

**Nursing and Midwifery Council  
Fitness to Practise Committee**

**Substantive Hearing**

**Monday, 22 July 2024 – Thursday, 1 August 2024**

Virtual Hearing

**Name of Registrant:** **Tendai Sandra Mukanganise**

**NMC PIN** 21D1239E

**Part(s) of the register:** Nurses part of the register Sub part 1  
RNA: Adult nurse, level 1 (24 July 2021)

**Relevant Location:** Manchester

**Type of case:** Misconduct

**Panel members:** Peter Fish (Chair, Lay member)  
Sharon Peat (Registrant member)  
Nicola Strother Smith (Lay member)

**Legal Assessor:** Trevor Jones

**Hearings Coordinator:** Franchessca Nyame

**Nursing and Midwifery Council:** Represented by Laurence Harris, Case  
Presenter

**Ms Mukanganise:** Present and unrepresented

**Facts proved:** Charges 1a, 1b, 2a, 2b, 3, 4 and 5

**Facts not proved:** Charge 1c

**Fitness to practise:** Impaired

**Sanction:** **Striking-off order**

**Interim order:** **Interim suspension order (18 months)**

## **Detail of charges**

That you:

1. Whilst employed by Person A as a carer for Person B:
  - a. on or around 17 May 2021 accepted a loan from Person A for £5,000;  
**[PROVED BY WAY OF ADMISSION]**
  - b. on or around 22 July 2021 accepted a loan from Person A for £10,000;  
**[PROVED BY WAY OF ADMISSION]**
  - c. took no action to address an overpayment of approximately £2,690 that you received from Person A.
  
2. On or around 19 August 2021 presented a cheque to a bank for £10,000 purporting to be signed by Person A which:
  - a. had not been signed by Person A;
  - b. you knew had not been signed by Person A.
  
3. Your conduct at charge 1 lacked integrity in that you accepted a loan(s) from Person A for your own financial gain.
  
4. Your conduct at charges 1(a) and/or 1(b) breached professional boundaries.
  
5. Your conduct at charge 2 was dishonest in that you sought to give the impression that Person A had signed the cheque when you knew he had not.

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

## **Facts found proved by way of admission**

You informed the panel that you made admissions to Charges 1a and 1b.

The panel therefore found the above charges proved by way of your admissions in accordance with Rule 24(5) of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004' ('the Rules').

## **Background**

You were referred to the Nursing and Midwifery Council ('NMC') on 24 August 2021 by Witness 2 regarding their concerns of your alleged financial abuse of Person A whilst employed as a carer for Person B.

On 17 May 2021, you accepted a cheque from Person A for £5000, and, on 22 July 2021, you accepted a cheque from Person A for £10,000. Witness 2 alleged that Person A may not have had full capacity and that you pressured Person A into giving these loans.

Witness 2 states that, on 19 August 2021, they were informed that you had presented a forged cheque of £10,000 to your bank. Witness 2 alleges that Person A's bank realised it was not Person A's handwriting or signature on the cheque and asked the payee's bank to put a stop on the cheque. Witness 2 reported their concerns about the forged cheque and financial abuse to the police on 24 August 2021.

Person A was diagnosed with Dementia on 30 September 2021 and passed away on the 10 September 2022. Following a review by Witness 1 and Witness 4 of Person A's paperwork of the amounts you were paid; it is also alleged that you received an overpayment of £2,690.

The police decided to take no further action on 23 May 2023.

## **The panel's direction for further documentation**

In the course of Witness 4's answers to questions from the panel, it was apparent that they were referring to photographs of pages from Person A's payment book which they believed had already been sent to the NMC but was, in fact, not before the panel. Earlier pages from the payment book were included in the Exhibit Bundle but they did not cover the dates between April 2021 and August 2021 relevant to Witness 4's calculations exhibited in the bundle in relation to Charge 1c.

The panel invited submissions from Mr Harris and you in turn.

Mr Harris indicated that he would seek to make this information available to the panel if they considered it relevant to the discharge of its functions.

You indicated that you would like to see these further notes of payments in order to understand Witness 4's oral evidence better and to be able to conduct a comprehensive cross examination in that you could more effectively question Witness 4's recollection of events.

In fairness to all, the panel considered advice from the legal assessor with reference to NMC guidance DMA-6: 'Evidence', last updated 1 July 2022 which states:

### *'Further Evidence*

*Our overarching objective is to the protection of the public. Because of this, the panel has a responsibility to ask us to obtain further evidence if they are concerned that there are gaps in the evidence which prevent them from properly performing their function.'*

There is a footnote attached to the above guidance which refers to the case of *Professional Standards Agency v (1) Nursing and Midwifery Council and (2) Jozi* [2015] EWHC 764 (admin).

The panel considered the relevant NMC guidance and was of the view that Witness 4 would be surprised that the information that they indicated they had submitted was not before the panel in reaching a decision on facts in relation to Charge 1c.

The panel determined that there was no injustice to you if the panel and the parties having sight the further notes of payments as you wished to better understand Witness 4's evidence and cross examine them in relation to these notes.

The panel adjourned the proceedings until the next hearing day to allow time for the further notes of payments to be recovered and considered by parties in accordance with NMC guidance DMA-6.

## **Decision and reasons on gathering further documentation**

During Witness 4's oral evidence, they referred to the existence of a daily "diary" of care notes from the relevant period with regard to Charge 1c in support of their calculations. Witness 4 indicated that they had copies on their iPad but had not previously sent them to the NMC.

Mr Harris stated that he could, again, make enquires with the NMC and seek to make this information available to the panel. However, he submitted that this information was not necessary as it was not a record which would truly reflect any hours worked in required detail.

You said that, if there is a record of hours worked in the care notes, it could clarify where the allegation of overpayment came from and might assist with your case.

The panel considered advice from the legal assessor with reference to NMC guidance DMA-6 and DMA-5: 'Directing further investigation during a hearing' last updated 23 June 2021 which states:

*'There are a number of reasons why a panel may direct us to carry out further investigations. These include:*

- *New information has come to light that neither we nor the nurse, midwife or nursing associate have seen, which could undermine our case, support our case, or support the case of the nurse, midwife or nursing associate.*
- *The information currently before a panel is obviously incomplete or does not cover all the areas of concern. One example of this could be missing pages from patient notes, or from some other important document.*

- *Further information is essential to clarify or expand on evidence already obtained.*
- *The nurse, midwife or nursing associate has provided new information about the context in which the incident occurred which would have a material impact on the outcome of the case.'*

The panel had an example of an entry from the care notes in its Exhibit Bundle. From the description of Witness 4 of how they approached the correlation, and from the example in the bundle, the panel noted that the care notes were a care record and not a detailed timesheet of hours worked by Person B's carers. The panel considered the relevant NMC guidance and was not satisfied that the care notes would clarify or expand on evidence already obtained in relation to Charge 1c.

The panel determined that it that there would be no unfairness or injustice to any party if the panel did not have sight of the further documentation.

The panel therefore decided to proceed without the further documentation from Witness 4.



## Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions from Mr Harris and from 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 heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: One of the attorneys for property and affairs appointed by Person A
- Witness 2: Person A's relative
- Witness 3: Corporate Banking Manager at Person A's bank
- Witness 4: Person B's relative

The panel also heard oral evidence from you.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The panel considered the witness and documentary evidence before it provided by both the NMC and you.

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

## **Charge 1c**

“That you, whilst employed by Person A as a carer for Person B, took no action to address an overpayment of approximately £2,690 that you received from Person A.”

### **This charge is found NOT proved.**

In reaching this decision, the panel took into account the oral evidence of Witnesses 1 and 4, Witness 1's payment spreadsheet from 25 April 2021 to 9 August 2021, Witness 1's photograph of a page from Person B's care notes dated January 2021, and Witness 4's photographs of payment notes from Person A's payment book dated 12 April 2021 to 22 August 2021, and Witness 4's calculations.

In their oral evidence, Witness 1 confirmed that the calculations on their payment spreadsheet were the total pay of all carers for Person B over a 24-hour period. Witness 1 confirmed that they could not discern the pay of individual carers or how many hours they worked. Witness 1 was not able to say that these calculations took into account, for example, bank holidays or overtime.

Witness 4 told the panel that their calculations of payment was synthesised from Person B's care notes, Person A's payment book and their understanding of the agreed daily rates of pay.

You said during your oral evidence that none of the calculations took account of possible areas of additional cost such as overtime, bank holidays, increased pay, food shopping or more. You also informed the panel that Person A was diligent in keeping accurate records, for instance the payment book showed deductions for the repayment of parts of the loans.

Whilst the panel considered Witnesses 1 and 4 to be reliable and credible witnesses, it noted that neither of their calculations factored in additional costs or included a detailed timesheet of hours worked by whom and when.

Although the panel did not find your evidence in respect of this charge to always be consistent, the panel accepted that there may have been periods of overtime and further expenses incurred. The panel considered that the care notes did not give sufficient detail to identify all the hours worked by the individual carers, and that there was some variation in the hourly and daily rates during the relevant period of your employment which were not sufficiently documented, and that there remained a dispute regarding the increase for coordination payments.

In the circumstances, the panel concluded that the NMC had not proved, on the balance of probabilities, that there had been an overpayment of approximately £2,690 as set out in the charge.

### **Charge 2a**

“That you, on or around 19 August 2021 presented a cheque to a bank for £10,000 purporting to be signed by Person A which:

- a) had not been signed by Person A .”

### **This charge is found proved.**

In reaching this decision, the panel had regard to the written statement and oral evidence of Witnesses 1 and 2, your oral evidence, and the photocopy of the cheque for £10,000 dated 26 July 2021.

In your oral evidence before the panel, you admitted to presenting the cheque dated 26 July 2021 at the bank. Although, in Witness 1’s police statement, they said:

*'She stated that it was "not completed by me" and that she knew nothing about it.'*

The panel noted from Witness 3's oral evidence that Person's A bank was different to typical high street banks in that the bank managers had a personal relationship with the customers which, in the panel's view, would have allowed for familiarity regarding Person A's signature. Witness 3 told the panel that a sample signature was kept by the bank for comparison purposes. Witness 3 stated that it was not always the case that the entirety of a cheque needed to be completed by the account holder provided that the account holder signed the cheque.

In their statement, Witness 3 said:

*'I knew Person A for four/five years... On the 19 August 2021 a cheque came through made out to [you] and I could instantly see that it was not Person A's handwriting or signature as I was very familiar with his signature and his style of writing... I immediately got in touch with our fraud and payment teams and asked that they stop the cheque as it wasn't in accordance with our mandate and the payment team stopped the cheque...*

*I showed [Person A] a copy of the cheque... [they] agreed that it wasn't [their] handwriting or signature and [they] got very angry.'*

In light of the above, the panel determined that you presented a cheque for £10,000 which was not signed by Person A. The panel therefore found this charge proved.

## **Charge 2b**

"That you, on or around 19 August 2021 presented a cheque to a bank for £10,000 purporting to be signed by Person A which:

b) you knew had not been signed by Person.”

**This charge is found proved.**

In reaching this decision, the panel took into consideration the written statements and oral evidence of all of the NMC witnesses, and your oral evidence.

When questioned by the panel, the panel noted that you were able to give a detailed explanation of your travel difficulties as a reason for the first loan on 17 May 2021 for £5,000, and that the second loan on 22 July 2021 for £10,000 was given with the intention of you buying a car.

However, the panel was mindful that you were closely cross examined and had a clear opportunity to give an explanation as to the circumstances of the third cheque and how it came into your possession and was, as admitted by you, presented by you to your bank. The panel considered your responses to be vague and evasive. It concluded that you did not give a truthful or transparent explanation of the circumstances in which you alleged you received a third cheque from Person A for £10,000 dated 26 July 2021.

The panel recognised that it had no direct evidence before it that you knew Person A had not signed the third cheque when you presented it at the bank. However, it noted that Person A had signed a £5,000 cheque for you on 17 May 2021, and another £10,000 cheque on 22 July 2021 for you, four days earlier than the third cheque on 26 July 2021. You had seen Person A’s handwriting and signature on these cheques and in Person A’s payment book. The panel determined that it was more likely than not that you would have identified that the signature on the third cheque was different and not Person A’s.

On this basis, the panel concluded that the NMC had proved, on the balance of probabilities, that you presented a cheque for £10,000 purporting to be signed by Person A which you knew had not been signed by Person A.

## Charge 5

“Your conduct at charge 2 was dishonest in that you sought to give the impression that Person A had signed the cheque when you knew he had not.”

### **This charge is found proved.**

When considering the issue of dishonesty, the panel took into account NMC guidance DMA-8: ‘Making decisions on dishonesty charges and the professional duty of candour’, and applied the test for dishonesty as set out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67:

*‘1. The Panel must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his/her belief is a matter of evidence going to whether he/she held the belief, it is not an additional requirement that his/her belief must be reasonable; the question is whether it is genuinely held;*

*2. Once his/her actual state of mind as to knowledge or belief as to facts is established, the question whether his/her conduct was honest or dishonest is to be determined by the Panel by applying the (objective) standards of ordinary decent people. There is no requirement that the individual must appreciate that what he/she has done is, by those standards, dishonest.’*

In reaching this decision, the panel had particular regard to the written statements and oral evidence of all of the NMC witnesses, your oral evidence, and your reflective piece.

In relation to the first limb of the test, the panel has already determined that you knew that the third cheque that you presented to your bank was not signed by Person A.

The panel acknowledged your evidence that you are '*not a dishonest person*' and that '*no incidents or complaints ever raised of [you] being dishonest*' from your current employers. However, in respect of the second limb of the test, the panel concluded that an objective person would consider you presenting a cheque purporting to be signed by Person A but which you knew was not to be dishonest.

Accordingly, the panel found this charge proved.

### **Charge 3**

"Your conduct at charge 1 lacked integrity in that you accepted a loan(s) from Person A for your own financial gain."

### **This charge is found proved.**

In reaching this decision, the panel took into account the written statement and oral evidence from all of the NMC witnesses, your oral evidence, and 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ('the Code').

You admitted Charges 1a and 1b which related to the acceptance of loans from Person A on or around 17 May 2021 and 22 July 2021. Person A was the relative of Person B for whom you were caring. Person B lacked capacity and required 24 hour care. Person A could be considered vulnerable owing to their full-time caring responsibilities for their terminally ill relative in the context of the COVID-19 pandemic. In September 2021, Person A was formally diagnosed with dementia. The panel heard evidence that they had started to become confused before then, and specifically from Witness 2 who had visited their father in June 2021 and noted definite concerns about their cognitive function and commenced the plan for their cognitive assessment. Whilst you denied you were aware of any problems with his mental capacity while you were employed, the panel accepts from the evidence of all 4 witnesses that at least towards the end of the period of your employment Person A was showing signs of confusion.

Your evidence was that your second loan of £10,000 was given to enable you to purchase a car to help with your travel to and from work. However, you made it clear in your evidence that you did not consider you were under any obligation to purchase a car and that you could use the money as you saw fit.

The panel considered that accepting loans from a close relative of a person for whom you were caring – in circumstances where the person giving the loans was vulnerable - showed a lack of integrity on your part. This was further demonstrated by the fact the second loan was given for a particular reason which you clearly had no intention of honouring.

The Code is not merely a rule book, but a compilation of attitudes and behaviours expected to be embodied and lived by nurses, midwives and nursing associates. Though there is no code for carers the public would be shocked if a carer and student nurse did not embody the same attitudes and behaviours as expected of them once they were qualified. To have integrity as described in section 21 of the Code is to have a high standard of morality and behave in a way that preserves the rights of all individuals and included in that is the right to experience the best possible care for yourself and loved ones without prejudice or the need to curry favour with those providing care. Accepting a loan is a direct breach of nursing integrity.

The panel noted that the charges as drafted refer to accepting loans on or around specific dates shortly before you entered onto the Register. At that time, although you were working as a Care Assistant, you were also a student nurse who had completed your clinical placements and were re-sitting some final modules in order to go onto the Register. The loan commitments were entered into shortly before you entered onto the Register – in the case of the second loan just two days. In relation to the second loan, it is very likely you had already submitted your formal application to be entered onto the Register before you accepted this. You were still in possession of Person A's loan once on the Register. In effect, you put yourself in a position where you were indebted to a



vulnerable close relative of the person for whom you were caring whilst a registered nurse. The panel considered that this conduct, much in line with the submissions made on behalf of the NMC on this point, can properly be regarded as continuing after you entered onto the Register.

In those circumstances, the panel considered that this charge is proved.

#### **Charge 4**

“Your conduct at charges 1(a) and/or 1(b) breached professional boundaries.”

#### **This charge is found proved.**

In reaching this decision, the panel took into account the written statement and oral evidence from all of the NMC witnesses, your oral evidence, and the Code.

At the outset of this hearing, you made admissions to Charges 1a and 1b so it has been established that you did accept the first two loans from Person A.

The panel considered your actions here to have breached professional boundaries and section 20.6 of the Code:

*‘20 Uphold the reputation of your profession at all times  
To achieve this, you must:...*

*20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers’*

For the reasons given above in relation to Charge 3, the panel considered that the conduct in Charges 1a and 1b could properly be regarded as continuing after you entered onto the Register on 24 July 2021 and to have breached professional boundaries for the purposes of Charge 4.

Accordingly, the panel finds this charge 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 defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, 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 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, 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 Harris made reference to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a '*word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.*'

Mr Harris made also reference to the case of *R (on the application of) Remedy UK Ltd v General Medical Council* [2010] EWHC 1245, particularly paragraph 37.1 which states:

*'(1) Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur*

*with the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession.'*

Mr Harris submitted that the facts found proved meet the threshold of acts that fall short of what would be proper in the circumstances and fall under both types of misconduct given that your actions did occur in a professional practice context, are sufficiently serious and morally culpable or otherwise disgraceful.

Mr Harris expanded on this point by stating that you became a carer for Person B very shortly before coming onto the Register. He said that there is a nexus between obtaining that employment and your status as a "student/expected nurse". He therefore submitted that all of the facts found proved occurred in the context of your professional practice and are sufficiently serious.

In respect of the second type of misconduct, Mr Harris drew the panel's attention to the terms of the Code, particularly on promoting professionalism and trust. He submitted that the facts found proved are clear breaches of sections 20 and 21 of the Code, specifically:

*'20 Uphold the reputation of your profession at all times  
To achieve this, you must:...*

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

*20.3 be aware at all times of how your behaviour can affect and  
influence the behaviour of other people*

*20.5 treat people in a way that does not take advantage of  
their vulnerability or cause them upset or distress*

*20.6 stay objective and have clear professional boundaries at*

*all times with people in your care (including those who have been in your care in the past), their families and carers*

...

21 *Uphold your position as a registered nurse, midwife or nursing associate*

*To achieve this, you must:*

21.2 *never ask for or accept loans from anyone in your care or anyone close to them*

21.3 *act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care'*

Further, given the dishonesty in relation to Charge 5, Mr Harris stated that the character of your actions is such that it is morally culpable or otherwise disgraceful conduct which would bring disgrace upon the reputation of the nursing profession.

You informed the panel that you were working alone and that you believe the stress from the lone-working environment contributed to your actions because, if you were in the work setting you are in now, you would have had a clear mind as there was continuity.

You stated that you were appreciated so much by your employer when you were in your caring role even when there were family conflicts. You told the panel that you would make sure you would safeguard Person B and distract them from the conflict by making them smile. You said that yourself and Person B has a good relationship in that they would ask for you to make them feel safe and comfortable.

### **Submissions on impairment**

Mr Harris 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) and *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Harris also made reference to the NMC guidance DMA-1: 'Impairment', last updated 27 February 2024 which sets out the factors to consider when assessing whether a professional's fitness to practise is impaired as follows:

1. The nature of the concern:

- a) Whether the professional has in the past acted and/or is liable in the future to act so as to put a person receiving care at unwarranted risk of harm
- b) Whether the professional has in the past breached and/or is liable in the future to breach a fundamental tenet of the profession
- c) Whether the professional has in the past acted and/or is liable in the future to act dishonestly
- d) Context of the error/conduct involved in the concern
- e) Whether it's highly unlikely that the conduct will be repeated

2. The public interest:

Consideration of the public interest will require the Fitness to Practise Committee to decide whether a finding of impairment is needed to:

- uphold proper professional standards and conduct
- maintain public confidence in the profession

Mr Harris submitted that, notwithstanding the facts found proved today, there is no evidence before the panel to indicate that you have any prior acts or omissions that could have put a patient at unwarranted risk of harm. He stated that you came on to the Register shortly after being employed as Person B's carer and so had recently completed your training and should have known not to breach professional boundaries in the way that you did. He reminded the panel that it must decide whether you are liable in the future to act so as to put a person receiving care at unwarranted risk of harm, but submitted that there is a likely risk of harm to other patients who might receive care from you for this reason alone.

Mr Harris submitted that the charges found proved show a clear breach of the fundamental tenet to prioritise people as you prioritised your own finances over your professionalism. He further submitted that you breached the fundamental tenet of promoting professionalism and trust because of your dishonesty.

With regard to whether you have in the past acted and/or whether you are liable in the future to act dishonestly, Mr Harris submitted that presenting a cheque to your bank with full knowledge that it had not been signed by Person A is not only serious, but a flagrant act of dishonesty.

Mr Harris stated that it would be for you to demonstrate to the panel the steps you have taken to address the concerns in order for the panel to determine whether the misconduct is likely to be repeated.

Mr Harris submitted that your breaches of the fundamental tenets of nursing are of such a serious nature that a member of the public who was appraised of all of the facts of this case would be shocked to hear that your fitness to practise was not found to be currently impaired. He said that it would seriously undermine the public confidence in the nursing profession and the NMC as a regulator.

You told the panel that you have undertaken training at every given opportunity seeking to improve your knowledge and skills. You told the panel that caring for others brings out the best in you and that this is something you wish to continue to do in the future. You said that you intended to seek further education in the caring profession as you intended to work looking after others for the foreseeable future.

You stated that you have never put a patient at risk and you take your role seriously. You said that you presently work as a Care Assistant employed by an agency and you largely work within the NHS in what the panel understood to be in hospital settings. You wish to continue working in a clinical setting because you love caring for others and making a difference in their lives. You said that you would prefer to work in an NHS setting with the agency support where you have people to turn to for advice in the event of any difficulties.

The panel accepted the advice of the legal assessor.

### **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. Specifically:

*'20 Uphold the reputation of your profession at all times*

*To achieve this, you must:...*

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

*20.3 be aware at all times of how your behaviour can affect and*



*influence the behaviour of other people*

20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*

20.6 *stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers*

...

21 *Uphold your position as a registered nurse, midwife or nursing associate*

*To achieve this, you must:*

21.2 *never ask for or accept loans from anyone in your care or anyone close to them*

21.3 *act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care'*

However, the panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel also had regard to NMC guidance FTP-2a: 'Misconduct' and FTP-3b: 'Serious concerns which could result in harm if not put right', both last updated on 27 February 2024.

The panel considered the NMC guidance and determined that your breaching of professional boundaries in accepting loans in the circumstances of the facts found proved,

the lack of integrity and dishonesty identified were sufficiently serious and fell significantly short of the conduct and standards expected of a nurse.

As such, the panel found that your actions amounted to serious misconduct.

### **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.

In coming to its decision, the panel had regard to the Fitness to Practise Library, in particular DMA-1, updated on 27 March 2023, which states:

*'The question that will help decide whether a professional's fitness to practise is impaired is:*

*"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

*If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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 *CHRE v NMC and 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; and/or*
- d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

In relation to the first limb, the panel considered that you had not in the past put a patient or patients at unwarranted risk of harm. The panel heard evidence that you had given good care to Person B. The conduct identified involved inappropriate loans from a close relative of a patient and dishonesty in relation to the presentation of a cheque. Having heard from you, the panel was satisfied that you would not put patients at unwarranted risk

through your clinical care. The panel was concerned that you did not fully recognise your ethical obligations to Person A as a close relative of Person B who was the patient. In the light of your limited insight in relation to the financial and ethical issues raised by your conduct, whilst the panel concluded that you were not liable in future to put patients at unwarranted risk of harm, you continue to pose a risk to the public in the future.

The panel was satisfied, in light of its findings of fact, that the remaining three limbs were engaged in relation to your past actions.

The panel found that your misconduct which included dishonesty had breached the fundamental tenets of the nursing profession and therefore brought it into disrepute, and looking forward, in light of your limited insight, there is a material concern that you are currently liable to do so again in the future. The panel was satisfied that confidence in the nursing profession would be undermined if it did not find the charge relating to dishonesty extremely serious.

The panel considered your submissions in which you expressed your efforts to maintain continuity of care for Person B and your continued compassion for patients in a clinical environment. You also gave context to the incidents and made reference to difficult working conditions during the COVID-19 pandemic. The panel acknowledged the unique set of circumstances in your case in that you were neither a qualified nor student nurse at the time. In your submissions, you told the panel that you were often working alone having not had experience of being a registered nurse or receiving the support you would have been accustomed to in your recent training. The panel is aware that newly qualified nurses are provided with a preceptorship programme to guide them as they take on the responsibilities of being a staff nurse; you did not have this mentorship at the time of these incidents.

The panel also took into account your reflective piece and your online training certificates, namely Safeguarding Adults at Risk completed 1 February 2023 and Safeguarding of Vulnerable Adults completed 7 February 2023.

Regarding insight, the panel noted that you expressed regret and demonstrated some insight into the facts found proved. However, the panel was concerned that you have not demonstrated an understanding of the ethical and financial issues in relation to the facts found proved and how your actions impacted negatively on public protection and the wider public interest. The panel was not satisfied that it had seen comprehensive insight, remorse or strengthening of practice from you.

The panel was of the view that, due to your lack of insight, you have not yet properly remediated the concerns, and currently the panel could not be satisfied that your misconduct is highly unlikely to be repeated in the future. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because a well-informed member of the public would be shocked if the panel was minded to make a finding that you are not currently impaired on the basis of the seriousness of the charges found proved. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

## **Sanction**

The panel considered this case very carefully and decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off 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 Harris submitted that no further action is not the appropriate sanction in your case. He said that the seriousness of the charges found proved is such that, on principle, some action must be taken to mark the breaches of fundamental nursing tenets and to promote professional standards and conduct. He added that a reasonable and informed member of the public would be shocked to hear that a registrant facing such serious charges was permitted to practise entirely unrestricted.

Similarly, with regard to a caution order, Mr Harris submitted that the charges proved are too serious because of the dishonesty, lack of integrity and context. He adopted the panel's findings with regard to future risk, and he reminded the panel that these acts were committed during or very shortly after registration. He therefore submitted that a caution order would be insufficient and a more serious sanction is necessary.

In relation to a conditions of practice order, Mr Harris submitted that there is evidence of a deep-seated attitudinal problem as you accepted three cheques for significant amounts of money from Person A for whom there was a credible and consistent body of evidence that they were deteriorating mentally. You then sought to cash the third cheque in the knowledge that it had not been signed by its purported maker which he characterised as flagrant dishonesty.

Mr Harris further submitted that there are no workable or measurable conditions that could address your fitness to practise because of the dishonesty. He said that the charges could not be monitored and assessed in the same way as for example, clinical failings.

For the reasons above, Mr Harris submitted that the panel would be entitled to find that the conditions of practice order is not fair, appropriate or proportionate.

In his submissions on the imposition of a suspension order, Mr Harris stated that this case is too serious for a temporary suspension to be a proportionate sanction.

Mr Harris added that the panel cannot be satisfied that you do not propose a significant risk to members of the public given that these incidents occurred in a context whereby you had ready access to vulnerable individuals, had only just come onto the Register and would have been recently trained in professional ethics. He therefore submitted that the risk to the public remains substantial, notwithstanding your expressed regret.

Mr Harris invited the panel to consider his submissions on seriousness and public protection and then weigh those against the public interest. He submitted that the public would be shocked to hear that a registrant who had taken advantage of a patient's relative was only suspended.

Mr Harris submitted that the proved charges are not a single act of misconduct, but rather are a course of conduct.

Mr Harris highlighted that no adequate explanation has been offered by you as to why you thought that taking the loans was appropriate. He stated that the panel is entitled to conclude that, at the time, you considered your actions to be wholly appropriate. For this reason, he submitted that a suspension order does not go far enough.

Mr Harris submitted that you have not shown significant insight in that you have not made any remarks on the impact of your actions on Person A's family, nor have you expressed any understanding of why it was a breach of professional boundaries to take a loan and why the NMC code is so explicit in its prohibition of taking loans, even from patients' families.

On this basis, Mr Harris submitted that a suspension order would not go far enough to meet the inherent seriousness of the conduct, to guard against the real risk to patients and to assuage what would be justified concerns the public would have in the nursing profession and its regulator were you permitted to practise.

Mr Harris invited the panel to impose a striking-off order.

Mr Harris submitted that the proven dishonesty and lack of integrity raises a fundamental question about your professionalism. He stated that the public confidence cannot be maintained in the nursing profession if you remain on the Register, in part because of how soon after registration this conduct occurred, and because of the extent of the harm caused. He said that your misconduct was unprofessional to the extent that public confidence in your practice could not be regained.

Mr Harris listed the following aggravating features:

- Person A was a vulnerable person
- You financially gained from your breach of professionalism and trust
- Your actions appear to have been premeditated in that Witness 4 spoke with you about other carers' exploitation of Person A and obtaining three cheques cannot be said to be opportunistic or spontaneous
- There were multiple instances of you accepting loans from Person A
- Your rejected defence and inability to offer a truthful or transparent explanation of the circumstances in which you alleged you received the third cheque
- Your lack of insight into your failings



In conclusion, for all the above reasons, Mr Harris submitted that the only appropriate sanction that can adequately reflect the severity of the proven charges whilst achieving the overriding objective of protecting the public and addressing the public interest is a striking-off order.

You stated that you have had time to reflect and a time to look at how things could be done differently during the course of the NMC proceedings.

You said that you feel you would not be able to learn and improve if you were subject to a suspension order or striking-off order.

You told the panel that you wanted an opportunity to implement what you have learned.

You said that you have never caused harm to a patient and have no intentions of doing that in the future. You also highlighted that you apologised to the family and to your regulatory body.

You stated that you have been subject to NMC proceedings for the past 21 months and it has not been easy, but it has given you an insight into the incidents outlined in the charges found proved which you will continue to reflect on.

You informed the panel that you have taken steps to understand the advantages and disadvantages of lone working, and you would never accept anything from a patient or their relatives again. You said that you understand the impact of your actions, not just on yourself, but on the family of Person A as well. You stated that, although it may have been done in good faith, your acceptance of the loans went beyond simple appreciation.

You told the panel that the work you do now is completely different to what you did during the period relevant to the proven charges, and that you understand that it is important that

you do not break the trust of patients, particularly vulnerable patients because they are depending on you.

### **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 bore 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:

- Your abuse of a position of trust
- Your failure to recognise Person A as vulnerable in that they were the relative of a terminally ill patient and later exhibited signs of confusion
- Your lack of insight into failings
- Although your misconduct was not repeated over an extended period of time, it involved more than one loan for significant sums of money over a period of three months

Whilst the NMC invited the panel to consider your rejected defence as an aggravating feature, the panel considered the applicable guidance to which it was referred and did not accept this characterisation as you are entitled to put your case forward for the panel to consider, and Charge 1c was rejected.

The panel also took into account the following mitigating features:

- You made apologies to Person A's family and the NMC

- You have made efforts to mitigate the risk of repetition with supervision and no lone working
- The lack of support you had in workplace in the context of the COVID-19 pandemic
- You went to great lengths to care for Person B in the context of the COVID-19 pandemic
- Confusion with regard to Person A's role as an employer, friend and relative of Person B
- Confusion in respect of your role in terms of what your specific obligations were

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. 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 of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case, protect the public or address the public interest.

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 took full account of the nature of the work you were undertaking at that time and the difficult context in which you were working, including the fact you were working extended hours alone and unsupported by senior colleagues during the COVID-19 pandemic.

However, the misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. Although there was no evidence of repetition of behaviours since the incidents, the panel was not satisfied that you have shown sufficient insight to conclude that the risk of repeating the behaviour is highly unlikely. The panel considered that, although it may not be appropriate to characterised what had occurred as demonstrating a deep-seated personal or attitudinal problem, it was nevertheless concerned about your lack of clear understanding of, and reflection on, the financial and ethical issues involved. The panel was particularly concerned that you provided no explanation of the circumstances in which you received the third cheque and presented it to your bank. The panel also considered that the nature of the breaches, including the proven dishonesty and the breach of trust involving a vulnerable person, were so serious as to be fundamentally incompatible with you remaining on the Register.

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

Finally, in looking at 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 bore in mind that your explanations of the circumstances in which you received the third cheque were vague and evasive, and it concluded that your response was not truthful or transparent. Given this, and the fact that the proven charges for the reasons stated above are so serious, the panel determined that your misconduct raises fundamental questions about your professionalism.

The panel concluded that your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you 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 nursing 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 concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was a necessary and proportionate response 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.

This will be confirmed to you in writing.

## **Interim order**

As a striking-off order cannot take effect until the end of the 28-day appeal period, the panel 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 own interests until the striking-off sanction takes effect.

## **Submissions on interim order**

Mr Harris submitted that an interim order is necessary to protect the public and meet the wider public interest. He invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

You did not oppose the application.

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

## **Decision and reasons on interim order**

The panel was satisfied that an interim suspension order is necessary to protect the public and otherwise in the public interest. The panel had regard to the seriousness of the misconduct and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It considered that to not impose an interim suspension order would be inconsistent with its earlier findings.

Therefore, the panel 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 will be confirmed to you in writing.

That concludes this determination.