Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday, 30 July 2024 – Thursday, 1 August 2024

Virtual Meeting

Name of Registrant:	Ian O'Connor
NMC PIN	99I0580S
Part(s) of the register:	Registered Nurse Sub part 1 RNA: Adult nurse, level 1 (7 September 2003)
Relevant Location:	Penarth
Type of case:	Misconduct
Panel members:	Peter Wrench (Chair, lay member) Catherine McCarthy (Registrant member) Jim Hurden (Lay member)
Legal Assessor:	Ashraf Khan
Hearings Coordinator:	Clara Federizo
Facts proved:	Charges 1a(i), 1a(iii), 1a(iv), 1a(v), 1b(i), 1b(iii), 1b(iv), 1b(v) and 1c
Facts not proved:	Charges 1a(ii) and 1b(ii)
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mr O'Connor's registered email address by secure email on 17 June 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, that this meeting will take place on or after 23 July 2024 and the fact that this meeting was to be heard virtually.

In the light of all of the information available, the panel was satisfied that Mr O'Connor has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse:

1) On 18 August 2020:
   a) In relation to Patient A:
      i. Changed their NEWS score from a 8 to a 6. **[PROVED]**
      ii. Your conduct at 1a) i) was dishonest as you intended to create a misleading impression in respect of the NEWS score in relation to Patient A. **[NOT PROVED]**
      iii. Failed to record your conduct at 1a) i). **[PROVED]**
      iv. Failed to assess and / or undertake your own observations. **[PROVED]**
      v. Failed to escalate their condition to senior management and / or a doctor. **[PROVED]**

   b) In relation to Patient B:
      i. Changed their NEWS score from a 7 to a 5. **[PROVED]**
      ii. Your conduct at 1b) i) was dishonest as you intended to create a

misleading impression in respect of the NEWS score in relation to Patient B. **[NOT PROVED]**

iii. Failed to record your conduct at 1b) i). **[PROVED]**

iv. Failed to assess and / or undertake your own observations. **[PROVED]**

v. Failed to escalate their condition to senior management and / or a doctor. **[PROVED]**

c) Carried a hospital bleep on your own, despite a requirement to be in the company of another nurse at all times. **[PROVED]**

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

Background

The charges arose whilst Mr O'Connor was employed as a registered nurse by Cardiff and Vale University Hospital Board (the Board). He first joined the NMC Register in 2003.

The NMC received a referral from the Head of Operations for the Board on 16 November 2020. This referral alleged that during a night shift on 18 and 19 August 2020, Mr O'Connor failed in his capacity to ensure two patients received timely treatment by not performing a clinical assessment of the patients, not making accurate documents in the patient notes and not escalating to another practitioner or clinician to follow up later in the shift.

These allegations included that Mr O'Connor lowered the patients' NEWS score (a way of assessing and monitoring for a deteriorating patient whilst on the ward and under observation) and altered their medical chart to create a misleading impression of their condition. Mr O'Connor allegedly failed to safeguard patients by not undertaking observations or reviewing the patients. It is also alleged that he acted outside the scope of his competence as he took responsibility of the full duties of a Nurse Practitioner when he was supposed to be working supernumerary, as he was subject to a performance development plan at the time.

Subsequent to a disciplinary hearing in relation to the 2020 incidents, Mr O’Connor was dismissed for gross misconduct on 21 June 2021.

Mr O’Connor had faced similar allegations in 2019 at a local level and in early 2021 he was issued a First Written Warning.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and from Mr O’Connor.

The panel noted that at the early stages of the local and NMC investigations, Mr O’Connor had partially admitted to the allegations at charges 1a and 1b in his statements, with the exception of the alleged dishonesty in relation to these. [PRIVATE].

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Agency Nurse who worked with Mr O’Connor in August 2020;
- Witness 2: The investigating officer who conducted the Board’s internal disciplinary investigation.

The panel also had regard to written reflections from Mr O’Connor.

Before making any findings on the facts, the panel accepted the advice of the legal assessor. It considered the documentary evidence provided by both the NMC and Mr O'Connor.

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

Charge 1a(i)

> *"That you, a registered nurse:*
> 1) *On 18 August 2020:*
>   a. *In relation to Patient A:*
>   i. *Changed their NEWS score from a 8 to a 6."*

This charge is found proved.

In reaching this decision, the panel took into account the NEWS Chart of Patient A, the local and NMC statements of Witness 1 and Mr O'Connor's admissions at the local disciplinary interview on 15 December 2020.

The panel had regard to Witness 1's statement:

> *"…This patient was continuously scoring high, I wanted to cover myself in terms of patient safety so I called Ian. When he came he started to cancel them, he was rubbing the scored off the NEWS chart, this was wrong and the record wasn't true."*

The panel recognised that Patient A's NEWS Chart showed a hand-written change in the total score.

The panel also considered Mr O'Connor's response at the local disciplinary interview, where he was asked: *"The second allegation says that you lowered the NEWS score of a patient. Did this occur on 18th August?"* and *"The NEWS chart for Patient A shows that she had scored 8. This prompted a request for you to assess her. Did you change her score from 8 to 6?"*. Mr O'Connor answered *"Yes"* to both questions.

Further, Mr O'Connor provided his account of the incident:

> *"I was met by an agency nurse, [Witness 1]. She started telling me about the patient. We talked it through for a few minutes. We looked at the NEWS chart…she said that the patient had been on oxygen, but that it wasn't documented on the side of the NEWS chart. That's how I came to reduce the score by two because she said they were on oxygen at that point..."*

The panel therefore finds charge 1a(i) proved by way of Mr O'Connor's admissions that he *"came to reduce the score by two"* and this is substantiated by the witness evidence and contemporaneous documentary evidence.

Charge 1a(ii)

"That you, a registered nurse:

1) *On 18 August 2020:*
    a. *In relation to Patient A:*
        ii. *Your conduct at 1a) i) was dishonest as you intended to create a misleading impression in respect of the NEWS score in relation to Patient A."*

This charge is found NOT proved.

In reaching its decision, the panel considered the statements of Witness 2, reviewed the local investigation report, and took into account the local disciplinary interview along with Mr. O'Connor's reflections.

The panel referred to the NMC guidance on *'Making decisions on dishonesty charges…'* (DMA-8) and considered the following:

- *"what the nurse, midwife or nursing associate knew or believed about what they were doing, the background circumstances, and any expectations of them at the time*

- *whether the panel considers that the nurse, midwife or nursing associate's actions were dishonest, or*
- *whether there is evidence of alternative explanations, and which is more likely."*

The panel applied the 'dishonesty test' set out the case of *Ivey v Genting Casinos* [2017] UKSC 67.

The panel first considered what was Mr O'Connor's actual state of knowledge or belief as to the facts. It had regard to Mr O'Connor's explanation for his conduct at charge 1a(i) of lowering Patient A's NEWS score:

> *"I was met by an agency nurse, [Witness 1]. She started telling me about the patient. We talked it through for a few minutes. We looked at the NEWS chart that she presented. I asked how the patient was doing. She said that 'the NEWS isn't dictated by what the obs are'. I asked how she felt about the two patients. I asked if they needed to be reviewed straightaway. She said they didn't need to be. We made a verbal plan that she would bleep me if there was a change in patient condition. Previous to that, she said that the patient had been on oxygen, but that it wasn't documented on the side of the NEWS chart. That's how I came to reduce the score by two because she said they were on oxygen at that point. She said they were on one or two litres. Oxygen should be signed for on the side of the NEWS chart."*

The panel noted Mr O'Connor's responses in relation to his state of mind at the time of the events, highlighting [PRIVATE] and how this impacted him during the night shift on 18 August 2020.

The panel noted the evidence of Witness 2 who produced a transcript of the local level disciplinary interview with Mr O'Connor where, at paragraphs 34-38 of exhibit AW/2, it is pointed out by Witness 2 that Mr O'Connor has incorrectly discounted the inspired oxygen from the patients' NEWS scores. When this was highlighted to him and he was asked if this was the correct way to calculate the NEWS score, Mr O'Connor acknowledged at paragraph 37: *"Looking back now, its not"*. The panel determined that this

acknowledgement was more likely the action of a nurse recognising a genuine mistake, than the actions of a person who had engaged in a deliberate act to mislead.

The panel then went on to consider whether Mr O'Connor's conduct was dishonest by the standards of ordinary decent people. It determined that, although Mr O'Connor's actions in incorrectly changing Patient A's NEWS score were unacceptable, his explanation for these actions was plausible. Given his conversation with Witness 1 about Patient A's condition at the time, a reasonable and well-informed member of the public would not find his actions dishonest. The panel was not convinced there was sufficient evidence to undermine Mr O'Connor's explanation or to establish that his conduct was intended to create a misleading impression. The panel had evidence before it that any score above 2 would be considered an elevated NEWS score. It concluded that if Mr O'Connor was seeking to create a misleading impression in relation to Patient A's condition, he would have changed the score to be significantly lower than '6'.

Therefore, in considering what Mr O'Connor knew or believed about what he was doing, the background circumstances and expectations at the time, the panel determined that Mr O'Connor's actions were not dishonest. It found that there was contemporary evidence from Mr O'Connor at the local disciplinary interview providing an alternative, more plausible explanation for his actions, rather than a deliberate intention to mislead.

The panel concluded that it did not have sufficient information to be satisfied that the NMC had discharged the burden of proving this charge on the balance of probabilities.

Accordingly, the panel finds charge 1a(ii) not proved.

Charge 1a(iii)

"That you, a registered nurse:

1) On 18 August 2020:

a. In relation to Patient A:

iii. Failed to record your conduct at 1a) i)."

This charge is found proved.

The panel had regard to Patient A's record and patient notes, the statements of Witness 1 and Witness 2 and Mr O'Connor's reflections.

In reaching this decision, the panel first considered whether there was a duty on Mr O'Connor to record the change he made to the score on Patient A's NEWS Chart. The panel determined that in making a decision regarding Patient A's care, there was an expectation and an obligation on Mr O'Connor to record that such a decision was made and the reasons for it.

The panel accepted Mr O'Connor's explanation that notes could not be recorded on the NEWS Chart. However, the panel determined that Mr O'Connor could have and should have done so on Patient A's notes. The panel noted that Mr O'Connor was an experienced Band 7 nurse, thus, he should have known he had a responsibility to record the reasons for the changes he made. The panel noted that Mr O'Connor would have had the appropriate system access to make an entry into Patient A's record.

The panel had sight of Patient A's NEWS Chart, Datix report and patient notes, however, there was no record of Mr O'Connor's actions or rationale in changing Patient A's NEWS score from an 8 to a 6. He simply crossed out one number and wrote in another.

Accordingly, the panel decided that, on the balance of probabilities, it was more likely than not that Mr O'Connor failed to record his actions in charge 1a(i) as there was no reason why this could not have been completed in some form. Therefore, the panel finds charge 1a(iii) proved.

Charge 1a(iv)

"That you, a registered nurse:

1) *On 18 August 2020:*
    a. *In relation to Patient A:*
        iv. *Failed to assess and / or undertake your own observations."*

This charge is found proved.

The panel took into account the documentation from the local investigation, the witness statements and Patient A’s records.

The panel first considered whether there was a duty on Mr O’Connor to assess and/or undertake his own observations of Patient A. The panel noted Mr O’Connor’s explanation that he changed Patient A’s NEWS score after speaking to Witness 1 about Patient A’s condition. However, the panel determined that there was an obligation on Mr O’Connor to undertake his own observations and assess the patient himself in order to be confident in his decision of changing the patient’s NEWS score.

The panel accepted the evidence of Witness 2, which set out what was expected of Mr O’Connor at the time:

> *“Ian should have assessed the patient and undertaken his own set of observations, he should have developed a plan for how he was going to deal with patient who was very unwell… Observations should include taking the patient’s temperature, respiratory rate, oxygen rate, blood pressure, heart rate and neurological observations.”*

The panel had regard to the evidence of Witness 1 at the local investigation interview, where Witness 2 asked *‘Did Ian review the patients?’* and Witness 1 answered:

> *“He looked at the notes, he didn’t see the patients. He stayed by the notes trolley. It wouldn’t have been possible to see the patient from where he was stood. I was concerned that he didn’t go to see the patients.”*

The panel accepted the evidence of Witness 1. There was no other evidence before the panel to suggest that Mr O’Connor undertook observations.

The panel concluded that, on the balance of probabilities, it was more likely than not that Mr O’Connor failed to assess and / or undertake his own observations.

Accordingly, the panel finds charge 1a(iv) proved.

Charge 1a(v)

"That you, a registered nurse:

1) On 18 August 2020:

a. In relation to Patient A:

v. Failed to escalate their condition to senior management and / or a doctor."

This charge is found proved.

The panel took into account the documentation from the local investigation, the witness statements and Patient A's records.

The panel first considered whether there was a duty on Mr O'Connor to escalate Patient A's condition to senior management and / or a doctor. The panel concluded that as Patient A's condition was deteriorating, and the NEWS score was relatively high for this specific patient, there was a duty to escalate this information to a doctor.

The panel accepted the evidence of Witness 2, which set out what was expected of Mr O'Connor at the time:

> *"Ian should have also escalated this patient to the medical team on call."*
>
> *"I would have expected the ward to continue to monitor patient and NEWS scoring. I would have expected Ian to have initiated some care plan and notified the medical team."*

The panel also had regard to the evidence of Witness 1, which corroborated this as she was *"unhappy with what he was doing"* and escalated her concerns to the nurse in charge. There was no other evidence before the panel to suggest that Mr O'Connor escalated the concerns regarding Patient A.

The panel concluded that, on the balance of probabilities, it was more likely than not that Mr O'Connor failed to escalate Patient A's condition to senior management and / or a doctor.

Accordingly, the panel finds charge 1a(v) proved.

Charge 1b(i)

> *"That you, a registered nurse:*
>
> *1) On 18 August 2020:*
>
> *b) In relation to Patient B:*
>
> *i) Changed their NEWS score from a 7 to a 5."*

This charge is found proved.

In reaching this decision, the panel took into account the patient records of Patient B and Mr O'Connor's admissions at the local disciplinary interview on 15 December 2020.

The panel considered Mr O'Connor's response at the local disciplinary interview, where he was asked: *"Did you alter the NEWS chart of another Patient B"* and *"Did you lower NEWS score '7' to '5"*. Mr O'Connor answered *"Yes"* to both questions.

The panel therefore finds charge 1b(i) proved by way of Mr O'Connor's admissions and this is substantiated by the contemporaneous documentary evidence.

Charge 1b(ii)

> *"That you, a registered nurse:*
>
> *1) On 18 August 2020:*
>
> *b) In relation to Patient B:*
>
> *ii) Your conduct at 1b) i) was dishonest as you intended to create a misleading impression in respect of the NEWS score in relation to Patient B."*

This charge is found NOT proved.

In reaching this decision, the panel applied the same approach as in its earlier decision in charge 1a(ii). In considering what Mr O'Connor knew or believed about what he was doing, the background circumstances and expectations at the time, the panel determined that although Mr O'Connor's actions were wrong in practice, it had not been proved that they were dishonest. The panel had an alternative explanation from Mr O'Connor, which it found to be plausible, and it was not satisfied that there had been a deliberate intention to mislead.

The panel concluded that it did not have sufficient information before it to be satisfied that Mr O'Connor was dishonest or intended to mislead. The NMC had not discharged the burden of proving this charge on the balance of probabilities.

Accordingly, the panel finds charge 1b(ii) not proved.

Charge 1b(iii)

> *"That you, a registered nurse:*
>
> *1) On 18 August 2020:*
>
> *b) In relation to Patient B:*
>
> *iii) Failed to record your conduct at 1b) i)."*

This charge is found proved.

The panel had regard to Patient B's patient notes, the statements of Witness 2 and Mr O'Connor's admissions.

First, the panel considered whether there was a duty on Mr O'Connor to record the reasons for the change he made to the score on Patient B's NEWS Chart. The panel determined that in making a decision regarding Patient B's care, there was an expectation and an obligation on Mr O'Connor to record that such a decision was made and the reasons for it.

The panel considered that Mr O'Connor was an experienced Band 7 nurse, thus, he should have known he had a responsibility to record his actions. The panel noted that Mr O'Connor would have had the appropriate system access to make an entry into Patient B's record.

The panel had sight of Patient B's patient notes, however, there was no record of Mr O'Connor's actions or rationale in changing their NEWS score from a 7 to a 5.

Accordingly, the panel decided that, on the balance of probabilities, Mr O'Connor failed to record his actions in charge 1b(i). Therefore, the panel finds charge 1b(iii) proved.

Charge 1b(iv)

> *"That you, a registered nurse:*
>
> *1) On 18 August 2020:*
>
> *b) In relation to Patient B:*
>
> *iv) Failed to assess and / or undertake your own observations."*

This charge is found proved.

The panel first considered whether there was a duty on Mr O'Connor to assess and/or undertake his own observations of Patient B. The panel determined that there was an obligation on Mr O'Connor to undertake his own observations and assess the patient himself in order to be confident in his decision of changing the patient's NEWS score.

The panel accepted the evidence of Witness 2, which set out what was expected of Mr O'Connor at the time:

> *"Ian should have assessed the patient and undertaken his own set of observations, he should have developed a plan for how he was going to deal with patient who was very unwell."*

The panel had sight of the patient records of Patient B. There was no evidence before the panel to suggest that Mr O'Connor undertook observations.

The panel considered Mr O'Connor's response at the local disciplinary interview, where he was asked in relation to Patient B: *"Did you asses this patient?"*. Mr O'Connor answered: *"No. As with [Patient A] I lowered the inspired oxygen NEWS score by two."*

The panel therefore finds charge 1b(iv) proved by way of Mr O'Connor's admissions and this is substantiated by the contemporaneous documentary evidence.

Charge 1b(v)

> *"That you, a registered nurse:*
>
> *1) On 18 August 2020:*
>
> *b) In relation to Patient B:*
>
> *v) Failed to escalate their condition to senior management and / or a doctor."*

This charge is found proved.

The panel first examined whether Mr. O'Connor had a duty to escalate Patient B's condition to senior management or a doctor. It concluded that, given Patient B's deteriorating condition and the relatively high NEWS score for this patient, there was indeed a duty to escalate this information to a doctor.

There was no evidence before the panel to suggest that Mr O'Connor escalated the concerns regarding Patient B.

The panel concluded that, on the balance of probabilities, it was more likely than not that Mr O'Connor failed to escalate Patient B's condition to senior management and / or a doctor.

Accordingly, the panel finds charge 1b(v) proved.

Charge 1c

“That you, a registered nurse:

1) On 18 August 2020:

c) Carried a hospital bleep on your own, despite a requirement to be in the company of another nurse at all times.”

This charge is found proved.

The panel took into account the witness statement of Witness 2, the meeting notes following the fast track disciplinary on 30 June 2020 and the development plan for Mr O’Connor dated 19 July 2020.

The panel considered Mr O’Connor’s development plan and was satisfied that this indicated that there was a requirement for Mr O’Connor to be in the company of another nurse at all times.

The panel then had regard to Mr O’Connor's responses at the local investigation interview, where he was asked *“What arrangements were in place for the night shift on 18th August?”* and Mr O’Connor answered:

> *“The plan was that I would be supernumerary with support. We normally have four people covering nights; a site manager, a medical prac, surgical prac and specialist prac. I was meant to be the fifth member of staff. When I arrived on shift on 18th August we had [Nurse 1] working as site manager and [Nurse 2] covering surgery. There was nobody covering medicine or speciality. [Nurse 2] is a band 6. He told me that surgery had been busy. The registrar had been sick and everything was backlogged. He wanted to carry on working in surgery on 18th because he knew what was going on. As I was the band 7, I was put in a position where I had to step up. I took the medical and speciality bleep…”*

The panel concluded that, although there may have been circumstantial reasons for Mr O’Connor’s actions during the shift, this charge was proved by way of Mr O’Connor’s

admission to have carried the bleep when he should not have, as he should have been working alongside another nurse in a supernumerary capacity.

Accordingly, the panel finds charge 1c 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 Mr O'Connor's 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, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr O'Connor's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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.'*

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

The NMC identified the specific, relevant standards where Mr O'Connor's actions amounted to misconduct and submitted the following in writing:

> *"We consider the misconduct serious because it put the safety and wellbeing of patients at risk of harm. The failure to undertake assessments, check on and/or escalate concerns for the unwell patients in this case could have had catastrophic consequences. [Witness 2] notes that any deterioration in the patients' condition could have led to cardiac or respiratory arrest.*
>
> *The conduct is further serious as, it's the NMC's case that, Mr O'Connor was also dishonest. Trust and integrity are fundamental tenets of the profession. Fellow practitioners would consider it deplorable that a registrant deliberately lowered the NEWS scores for significantly unwell patients. Particularly as the NEWS scoring system is designed to protect patients by setting guidelines for them to be appropriately monitored and action taken before their score reaches unsafe levels.*
>
> *In addition, the public would be alarmed that a registered nurse failed to follow basic nursing principles such as preserving patient safety and practising effectively."*

The NMC requires the panel to bear in mind its overarching objective to protect 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.

The panel was referred to the cases of *Roylance v GMC (No 2)* [2000] 1 A.C. 311, *Calheam v GMC* [2007] EWHC 2606 (Admin), *Nandi v GMC* [2004] EWHC 2317 (Admin), *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC [2008] EWHC 581 (Admin).*

The NMC submitted that all four limbs of *Grant* were engaged. However, the NMC emphasized that impairment is a forward-thinking exercise which looks at the risk in the future and whether the concern is easily remediable, has been remedied or likely to be repeated.

The NMC invited the panel to find Mr O’Connor’s fitness to practise impaired on the grounds of public protection and public interest.

In terms of public protection, the NMC submitted that Mr O’Connor has displayed limited insight. He has recognised the seriousness of the concerns [PRIVATE]. [PRIVATE]. Further, Mr O’Connor has not provided evidence to show that he has developed his practice since the incidents by undertaking relevant training, or sufficiently reflecting on the risks his conduct caused to the public and to the public interest.

The NMC submitted that there is a continuing risk to the public due to Mr O’Connor’s lack of full insight and having not had the opportunity to demonstrate strengthened practice through work in a relevant area. Mr O’Connor has not worked in a nursing role since the issues of concern, so has not had the opportunity to demonstrate within a nursing role that he can practice safely, without difficulty.

The NMC submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Mr O’Connor’s conduct engages the public interest because the role of a registered nurse is to provide safe, kind and effective care to patients, when this does not happen the public may feel they cannot trust nurses to look after them when they are unwell. As a result, the public could be reluctant to seek treatment such as by attending a hospital when required.

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 Mr O’Connor’s actions did fall significantly short of the standards expected of a registered nurse, and that Mr O’Connor’s actions amounted to a breach of the Code. Specifically:

‘1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

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

13.4 take account of your own personal safety as well as the safety of people in your care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must, as appropriate:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

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'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel concluded that Mr. O'Connor's actions in changing a patients' risk assessment levels (NEWS score) without first assessing the patients constituted a serious lapse in judgment. This decision, based solely on information from

another staff member, was deemed inadequate. Mr O’Connor’s actions put the patients at risk as it could have resulted in very serious consequences given that the NEWS score affects the level of attention and/or intervention the patient receives. Further, given his role and responsibilities that night (in holding the medical and speciality bleep), Mr O’Connor was expected to support ward nurses and ensure proper escalation of patient concerns. His failure to do so fell short of the conduct expected, particularly from a Band 7 nurse practitioner with his level of experience.

The panel was troubled that Mr O’Connor repeated these actions with two different patients on the same shift, indicating that it was not an isolated mistake. Additionally, his failure to document or note his decision-making process was viewed as a significant breach of nursing standards. Proper record-keeping is a fundamental aspect of nursing practice.

The panel determined that Mr O’Connor neglected clear duties and obligations, such as patient assessment and documentation. These omissions fell significantly below the expected standards of a nurse. Consequently, the panel found that Mr O’Connor’s actions amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr O’Connor’s 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. 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/their fitness to practise is impaired in the sense that S/He/They:

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.'

The panel determined that only the first three limbs of *Grant* were engaged. Having not found dishonesty in its earlier decisions on facts, the panel did not find that the last limb was applicable in this case.

The panel finds that patients were put at risk of harm by lowering the NEWS score of two patients without clinical justification, failing to undertake assessments on them and failing to escalate the concerns regarding their condition to a doctor. Mr O'Connor's misconduct

had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mr O’Connor showed developing insight during the local investigation and made admissions in 2020. The panel acknowledged his reflections on the incident but noted they were primarily focused on [PRIVATE]. The panel was conscious that [PRIVATE] would have been beneficial to further explore this matter and determine if the nexus of these misconduct matters arose as a result of [PRIVATE] that could be supported and managed.

While Mr O’Connor has acknowledged his failings, the panel identified that he has yet to demonstrate an understanding of how his actions put patients at risk of harm, negatively impacted the reputation of the nursing profession, and how he would handle similar situations differently in the future. The panel noted that Mr O’Connor disengaged from these proceedings in 2022, leaving no evidence of further development in his insight since then.

The panel was satisfied that the misconduct in this case could be addressed. Therefore, it carefully considered the evidence before it to determine whether Mr O’Connor has taken steps to improve his practice. The panel took into account Mr O’Connor's reflective accounts; however, the panel had limited information regarding any efforts he has made to enhance his practice. Due to the lack of recent engagement and insufficient evidence of practical improvement, the panel was unable to discern if Mr O’Connor had taken steps to strengthen his practice.

Consequently, the panel determined that there is a risk of repetition based on the absence of any evidence, at this time, which shows Mr O’Connor has developed his insight or strengthened his practice. Therefore, the panel 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 reasonable and will-informed member of the public would be concerned about a nurse that did not undertake the necessary clinical examinations prior to making decisions about a patient's care.

Having regard to all of the above, the panel was satisfied that Mr O'Connor's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mr O'Connor's registration has been suspended.

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.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 17 June 2024, the NMC had advised Mr O'Connor that it would seek the imposition of a striking-off order if the panel found Mr O'Connor's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mr O'Connor's 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:

- Conduct which put two patients at risk of suffering harm by amending their NEWS scores without assessing them.
- Failure of clinical leadership, in that Mr O'Connor was in a senior position as a Band 7 nurse, albeit that he was supposed to be working in a supernumerary capacity at the time.
- Limited insight into failings – whilst Mr O'Connor has provided reflection, it focuses on [PRIVATE] and not the risk of harm to patients.

The panel also took into account the following mitigating features:

- Mr O'Connor has advised of personal mitigation, which includes [PRIVATE].
- Contextual factors – there was short staffing on the night of 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. 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 Mr O'Connor's 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 Mr O'Connor's 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 Mr O'Connor's registration would be a sufficient and appropriate response. The panel is mindful that any

conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are practical and workable conditions that could be formulated, given that the concerns it identified were clinical and it did not find dishonesty or deep-seated attitudinal concerns in this case. The panel considered that the misconduct identified in this case was something that can be addressed through retraining. However, the panel was not convinced that there was a potential and willingness to respond positively to retraining at this time considering Mr O'Connor's disengagement since 2022. The panel would require re-engagement from Mr O'Connor in order to produce workable conditions of practice which mitigate the risks identified and 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;*
- *In cases where the only issue relates to the nurse or midwife’s health, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The charges in this case arose from a single shift and there is no evidence of any repetition. Mr O’Connor has shown some insight and made earlier admissions. The panel did not find any evidence of deep-seated personality or attitudinal problems. The panel was therefore satisfied that in all the circumstances of this case, the misconduct was not fundamentally incompatible with remaining on the register.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr O’Connor’s case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order may cause Mr O’Connor. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel also considered that Mr O’Connor had a nursing career of 18 years prior to this incident and occupied a Band 7 role. It would be in the public interest if he were to re-engage with proceedings to enable him to return to safe practice.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct and to allow Mr O'Connor some time to reflect and re-engage if he decides that he wishes to return to nursing.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Engagement from Mr O'Connor.
- [PRIVATE].

This will be confirmed to Mr O'Connor in writing.

Interim order

As the suspension 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 Mr O'Connor's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC:

> *"If a finding is made that Mr O'Connor's fitness to practise is impaired on a public protection basis and a restrictive sanction imposed, we consider an interim suspension order be imposed if a striking off or suspension substantive order imposed or interim conditions of practice order if conditions are imposed. An interim order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest."*

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 to reflect the seriousness of the charges found proved because to do otherwise would be incompatible with its earlier findings. The period of this order is for 18 months to allow for the possibility of an appeal to be made and concluded.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Mr O'Connor is sent the decision of this hearing in writing.

That concludes this determination.