, which shows that the volume in the syringe driver was 30 mls at 16:05. At 17:15 the remaining volume was 27mls, showing that 3mls had been used in the previous 70 minutes. The panel noted that although you recorded the insulin rate as running at 4mls per hour, according to Patient A's diabetes chart, the remaining volume indicates that it was running at up to 2-3mls per hour and therefore factually the charge cannot be found proved.

Charge 10)

> 10. Your actions in charge 9 above were dishonest, in that you recorded that the insulin rate was running at 4ml per hour when you knew that was not the case

This charge is found not proved.

In reaching its decision the panel considered the same evidence as set out in charge 9 and decided for the same reasons that this charge cannot be found proved.

Charge 11)

11. Recorded the times 18:00 and 19:20 on Patient A's chart, which:

(a) Were pre-populated;

(b) Were incorrect as subsequent blood glucose checks were required at regular one hour intervals.

This charge is found not proved in its entirety

In reaching this decision the panel had regard to Patient A's diabetes chart, which had hand written pre-populated entries at 18:00 and 19:20. There were no blood glucose readings entered at these times, only the time had been entered alongside the scale of the insulin being used. There were no signatures on either entry and the panel had received no written or oral evidence as to who had recorded these entries. The panel was not satisfied that on the balance of probabilities this charge was found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, and only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Claydon invited the panel to take the view that the facts found proved amount to misconduct. He directed the panel to have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (The Code) in making its decision.

Mr Claydon referred to the specific points of The Code where your actions amounted to misconduct.

Submissions on impairment

Mr Claydon moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Claydon submitted that if the panel are satisfied that the matters found proved do amount to misconduct, the next matter the panel must consider is whether your fitness to practise is currently impaired by reason of that misconduct.

Mr Claydon referred the panel to the judgment of Mrs Justice Cox in the case of *Grant* and the test when considering impairment. He submitted submitted that the panel is likely to find the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of *Grant* instructive. Those questions as are relevant in this case are:

a) Has in the past, and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;
b) Has in the past and/or is she liable in the future to bring the profession into disrepute;
c) Has in the past, and/or is she liable in the future to breach one of the fundamental tenets of the professions;
d) Been dishonest.

He submitted that limbs a, b, c and d of the test are engaged in this case. He submitted that current impairment can be found both on the basis that there is a continuing risk and that the public confidence in the nursing profession and the NMC as regulator would be undermined if such a finding were not made.

Mr Claydon submitted that the clinical errors are remediable and although difficult, your dishonesty is also remediable. He submitted that any evidence of remediation is not present in this case and on that basis there is a high risk of repetition of the charges found proved.

In relation to misconduct and impairment you told the panel that it should consider your unblemished ten year career prior to the incidents that took place. You said had the nurse

manager listened to you and provided you with assistance, the incidents would not have occurred.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of The Code.

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of The Code. It was of the view that your actions breached the following tenets of The Code:

'1.2 make sure you deliver the fundamentals of care effectively

6.2 maintain the knowledge and skills you need for safe and effective practice

8.6 share information to identify and reduce risk

10.1 complete all records at the time or as soon as possible after an event recording if the notes are written sometime after the event

10.3 complete records without falsification

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitability qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

19.1 take measures to reduce as far as possible the likelihood of mistakes near misses, harm and the effect of harm if it takes place

20.1 keep to and uphold the standards and values set out in The Code

20.2 act with honesty and integrity'

The panel appreciated that breaches of The Code do not automatically result in a finding of misconduct. It took account of all the evidence before it and the circumstances of the case as a whole and determined that your actions did amount to misconduct.

The panel determined that your actions fell significantly short of the standards expected of a registered nurse. It was of the view that your misconduct was serious and would be considered deplorable by members of the profession and the public. It noted that you felt that there were issues surrounding your training of the sliding scale insulin and how much support you were given on the ward on the shift in question. However it was of the view that it is inexcusable to falsify a patient's blood glucose readings multiple times, as this put the patient at risk of hypoglycaemia, and the panel considered that this showed a callous disregard for the patient's safety.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

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

The panel found that all of the limbs were engaged in this case.

The panel found that you placed the patient at a risk of harm and was of the view that you are liable to act in a similar way in the future. The panel considered that you did not adhere to the standards expected of a nurse and your behaviour brought the profession into disrepute and breached the fundamental tenets of the profession. In relation to the charges found proved regarding dishonesty, the panel determined that you did not acknowledge or address your misconduct in this respect. To date you have not given any reasons to account for your dishonest actions, expressed any remorse or showed any insight, the panel therefore considered that there is a risk you may act dishonestly in the future.

The panel considered whether your misconduct is capable of remediation. It determined that your clinical misconduct can be addressed by demonstrating sufficient insight and retraining. The panel determined that although a difficult process, your misconduct in relation to dishonesty is such that it is also capable of remediation.

In your oral evidence, you showed no remorse towards the patient, their family, or your colleagues. Since the incident, you have not demonstrated any reflection or undertaken any training in record keeping or in diabetes blood sugar management. Your only response has been to attempt to justify your actions, and you have shown no compassion to the patient.

On the shift in question, the Nurse in Charge had to pass the care of your patients on to other nurses, as they felt these patients would not be safe under your care. You have not shown any insight into how your actions have negatively impacted on the nursing profession.

The panel was not satisfied that you have insight into your actions, that you have demonstrated any remediation, and as such there remains a risk of repetition of your actions.

The panel therefore concluded that a finding of current impairment is necessary on the grounds of public protection and in the public interest.

Sanction

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

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

Submissions on sanction

Mr Claydon submitted that given the seriousness of the regulatory concerns, together with your insufficient insight, the appropriate sanction is to impose a six month suspension order with a review at the end of the order.

Mr Claydon provided the panel with a list of aggravating factors and submitted that your misconduct related to the deliberate cover up of basic errors that put the patient at a risk of serious harm. He submitted that the incident was entirely avoidable.

Mr Claydon also provided the panel with mitigating factors including no previous referrals to the NMC and a long career in nursing.

You told the panel that you have reflected on the incidents and you expressed remorse for how your actions had impacted the patient, the patient's family and colleagues. You also apologised to the panel for the time they have had to spend on your case. You informed the panel that you [PRIVATE].

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Put a patient at a risk of harm

- Multiple dishonest falsification of records
- Repeated and continued denial of the incidents you were involved in
- Lack of insight

The panel also took into account the following mitigating features:

- You apologised and expressed remorse for your actions at the final stage of the hearing
- Long previously unblemished career in nursing

Further the panel had regard to the NMC sanctions guidance 'Considering sanctions for serious cases'. The panel determined that your misconduct was serious in that it involved a vulnerable diabetic patient and a deliberate breach of your professional duty of candour by attempting to cover up the incidents.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues identified. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case relate to dishonesty. Furthermore, the panel concluded that the placing of conditions of practice on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *'A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour'*

The panel considered that yours was not a single instance of misconduct and that there was evidence of attitudinal concerns. Further, it considered that you have not displayed any insight into the regulatory concerns and that there remains a risk of the misconduct being repeated.

The panel found that whilst the charges relate to one day and one patient, you failed to take multiple blood sugar readings, falsified patient records to imply that you had taken them, and persisted in your denial of what you had done. It was only in the final stage of this hearing that you expressed any remorse. You still however had no insight into the significance of your misconduct. The panel noted that at the time of the incidents, despite

having a number of opportunities to correct your behaviour and act in a professional and honest way, you sought to blame others for your actions and disregarded those impacted by your misconduct. Further, you have maintained this attitude through-out these proceedings. The panel has found that it is likely that your behaviour would be repeated and, as a consequence, you pose a risk to patients or service users.

Your misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel determined that your misconduct raises concerns about your professionalism, and considered that other nurses would find it difficult to place their confidence in a colleague who had acted in such a dishonest manner, and placed a patient at risk of harm. Further, members of the public would find it difficult to place their trust in a nurse who had falsified records and put a patient at real risk of significant harm.

The panel also considered the NMC guidance *'*Cases involving dishonesty*',* in particular:

"The most serious kind of dishonesty is when a nurse, midwife or nursing associate deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone's care…

… Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients"*

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

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

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

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Claydon. He submitted that an interim suspension order is necessary for a period of 18 months.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

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

This decision will be confirmed to you in writing.

That concludes this determination.