Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
11 – 15, 19, 22 & 25 – 28 March 2024,
3 – 5, 8 – 9 & 15 – 19 April 2024,
1 – 4 July 2024,
14 – 15 August 2024,
7 & 11 October 2024,
6 – 13 December 2024

Virtual Hearing

Name of Registrant:	**Gareth Brendan McGrattan**
NMC PIN:	91Y0029N
Part(s) of the register:	Registered Nurse Mental Health Nursing – October 1994
Relevant Location:	Antrim and Newtownabbey
Type of case:	Misconduct
Panel members:	Adrian Blomefield (Chair, Lay member) Lisa Holcroft (Registrant member) Seamus Magee (Lay member)
Legal Assessor:	Charlotte Mitchell-Dunn (11 – 28 March 2024, 8 – 9 April 2024, 1 – 4 July 2024, 14 & 15 August 2024, 6 – 13 December 2024) Paul Housego (3 – 5 April 2024) Fiona Moore (15 – 19 April 2024) Patricia Crossin (7 & 11 October 2024)
Hearings Coordinator:	Claire Stevenson (11 – 28 March 2024) & (4 – 15 April 2024) Khadija Patwary (3 April 2024) Dilay Bekteshi (15 – 19 April 2024) Leigham Malcolm (1 - 4 July 2024, 14 & 15 August 2024, 7 & 11 October 2024, and 6 - 10 December 2024)

	Jumu Ahmed (11 - 13 December 2024)
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter
Mr McGrattan:	Present and represented by Dennis Hamill, of Thompsons NI
Facts proved by admission:	Charges 5, 6, 7, 8 and 9
Facts proved:	4a, 4b, 11a, 11b, 12, 13, 14a, 14b, 15b, 16, 17a, 17b, 18a)i) – vi), 18b, 19a, 19b, 21a), 21b)i)-iii), 22a, 22b & 23
Facts not proved:	1a, 1b, 1c, 2a, 2b, 2c(i), 2c(ii), 3, 10a, 10b, 15a, 17c, 17d and 20
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge (as amended)

That you, a registered nurse, working at Carrickfergus Community Mental Health Team:

1. On an unknown date, between 2019 and 29 January 2020, without clinical justification, asked Service User 1 about:
   a) her sex life with her husband; **[NOT PROVED]**
   b) going onto on-line dating sites; **[NOT PROVED]**
   c) whether she ever met strangers for sex or words to that effect. **[NOT PROVED]**

2. By your conduct at Charge 1 above you sexually harassed Service User 1 in that:
   a) it was unwanted; and **[NOT PROVED]**
   b) it was sexual in nature; and **[NOT PROVED]**
   c) it had the purpose or effect of:
      i) violating Service User 1's dignity; or **[NOT PROVED]**
      ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for Service User 1 **[NOT PROVED]**

3. Your actions in Charge 1 above were a breach of professional boundaries. **[NOT PROVED]**

4. On unknown dates between 2019 to 9 March 2020, you:
   a) failed to respond to Service User 2's telephone calls and/or messages; **[PROVED]**
   b) did not telephone Service User 2 back after informing her you would do so. **[PROVED]**

5. On unknown dates between 2018 – June 2020, you failed to: **(proved in its entirety by admission)**
    a) Fully complete and/or record initial assessments for one or more service users including but not limited to those in Schedule 1;
    b) complete and/or record risk assessments of one or more service users including but not limited to those in Schedule 2;
    c) complete and/or record care/management plans assessments for one or more service users including but not limited to those in Schedule 3;
    d) update the Epex system following consultations with service users;
    e) make contemporaneous notes and/or did not mark retrospective entries as retrospective in service users' records;
    f) keep service users' records updated;
    g) left gaps in the running records of service users;
    h) failed to provide information to onward stakeholders.

6. You failed to maintain proper file management by: **(proved in its entirety by admission)**
    a) Not setting up case files for service users;
    b) Using post it notes and loose papers to record patient notes on;
    c) Failing to keep service users records in a secure locked manner.

7. Your actions in Charge 6 above put confidential information at risk of being lost and/or confidentiality being breached. **(proved in its entirety by admission)**

8. You lost and/or failed to report and/or escalate the loss of notes/files for: **(proved in its entirety by admission)**
    a) Service User 16;
    b) Service User 17.

9. Your actions in charge 8 above: **(proved in its entirety by admission)**
    a) Put Service Users 16 and/or 17 at risk of harm;
    b) Breached confidentiality;
    c) Breached data protection;
    d) Breached information governance provisions;
    e) Were a breach of the duty of Candour.

10. On or around 22 June 2020, you failed to follow Covid infection prevention controls by:
    a) not using the outside changing area to put on PPE; **[NOT PROVED]**
    b) entering the Home without wearing PPE. **[NOT PROVED]**

11. On or around 22 June 2020, did not work co-operatively with colleagues by:
    a) Not following instructions regarding the swabbing process; **[PROVED]**
    b) Not helping to clean down the mobile swabbing unit. **[PROVED]**

12. On or around 22 June 2020, informed at least one other person that you were a band 8a qualified nurse when you were not. **[PROVED]**

13. Your actions in Charge 12 above were dishonest in that you sought to misrepresent your level of seniority. **[PROVED]**

Whilst working as a registered nurse at Chester Nursing Home:

14. On or around 18 December 2020 you:
    a) failed to administer Lansoprazole to Residents A and B; **[PROVED]**
    b) signed one or more MAR charts to show the medication had been administered. **[PROVED]**

15. Failed to follow safety procedures in respect of insulin pens, in that:
    a) between 17 and 30 December 2020, you left a needle on an insulin pen; **[NOT PROVED]**
    b) on or around 18 February 2021, left a used insulin needle on an insulin pen. **[PROVED]**

16. On or around 16 January 2021, you failed to check and/or record the blood glucose levels of Resident F before drawing up the insulin and signing the insulin chart. **[PROVED]**

17. On or around 2 February 2021, you:
    a) Failed to administer Levothyroxine to Resident C; **[PROVED]**
    b) Signed the MAR chart that the Levothyroxine had been administered when it had not been; **[PROVED]**
    c) administered two doses of Fultium D3 to Resident D instead of one dose; **[NOT PROVED]**
    d) administered two tablets of Furosemide to Resident E instead of one tablet. **[NOT PROVED]**

18. On or around 14 February 2021, you:
    a) failed to administer the following medications to Resident A:
        ii) Aspirin; **[PROVED]**
        ii) Bisiprolol; **[PROVED]**
        iii) Lercandipine; **[PROVED]**
        iv) Levothyroxine; **[PROVED]**
        v) Moxonidine; **[PROVED]**
        vi) Sodium bicarbonate. **[PROVED]**
    b) Incorrectly signed the record that the medications in a) above had been administered. **[PROVED]**

19. On or around 17 February 2021, failed to record the administration of a new medication namely Cephalexin to Resident F, on:
    a) the MAR chart; **[PROVED]**
    b) the computerised records. **[PROVED]**

20. On or around 17 February 2021, failed to administer Baclofen to Resident D and/or record the administration of Baclofen on the MAR sheet. **[NOT PROVED]**

21. On or around 21 February 2021, you:
    a) Failed to give controlled drug MST to resident G; **[PROVED]**
    b) Incorrectly recorded that you had administered MST to Resident G:
        i) On Resident G's MAR chart; **[PROVED]**
        ii) In the Controlled Drug book; **[PROVED]**
        iii) Without a second checker. **[PROVED]**

22. On or around 21 February 2021, you altered the following records to show that MST had not been administered to Resident G:
    a) Resident G's MAR chart; **[PROVED]**
    b) The Controlled drug book. **[PROVED]**

23. Your actions in Charge 22 above were dishonest in that you sought to conceal your error(s) as set out in Charge 21 above. **[PROVED]**

And, as a consequence of the above, your fitness to practise is impaired by reason of your misconduct.

Decision and reasons on application to amend the charge (day 1)

The panel heard an application made by Mr Kabasinskas, on behalf of the NMC, to amend the wording of charge 9. It was submitted by Mr Kabasinskas that an amendment would correct a typographical error and would not be prejudicial to you.

9. *'Your actions in charge ~~7~~ **8** above:*
    a) *Put Service Users 16 and/or 17 at risk of harm;*
    b) *Breached confidentiality;*
    c) *Breached data protection;*
    d) *Breached information governance provisions;*
    e) *Were a breach of the duty of Candour.'*

Mr Hamill on your behalf did not object to the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to correct a typographical error.

Decision and reasons on application for hearing to be held in private (day 1)

At the outset of the hearing, Mr Hamill, made a request that parts of your case be held in private on the basis that proper exploration of your case may involve reference to your health. The application was made pursuant to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules).

Mr Kabasinskas indicated that he supported the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public. Rule 19(3) states that the panel may hold

hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session should any reference be made to your health in order to protect your privacy.

Decision and reasons on application to admit hearsay evidence (day 1)

After opening the NMC case, Mr Kabasinskas made four applications under Rule 31 to admit hearsay evidence in respect of the following evidence. The applications related to:

i. Witness 1; statement and exhibits;
ii. Service User 2; two handwritten records of a complaint made by Service User 2 produced by two separate nurses;
iii. Witness 2; local statements; and
iv. Witness 3; record of a meeting between Witness 3 and Witness 10.

The panel heard applications on each application and considered them separately.

Mr Kabasinskas drew the panel's attention to the case of *Bonhoeffer v GMC* [2011] *EWHC 1585 (Admin)* and *Thorneycroft v NMC [2014] EWHC 1565 (Admin)*, particularly the factors a panel is required to consider when admitting hearsay evidence as outlined in paragraph 56 of Thorneycroft:

- *'Whether the statements were the sole and decisive evidence in support of the charges;*
- *The nature and extent of the challenge to the contents of the statements;*
- *Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
- *The seriousness of the charge, taking into account the impact which adverse findings might have on the Registrant's career;*

- *Whether there was a good reason for the non-attendance of the witnesses;*
- *Whether the Regulator had taken reasonable steps to secure the attendance of the witness;*
- *The fact that the Registrant did not have prior notice that the witness statements were to be read.'*

Mr Kabasinskas also referred the panel to *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin).

Witness 1; Statement and exhibits;

Mr Kabasinskas invited the panel to accept the written statement of Witness 1. He submitted that despite their non-attendance, the evidence is relevant in this case. He further stated that there would be no injustice to you by admitting the hearsay evidence of the written statement of Witness 1 as it is not sole and decisive evidence. He submitted there is a way to test their evidence. The panel will hear from Witnesses 4 and 5 who can also speak to the same charges.

Mr Kabasinskas stated that the hearsay statement is challenged by you. He submitted that there is no evidence before the panel to suggest Witness 1 fabricated the allegations.

Mr Kabasinskas acknowledged that the charges are serious, and if found proven, may have a negative impact on your career.

In relation to the reasons for the non-attendance of Witness 1, he submitted the NMC had done it's best to secure the witness' attendance. He told the panel that the witness is going to be overseas with no access to the internet. Unfortunately, in these circumstances, the NMC cannot ask a witness to cancel or postpone their arrangements. He stated that were the hearing postponed, this could have a negative impact on the availability of the rest of the witnesses.

Mr Hamill submitted that Witness 1's evidence is sole or decisive in respect of a number of charges. Witness 1 conducted the audit which led to a number of the record keeping charges. The evidence matrix shows she is the only witness in respect of a number of those charges. He submitted other witnesses such as Witness 4 and Witness 5 simply comment on what was reported to them. It is submitted that the audit is key in respect of these charges.

Mr Hamill submitted that you dispute this evidence entirely.

Mr Hamill further submitted that these charges are serious and will have a significant impact upon you if found proved.

Mr Hamill submitted that there is no good reason for the witness not to be present. She has been a willing witness. She told the NMC that she was not available due to being overseas but the NMC have elected to proceed rather than seek to defer the case until the witness was available. He submitted that this is entirely the NMC's right. However, he submitted the NMC must bear the consequences of that decision which he submitted should be the exclusion of Witness 1's evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor referred the panel to the relevant cases which included: *Thorneycroft v Nursing and Midwifery Council*, *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin)*, Mansaray v Nursing and Midwifery Council [2023] EWHC 730 (Admin), Ogbonna v Nursing and Midwifery Council* [2010] EWCA Civ 1216 and *R (Bonhoeffer) v General Medical Council* [2011] EWHC 1585 (Admin).

The Legal Assessor reminded the panel of the principles set out in *Thorneycroft*. With regard to admitting the statements of absent witnesses it was held that, having considered *NMC v Ogbonna [2010] EWCA Civ 1216* and *Bonhoffer*, the following principles emerge:

1. *The admission of the statement of an absent witness should not be regarded as a routine matter and the Fitness to Practise (FTP) rules require the Panel to consider the issue of fairness before admitting the evidence.*

2. *The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but will not always be a sufficient answer to the objection to admissibility.*

3. *The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.*

4. *Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit requires the Panel to make a careful assessment, weighing up the competing factors. The assessment should involve a consideration of the issues in the case, the other evidence to be called and the potential consequences of admitting the evidence and the Panel must be satisfied having undertaken this assessment that, either the evidence is demonstrably reliable or that there is some means of testing its reliability.*

The judgment in *Thorneycroft* went on to summarise the principles arising from previous cases and set out seven considerations which the panel may wish to take into consideration. These considerations are set out above.

The panel accepted that all of the materials presented before it which are subject to the hearsay application are relevant. The panel then considered whether it is fair to admit

hearsay evidence. The panel bore in mind the principles in *El-Karout, Mansaray* and *Thorneycroft* when deciding whether it is relevant and fair to admit evidence.

The panel considered whether the evidence of Witness 1 was sole or decisive. The panel determined that the evidence of Witness 1 was not the sole and decisive evidence which goes to charges 5) and 6). It noted that Witness 1 was responsible for the audits which were done on a contemporaneous basis. The panel noted that Witnesses 4 and 5 both speak to this evidence and are able to comment upon these audits. The panel considers that they have the ability to test the evidence, as Witnesses 4 and 5 are in a managerial capacity and can provide evidence on how the case files are set up. The panel noted that Witness 5 met with you to discuss the issues that arose from the audit therefore that witness can give testimony which directly relates to these discussions.

The panel noted that in terms of challenging Witness 1's evidence, audits had been undertaken contemporaneously by Witness 1 who had significant nursing experience. The audits were routine in nature and resulted in the need for further auditing. There is no information before the panel, and there is no suggestion by any party, to suggest that this witness had fabricated evidence.

The panel determined that there was a good reason for Witness 1 not attending the hearing. The panel noted Witness 1 was overseas for a significant period of time. In reaching its decision the panel noted that this case involves a significant number of witnesses, and as such rescheduling would likely cause further availability issues for other witnesses.

The panel noted that it appears you were advised of hearsay applications during a Case Management hearing in February 2024. However, no bundles were received until some days before the hearing. It noted that Mr Hamill acknowledged that you were not "*ambushed*", and that sufficient time was available to allow you to prepare a response.

The panel conducted a careful balancing exercise and took account of the principles in *El-Karout*, *Mansaray and Thorneycroft*. It considered fairness to the NMC and to you. The panel noted that these are serious allegations however, there is a signed statement from Witness 1 who would have been content to give evidence. The panel considered that the evidence in respect of Witness 1 was not the sole and decisive evidence in respect of charges 5) and 6) and there are other witnesses who can speak to the content of the audit. The panel were content that the NMC had made sufficient attempts to secure the attendance of the witness, but the circumstances precluded this due to them being overseas for a period of time. There was no suspicion nor allegation of fabrication by this witness. In these circumstances, the panel determined that this evidence can be admitted. At a later stage it will consider the weight to be given to that evidence. The panel is aware that it has a responsibility to examine carefully the evidence placed before it by the NMC and not accept at face value without question.

Service User 2; two handwritten records of a complaint made by Service User 2 produced by two separate nurses;

Mr Kabasinskas invited the panel to accept the two handwritten statements submitted by the nursing staff who spoke to Service User 2 about their complaint. He submitted that despite their non-attendance, the evidence is relevant in this case. He further submitted there would be no injustice to you by admitting the hearsay evidence in respect of Service User 2 as it is not sole and decisive evidence for charge 4). He submitted there is a way to test that evidence. He submitted that the panel would hear from Witness 4 who can speak to the complaint made against you by Service User 2.

Mr Kabasinskas stated that the hearsay evidence in respect of Service User 2 is also challenged. He submitted that there is no evidence before the panel to suggest that Service User 2 fabricated the allegations.

In relation to the reasons for the non-attendance of Service User 2, he stated the NMC had done its best to secure the witness' attendance. He submitted that Service User 2 is a

vulnerable person. He told the panel it has not been possible for the NMC to contact this witness. He referred the panel to an email from Witness 6, dated 9 October 2023, which said they had attempted to contact Service User 2 on 6 October 2023. However, there was no response and there was no ability to leave a voicemail message. He submitted that the NMC has tried to secure the attendance of this witness. He submitted that the absence of Service User 2 is not a fatal factor determining whether the evidence should be admitted. Mr Kabasinskas submitted that you had known that this evidence was relied upon by the NMC, and you did not raise any objection.

Mr Kabasinskas acknowledged that the charges are serious and if found proven, they may have a negative impact on your career.

Mr Hamill submitted that the evidence of this witness is the sole or decisive evidence in respect of charge 4a) and b). Service User 2 made a complaint the details of which are set out in the statement of Witness 4, and she exhibits various documents as already noted. These documents simply record the complaints of the service user. Service User 2 was transferred to another key worker. There is no evidence of any investigation of the matter and no response from you. He submitted that Witness 4 simply relays what she was told and cannot offer any first-hand account of the alleged issues.

Mr Hamill submitted that charge 4) a) and b) rely on this evidence as set out in the evidence matrix. He noted that Witness 4 exhibits material but cannot give any direct evidence about the allegations.

Mr Hamill stated that all the evidence which the NMC seeks to adduce in this application is challenged by you.

Mr Hamill submitted the charges are serious and an adverse finding against you on this issue may be of significance later in the proceedings.

Mr Hamill told the panel that it appears as though a conscious decision was made by the NMC not to contact this witness initially. He submitted belated attempts to contact the witness were made after an internal review following the case examiners' decision on this case. He submitted some limited attempts were made to contact the service user via the Trust and these were unsuccessful. Mr Hamill submitted that the panel cannot be satisfied that there is a good reason for the non-attendance of the witness.

Mr Hamill submitted the application to admit the material related to Service User 2 should be refused in all the circumstances.

The panel accepted that all the materials presented before it which are subject to the hearsay application are relevant. The panel then considered whether it is fair to admit hearsay evidence. The panel bore in mind the principles in *El-Karout, Thorneycroft* and *Mansaray* when deciding whether it is relevant and fair to admit evidence.

The panel considered whether this is the sole or decisive evidence for charge 4a) and b). The panel noted Service User 2's hearsay evidence relates solely to charge 4a) and b). The panel has the contemporaneous notes recorded on two occasions by two separate nurses regarding the complaint made by Service User 2. The panel determined the evidence of Service User 2 was not sole and decisive evidence for this charge. Witness 4 followed up the initial complaint. She spoke to Service User 2 by telephone and escalated and recorded the complaint. The complaint was referred onto the Director of Mental Health Services at the Trust.

The panel noted that you challenged this evidence.

In relation to whether there is a good reason for non-attendance, the panel noted the NMC have attempted to contact Service User 2 twice via the Trust but have received no response. Although it acknowledges that the NMC has attempted to contact this witness, it determined that more efforts could have been made to contact the witness. The NMC did not pursue further contact after the initial attempts.

The panel carried out a careful balancing exercise and took account of the principles in *El-Karout*, *Mansaray and Thorneycroft*. It gave consideration to the fairness to the NMC and you. The panel noted that these are serious allegations. The panel considered that the evidence in respect of Service User 2 was not the sole and decisive evidence in respect of charges 4 (a) and (b) and Witness 4 can provide evidence in respect of Service User 2. The panel noted the vulnerability of Service User 2. While these allegations are contested given the availability of Witness 4 the panel determined in all the circumstances it would be fair to admit the hearsay evidence. When making its findings of fact the panel will give careful consideration as to the weight to attribute to that evidence.

Witness 2; local statements;

Mr Kabasinskas invited the panel to accept two local statements written by Witness 2 dated 8 February 2021 and 21 February 2021. He submitted that despite their non-attendance, the evidence is relevant in this case. He submitted that there would be no injustice to you by admitting the hearsay evidence of Witness 2 as it is not sole and decisive, and the panel would be able to test the evidence on the basis that questions can be put to Witness 10, Witness 12 and Colleague A relating to the content of the local statements. Mr Kabasinskas also submitted that there is always documentary evidence contained in the evidence. He stated this statement is also challenged. He submitted that there is no evidence before the panel to suggest Witness 2 fabricated their evidence.

In relation to the reasons for the non-attendance of Witness 2, Mr Kabasinskas referred the panel to an email from Witness 2 dated 12 June 2022. The witness clearly sets out the concern that there appears to be a '*history*' between them and yourself. He informed the panel that Witness 2 stated that there have been reports of police involvement of a very sensitive nature. He submitted that this witness provides a good reason as to why she is not attending.

Mr Kabasinskas submitted that the NMC tried to secure Witness 2's attendance and offered support in attempting to secure her attendance. He submitted that the evidence is not the sole and decisive evidence in relation to charges 18), 20), 21) and 22) and the panel have a way of testing the contents of the evidence and submitted it would be fair to admit these two statements into evidence.

Mr Kabasinskas acknowledged that the charges are serious and if found proven, they may have a negative impact on your career.

Mr Hamill stated this witness gave two local statements which it is submitted are the sole or decisive evidence in relation to a number of the charges arising out of your time at the Home. She was the direct witness to these matters and other witnesses relied on by the NMC are largely reliant on what was reported to them by Witness 2.

Mr Hamill submitted that the allegations made by this witness are strongly contested and that is apparent from the papers. He told the panel there were allegations, counter allegations and the PSNI were involved.

Mr Hamill submitted the charges are very serious and will undoubtedly have a significant bearing on the outcome of this case.

Mr Hamill further submitted that there is no good reason for this witness not to attend. They have indicated they are in fear of attending and would participate anonymously. He submitted you do not accept they have a good reason to be in fear. However, leaving that aside, there has been no suggestion of any special measures application for this witness. He submitted that these concerns could easily have been addressed by the fact that they could have attended the hearing virtually where there was no risk of coming in to contact with you. An application could have been made to have their camera turned off, so they did not have to see you on screen.

Mr Hamill submitted that the evidence of this witness should also be excluded.

The panel accepted that all the materials presented before the panel which are subject to the hearsay application are relevant.

The panel then considered whether it is fair to admit hearsay evidence. The panel bore in mind the principles in *El-Karout*, *Mansaray and Thorneycroft* when deciding whether it is relevant and fair to admit evidence.

The panel considered whether this is the sole or decisive evidence in relation to these charges. The panel determined that it is not, as Witness 10, Witness 12 and Colleague A can give evidence about them, and the substance of both statements can be challenged in cross-examination. The panel acknowledged there is potential for a dispute between this witness and you which affected their relationship with you. However, it determined that there is no evidence before it to suggest the witness fabricated their evidence.

The panel noted that you challenge this evidence.

In relation to whether there is a good reason for non-attendance, the panel noted the NMC have attempted to contact Witness 2. However, it is disappointed that no further attempts have been made by the NMC to contact this witness, particularly as the witness is a registered nurse and has a professional duty to assist in such an investigation.

The panel carried out a balancing exercise and noted the principles in *El-Karout*, *Mansaray and Thorneycroft.* It gave consideration to the fairness to the NMC and to you. The panel noted that these are serious allegations, and it considers that the NMC could have done more to secure the attendance of the witness. However, other witnesses speak to this evidence. There is no allegation or suggestion of fabrication, and that Mr Hamill accepted that you had enough time to prepare a response to the hearsay application. The panel determined that this evidence can be admitted. When making its findings of fact the panel will give careful consideration as to the weight to attribute to that evidence.

<u>Witness 3; record of a meeting between Witness 3 and Witness 10</u>

Mr Kabasinskas invited the panel to accept the written statement of Witness 3. He submitted that despite their non-attendance, the evidence is relevant in this case. He submitted that there would be no injustice to you in admitting the hearsay evidence of Witness 3 as it is not sole and decisive in relation to charges 21) and 22), and the panel would be able to test the evidence on the basis that questions can be put to Witness 10. He submitted there is relevant documentary evidence contained in the exhibits.

Mr Kabasinskas stated it appears this statement is also challenged. He submitted that there is no evidence before the panel to suggest Witness 3 fabricated the allegations.

In relation to the reasons for the non-attendance of Witness 3, Mr Kabasinskas told the panel that the home which employed the witness has been transferred to new ownership and they do not have any contact details for Witness 3. He submitted the NMC has made attempts to contact this witness but have been unable to do so.

Mr Kabasinskas acknowledged that the charges are serious and if found proven, they may have a negative impact on your career.

Mr Hamill submitted the evidence of this witness is limited to providing some commentary on the dispute between Witness 2 and you. Whilst Witness 10 can presumably confirm this was the content of their discussion with the witness, it is submitted that if Witness 2 evidence is excluded then it follows this evidence should also be excluded.

Mr Hamill submitted this witness has not been contactable due to a change in ownership at the home. A belated attempt was made to contact her through the HR team at the new owners presumably to no avail. He submitted that there is no good reason why this witness could not have attended. It appears the NMC did not seek to contact them until a very late stage.

The panel considered the record of the meeting between Witness 3 and Witness 10 is not sole and decisive evidence. It noted that other evidence from witnesses that are due to appear will be given. It further noted there is also documentary evidence that also relates to charges 21) and 22).

The panel noted that Mr Hamill submitted that should the hearsay application in respect of Witness 2 be refused then it necessarily follows that Witness 3's evidence should not be admitted either. The panel determined there is no evidence before it to suggest any reason for this witness to fabricate this evidence. This is a serious charge centred around failure to give controlled drugs and alteration of records (meaning that *Thorneycroft* indicated that the panel should be slow to accept hearsay evidence in support of it).

The panel noted the NMC has attempted to contact this witness but have been unable to trace the witness as the care home they were employed in has been sold and the new owner of the care home does have not access to previous employee records. It noted this witness is not a registered nurse so the NMC did not have opportunity to contact them through those records.

The panel carried out a balancing exercise and noted the principles in *El-Karout*, *Mansaray and Thorneycroft.* It gave consideration to the fairness to both the NMC and you.

The panel determined that although the attempts to secure Witness 3's attendance were limited there was no other avenue available to the NMC. There is no suggestion of this evidence being fabricated. The panel noted that these are serious allegations which are contested. However, given that another witness can speak to this evidence it is not sole and decisive. The panel grants the application. When making its findings of fact the panel will give careful consideration as to the weight to attribute to that evidence.

Application to admit Diary entries relating to Service User 1 (day 2)

On day 2, before any evidence was heard from witnesses, Mr Hamill made a submission under Rule 31 which states that the panel can admit any evidence subject to the requirements of relevance and fairness. He invited the panel to admit a bundle of nine pages that consist of eight diary entries which you say relate to work appointments you had with Service User 1.

Mr Hamill submitted this evidence is relevant because the case is made on behalf of Service User 1 that they only had one appointment with you. Mr Hamill submitted that you told the panel that a number of appointments had been arranged for Service User 1 to meet with you, some of which you say Service User 1 attended.

Mr Hamill submitted this is relevant evidence as it is alleged Service User 1 disengaged from Mental Health Services because of your alleged behaviour at the first meeting. He further submitted in terms of fairness the diary entries show that Service User 1 did in fact have further appointments with you. He submitted that Witness 4 can be asked about the documents so the NMC will have the opportunity to address these matters.

Mr Hamill submitted that there is no unfairness in the documents being admitted as evidence and the NMC does not oppose the application.

Mr Kabasinskas submitted the NMC does not oppose the diary entry bundle in respect of Service User 1 being admitted into evidence providing it is sufficiently redacted.
The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel determined that, as there is no opposition from the NMC and subject to redactions, the evidence provided by Mr Hamill is accepted into evidence.

Application to hear Service User 1's evidence in private (day 2)

On day 2, Mr Kabasinskas made a request that the evidence of Service User 1 should be heard in private on the basis that the witness' name would appear on the Microsoft Teams Platform that was being used for the hearing. Service User 1 wished to remain anonymous and by virtue of the name appearing when they were giving evidence that anonymity would be compromised. The application was made pursuant to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules).

Mr Hamill offered no objection.

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

The panel determined to go into private session as this enabled the witness to give evidence in a way in which they were comfortable and prepared to appear. The granting of the application did not prejudice you and was unopposed.

Application to admit Diary entries relating to Service User 2 (day 3)

On day 3, after evidence had been heard from Service User 1, before evidence had been heard from any other witnesses, Mr Hamill made a further application under Rule 31 and invited the panel to admit a bundle of fourteen pages that consist of thirteen diary entries which you say relate to appointments that you had with Service User 2.

Mr Kabasinskas opposed the application on the basis that Service User 2 did not attend any appointments with you.

Mr Hamill submitted this evidence is relevant to charges 4a) and b), in that it demonstrates contact with Service User 2. He further submitted in terms of fairness that the documents

supported your case, and so should be admitted as evidence. He submitted that the NMC would have the opportunity to address these matters, and as so it was not unfair to the NMC to admit the documentation. Mr Hamill acknowledged that it was not a satisfactory position that this evidence was being served during the hearing. However, he submitted that in all the circumstances as it was relevant fairness to you required that it be admitted.

Mr Kabasinskas submitted that the NMC oppose the application, on the basis that the diary entries were not relevant. He further submitted that it would not be fair to admit the diary entries.

Mr Kabasinskas submitted that the entries within the diary consisted of a number of entries in 2018, which he submitted were not relevant to charges 4)a) and b). In respect of the entry in July 2019, he submitted that it was unclear whether this entry related to a call to or from the service user, and he submitted that there was no way of ascertaining the answer to this.

Mr Kabasinskas further argued that it would be unfair to admit the evidence, as unlike the diary entries in respect of Service User 1, the evidence in respect of Service User 2 could not be tested. He noted that Service User 2 was not being called to give evidence and Service User 2 would not be able to answer questions in respect of your personal diary entries.

The panel considers that this evidence is relevant in parts but is unclear how diary entries one to eight can be relevant as they fall outside the dates of the charge. The panel is of the view that diary entries from 9 to 13 could have relevance. It is accepted by the NMC that you can be asked questions on these if needed. Therefore, although the panel does not have Service User 2 appearing to give evidence, both you and other witnesses can be asked questions about this evidence. Therefore, the panel determined it is fair that the diary entries are admitted so that you can use them to defend the allegations.

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

The panel considered that you could be asked questions in respect of the entries which relate to charges 4a) and b). The panel determined that the bundle consisting of diary entries relating to Service User 2 was relevant and it was fair to admit this documentation into evidence. The panel was of the view that the diary entries from pages nine to thirteen of the bundle provided by you were directly relevant to charges 4a) and b). The panel therefore decided that the bundle as a whole should be admitted into evidence.

The panel considered that the weight to be attached to this evidence would be a matter for the panel to determine at a later stage in the proceedings.

The panel noted that it could not be held against you that Service User 2 was unavailable to answer questions. The panel had previously decided to admit documentary evidence relating to Service User 2 in respect of the NMC's hearsay applications. There was no difference in principle in your application which accordingly the panel accepted.

Response to panel questions about the exhibit bundle (day 8)

The panel asked about page 296 of the exhibit bundle. No witness had spoken to this page and the panel had not been given any details regarding it. Therefore, the panel wished to know its origin, and which witness it related to.

Mr Kabasinskas stated that it was not known to which witness page 296 in the exhibit bundle related.

Mr Hamill submitted that given the fact this is an unknown anonymous document in the middle of the bundle and no witness has spoken to it, it should not be admissible because it cannot be dealt with at this stage.

The panel determined that this document would be given no weight.

The panel also asked about pages 303 and 304 which had not been adopted by any of the witnesses in their evidence.

Mr Kabasinskas made an application to admit pages 303 and 304 under Rule 31. He submitted that the documents are relevant and that it is fair to admit them. The documents should have been put before witnesses.

Mr Hamill did not object to these documents being admitted.

The panel determined that page 303 of the exhibit bundle is a note of a meeting on 22 December 2020 at which Witness 13 was present. Witness 13 was asked about this meeting in her oral evidence although she was not taken to this document. The meeting noted on page 303 was also included in reference to other exhibits that have been admitted including the timeline of Witness 10 which Witness 10 was questioned about during cross examination. It determined that the document is relevant and fair and is admitted into the record.

The panel next considered page 304 in the exhibit bundle which relates to the policies and procedures in the care home. This page goes directly to showing some induction was undertaken, contrary to your case that no induction had taken place. It determined, in fairness, that whilst the application has been made by the NMC after the panel has heard from all of the NMC's witnesses, you will have the opportunity to challenge the evidence and be questioned on it.

Decision and reason on special measures application (day 7)

Mr Kabasinskas made an application under Rule 23(1) for special measures to treat Colleague A as a vulnerable witness and to adopt special measures to assist in the giving of oral evidence. He invited the panel, in order for this witness to give evidence, to adopt the following:

- Colleague A wished to be known as Colleague A;
- For you to keep your camera and microphone off; and
- To give evidence wholly in private under Rule 23.3.

Mr Kabasinskas submitted that Colleague A feels threatened and intimidated by you. He submitted that there is no prejudice to you in these special measures being granted.

Mr Hamill submitted that you do not object to the application and that it is a matter for the panel whether or not to grant it. He told the panel that you do not accept the witness has any reason to feel threatened or to be intimidated by you.

The panel considered the application and noted the representations from Mr Kabasinskas and Mr Hamill. It noted that Colleague A states that they have a perception of a threat of intimidation from you.

The panel decided to grant the application to refer to the witness as Colleague A, that you should keep your camera off and the evidence from Colleague A to be heard in private. This will allow Colleague A to engage and give witness evidence in the best environment. It determined that no prejudice to you comes from granting this application.

[PRIVATE]

[PRIVATE]

Panel request that enquiries be made to request Service User 1's Clinical records (day 11)

[PRIVATE]

Following the evidence that you gave, the panel determined that it wished to ascertain whether Service User 1's clinical records were available for the period January 2018 to March 2020. Mr Kabasinskas was requested to review his papers to identify whether Service User 1's clinical records were available.

Mr Kabasinskas reviewed the papers available to him and advised that there were no clinical records for Service User 1. In answer to the panel's questions Mr Kabasinskas stated that he had no record that the NMC had asked for Service User 1's clinical records.

Mr Kabasinskas explained that the papers available to him may not include all the papers that the NMC had collated in advance of the exhibit bundle being agreed.

The panel requested that Mr Kabasinskas make enquiries with the NMC to ascertain what enquiries (if any) had been made about Service User 1's clinical records and if they had been secured at any stage. Should the records be available the panel would wish to see them.

On day 12, following enquiries with the NMC, Mr Kabasinskas advised the panel that the NMC has never requested Service User 1's clinical records and there are none in its files.

Mr Kabasinskas submitted that the clinical records were not required in order that the panel address the charges relating to Service User 1. He submitted that the charges relate to inappropriate questions being asked by you and that it was unlikely that those would have been recorded in the clinical records.

Furthermore, Mr Kabasinskas submitted that Witness 5 addresses the records in their witness statement indicating that the records did not reflect Service User 1's account of the meeting.

Mr Kabasinskas submitted that the charges do not cover how many appointments Service User 1 had with you. The charge is drafted in such a way that the alleged incidents took place between 2019 and January 2020. It does not refer to the specific date of, or number of appointments held between you and Service User 1.

Mr Kabasinskas further submitted that the panel has sufficient evidence in order to make its decisions. It has the witness statement and oral evidence of Service User 1 and the notes taken by a nurse regarding the complaint. He submitted that requesting evidence at this stage is disproportionate, as it will take significant time to deal with the request and there is a risk of adjournment. He further submitted that this was a matter of fairness; at no point did you put the diary entries to the NMC before the hearing commenced and so the NMC was not able to consider those dates.

Mr Kabasinskas suggested that the panel could listen to both his and Mr Hamill's submissions on how to approach the evidence available. He further submitted that just because there may be no mention of the inappropriate questioning in the clinical records it does not mean that they were not asked. He submitted that whilst the records may be helpful, the panel does have sufficient evidence. The burden of proof is on the NMC on the balance of probabilities, and the NMC relied upon the evidence put before the panel.
Mr Kabasinskas finally submitted that there were no half time submissions on behalf of you in respect of this matter.

Mr Hamill initially addressed the half time submissions point. He indicated that this was simply a matter of judgement as to whether half time submissions should be made and there should be no inference drawn from this.

Mr Hamill submitted that there is a very clear disagreement between you and Service User 1 about what has occurred in respect of the date that the alleged incident occurred and the other meetings that you say occurred. He further submitted that the allegation is that

Service User 1 disengaged with the Carrickfergus Mental Health Team at the Trust. This is also contradicted by you.

Mr Hamill submitted that it is important that the panel consider the context of the conversations between you and Service User 1 and whether they were clinically justified. Service User 1's clinical records would provide that context enabling the panel to consider the situation in more detail rather than simply having to choose between two oral accounts.

Mr Hamill conceded that you did not put these matters to the NMC before the hearing, however, the NMC knew from Witnesses 4 and 5 that there was reference to Service User 1's clinical records in their statements. Mr Hamill further reminded the panel that it is a panel of enquiry. While he accepted that making these inquiries would cause some delay in the proceedings, it was apparent that a fair hearing requires these records to be obtained and inspected.

In answer to a question from the panel Mr Hamill confirmed that you had not asked for the clinical records of Service User 1 before the hearing.

The legal assessor advised that the burden of proof was on the NMC to put evidence before the panel, and if the NMC provided inadequate evidence the charge would be found not proved. The panel could ask for additional evidence, but that was usually in the context of concern about undercharging. Here the registrant had not asked for these records. On the other hand, the NMC should have obtained and disclosed these records to you. The issue was whether the panel can deliver a fair hearing as is required by Article 6 of the ECHR without considering these records. The point that there was no application of no case to answer was not a good submission. The issue is whether there is an answer to the case put by the NMC. The issue for the panel was whether, in assessing the credibility of both your and Service User 1's accounts overall, these records would assist in delivering a fair outcome. If the NMC witnesses referred to notes, the panel might

consider that seeing that material would assist the panel's determination of whether the charges are found proved or not.

The panel accepted advice of the legal assessor.

The panel decided that it needed to see these records. While they might not show anything relevant, neither the NMC nor you had considered whether they were material to the case. This was a case involving a direct conflict of evidence between the complainant and you about a verbal conversation to which there was no witness. The issue for the panel was whether fairness required it to consider documentary evidence which might be available, particularly contemporaneous evidence, to assist in the evaluation of the credibility of the differing accounts.

Accordingly, the panel adjourned and required Mr Kabasinskas to make enquiries of the Trust and seek to obtain copies of those records.

Directions

Having directed that the following be served by the NMC;

a) All relevant clinical records held by the Northern Health and Social Services Trust, including but not limited to nursing and medical notes and appointment history in respect of Service User 1 (including but not limited to paper, electronic and EPEX files) for the period of 1 January 2018-31 March 2020.

The panel further directs that the NMC provide the following information in respect of their efforts to obtain such information.

1. The NMC is to provide a full chronology of the efforts made to date to obtain the above information, including information in respect of when matters were followed

up. The panel expects that the NMC will engage daily with Northern Health and Social Services Trust to ensure that progress is made and monitored.

2. The NMC is to provide a realistic timescale for when, if at all, it will be able to comply with the panels above direction.

On day 17 Mr Kabasinskas confirmed that the Trust had provided Service User 1's complete records as requested. However, these were not received until late on the previous working day and therefore had not been forwarded to him or Mr Hamill until this morning. Both sides advised that they needed to take instructions. Mr Kabasinskas confirmed that a total of nine pages have been received. He then asked the panel to confirm that the NMC had complied with the directions as set out above.

Mr Hamill submitted that in addition to taking instructions he did not think it feasible that he would be in a position to advance matters today. He submitted that although he doubted that there would be an argument regarding admissibility, he needed to liaise with both the instructing solicitors and you. Mr Hamill also indicated that you may say that more documents were expected than had been received.

The panel took legal advice regarding Mr Kabasinskas' request for confirmation of compliance with the panel's directions.

Mr Kabasinskas submitted that subject to the panel's confirmation he would then be making an application to adjourn.

The panel considered that the request for confirmation of compliance of directions was premature as it has not had sight of the documentation produced and requested that the application to adjourn was made before it considered those issues.

Application for Adjournment (Day 17)

Mr Kabasinskas invited the panel to adjourn the hearing scheduled for 16 - to 19 April 2024.

Mr Kabasinskas informed the panel that he will not be available on those dates and that the NMC is facing capacity issues.

Mr Kabasinskas emphasised that, following a review with senior staff within the NMC, it was decided that replacing the Case Presenter at this stage of the hearing would not be appropriate. He submitted that it could lead to delays, impacting their professional duties and potentially compromising public protection. Providing further context, he informed the panel that the NMC considered that it would not be feasible to assign a new Case Presenter within the given timeframe. He highlighted that the legal support team faced challenges due to the hearing's length and the holiday period.

Mr Kabasinskas confirmed that the issue of potential adjournment was communicated to you and Mr Hamill in advance.

Mr Kabasinskas acknowledged the importance of the expeditious disposal of the proceedings. However, having received further evidence and the need for further instructions, he highlighted the potential for delays. He raised concerns about witness availability, indicating that recalling witnesses may further impact the case's progress over the next four days.

Mr Kabasinskas submitted that there might be a minor disadvantage to Mr McGrattan in adjourning the hearing. However, the NMC, as the regulator, would face a larger disadvantage as it would not be possible to continue without a Case Presenter. He, therefore, invited the panel to accede the application for adjournment.

Mr Hamill expressed consent to the application to adjourn, viewing it as a sensible way to proceed until the proposed resuming dates.

The panel accepted the advice of the legal assessor. Rule 32.2 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules") states the following:

Rule 32.2

(1) ….

(2) A Practice Committee considering an allegation may, of its own motion or upon the application of a party, adjourn the proceedings at any stage, provided that:

(a) no injustice is caused to the parties; and

(b) the decision is made after hearing representations from the parties (where present) and taking advice from the legal assessor.

…

(4) In considering whether or not to grant a request for postponement or adjournment, the Chair or Practice Committee shall, amongst other matters, have regard to–

(a) the public interest in the expeditious disposal of the case;

(b) the potential inconvenience caused to a party or any witnesses to be called by that party; and

(c) fairness to the registrant.

The panel had previously decided to request Service User 1's records in order to ensure a fair hearing to you. Having received the records, the NMC and Mr Hamill, on your behalf will need to review the information. Whilst there is a public interest in proceeding without delay, the panel is mindful of the unavailability of Mr Kabasinskas from the hearing over the next four days and the need to ensure all parties have agreed the evidence and considered the implications when presenting their cases.

The panel considered there is no additional inconvenience to witnesses because none were scheduled to appear this week. The panel further considered that it very unlikely that any witnesses that might be required by either side would not be available at such short notice.

In fairness to you, whilst you would want decision as soon as possible your representative, Mr Hamill, is on record as being keen to see the evidence that has been requested by the panel and therefore there is no unfairness to you by granting the application for an adjournment.

With regard to the Case Presenter's unavailability between 16 – 19 April 2024, the panel had been advised of this after the hearing had started. However, this was not originally considered to be an issue given the timetable set out for the hearing. The panel understood the representations of Mr Kabasinskas relating to a new Case Presenter taking over the case and noted his representations with regard to the possible disadvantages of this to the NMC.

The panel decided to grant the application for adjournment.

Case management directions

The panel reviewed the case management directions, which were mutually agreed upon by both Mr Kabasinkas and Mr Hamil. The directions include:

- *The Registrant shall confirm within 14 days whether SU1 records are complete.*
- *If the Registrant's position is that SU1 records are complete than at the same time the registrant must confirm his position whether he wishes to raise any issues regarding the admissibility of these records? If there are any issues, he shall inform the NMC.*
- *If the Registrant is of the view that SU1 records are incomplete than he must state what records, for what period are missing and where they could be located.*

- *Subject to the direction above the NMC shall use their best endeavours in obtaining these records. If they are unable to comply with this direction they shall notify the Registrant as soon as reasonably practicable as to why they are unable to comply with this direction.*
- *Subject to the issue of admissibility the parties agree that the NMC and the Registrant can recall their respective witnesses to comment on SU1 records.*
- *The parties shall confirm to each other no later than 28 days before the next hearing whether they will be recalling any witness and which witnesses.*
- *Subject to the above direction, the parties shall co-operate with each other and agree timetable for witnesses no later than 14 days before the next hearing."*

During the panel's questioning, Mr Kabasinskas said that there is no issue with the proposed timetable for witnesses and the hearing. However, when asked about providing written closing submissions on facts, Mr Kabasinskas submitted the NMC does not consider that there is an obligation to provide written submissions. He explained that it is common practice for oral submissions to be captured by the hearing coordinator, and all submissions should be made available to the public in the interest of open justice. He submitted that written submissions could be requested through the Freedom of Information Act.

The panel made a request to receive written submissions from Mr Kabasinskas. However, Mr Kabasinskas is unable to provide written submissions.

Mr Kabasinskas emphasised that making submissions orally is more practical. He also raised concerns about the significant increase in resources, both financial and otherwise, if written submissions were to become mandatory.

Mr Hamill informed the panel that he has written submissions prepared and will submit them.

The panel would have preferred written submissions to assist it, especially with the anticipated delay between submissions and the panel reconvening to find facts. However, the panel understood and acknowledged the submissions made by Mr Kabasinskas in respect of not providing written submissions.

Mr Hamill suggested providing an indicative timetable for the hearing, estimating when further witness evidence would be heard and when closing submissions could be made.

The panel gave careful consideration to the proposed directions and accepted them.

Considering the submissions and proposed timetables, the panel introduced additional directions, which were agreed upon:

- Service User 1's agreed records must be submitted seven days before the hearing resumes on 1 July 2024.
- Parties should lodge an agreed proposed timetable and schedule for witnesses and anticipated timing for closing submissions seven days before the hearing resumes on 1 July 2024.

The panel acknowledged the submissions from both parties and confirmed the proposed directions.

Directions

- Mr McGrattan shall confirm within fourteen days whether Service User 1's records are complete.
- If Mr McGrattan's position is that SU1 records are complete than at the same time he must confirm his position whether he wishes to raise any issues regarding the admissibility of these records? If there are any issues, he shall inform the NMC.
- If Mr McGrattan is of the view that SU1 records are incomplete than he must state what records, for what period are missing and where they could be located.

- Subject to the direction above the NMC shall use their best endeavours in obtaining these records. If they are unable to comply with this direction they shall notify Mr McGrattan as soon as reasonably practicable as to why they are unable to comply with this direction.
- Subject to the issue of admissibility the parties agree that the NMC and Mr McGrattan can recall their respective witnesses to comment on Service User 1's records.
- The parties shall confirm to each other no later than 28 days before the next hearing whether they will be recalling any witness and which witnesses.
- Subject to the above direction, the parties shall co-operate with each other and agree timetable for witnesses no later than fourteen days before the next hearing.
- Service User 1's agreed records must be submitted seven days before the hearing resumes on 1 July 2024.
- Parties should lodge an agreed proposed timetable and schedule for witnesses and anticipated timing for closing submissions seven days before the hearing resumes on 1 July 2024.

Background

Case reference 079992/2020

The NMC received a referral on 25 September 2020 from the Northern Health & Social Care Trust (the Trust) where you were employed as a Band 6 Community Mental Health Nurse within the Carrickfergus Community Mental Health Team (CMHT). The Trust had raised numerous concerns relating to your practice.

It is alleged that you:

- Were dishonest in that you intended to create a misleading impression that you were a Band 8a qualified nurse when you were not;

- Failed to maintain professional boundaries in that you asked a vulnerable service user about her sex life during a clinical session;
- Kept poor records;
    - Failed to record initial assessments of service users
    - Failed to complete risk assessments
    - Failed to update the Epex system following consultations with service users
- Provided poor patient care in that you neglected Service User 2 when they tried to contact you about their deteriorating health;
- Breached your duty of candour in that you failed to disclose and escalate the loss of two service user files;
- Practiced poor infection control by failing to follow Covid-19 infection prevention controls; and
- Deliberately refused to work co-operatively with colleagues.

Case reference 082562/2021

The NMC received a further referral on 8 March 2021 from Chester Nursing Home (the Home) whilst you were employed as a registered nurse. In the referral the Home confirmed that they were aware of your previous NMC referral. The Home noted that there were ongoing issues around your medication administration and that the last error resulted in you falsifying records with regards to controlled drugs.

Decision and reasons on facts

On day 3, the panel heard from Mr Hamill on your behalf, who informed the panel that you made full admissions to charges 5), 6), 7), 8) and 9).

The panel therefore finds charges 5), 6), 7), 8) and 9) proved in their entirety, by way of your admissions.

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 made by Mr Kabasinskas on behalf of the NMC and by Mr Hamill on your behalf.

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:

- Service User 1: Service User at the Trust at the time of the allegations relating to the Trust;
- Witness 4: Carrickfergus Mental Health Team (CMHT) Team Leader at the Trust at the time of the allegations relating to the Trust;
- Witness 5: Locality Manager at the Trust at the time of the allegations relating to the Trust;
- Witness 6: Head of Service for Inpatients and Crisis Team at the Trust at the time of the allegations;
- Witness 7: Community Psychiatric Nurse (CPN) doing partial secondment to the COVID Swabbing Team at the Trust

at the time of the allegations relating to the Trust;

- Witness 8: Professional Nurse and Service Improvement Lead for Community Nursing at the Trust at the time of the allegations relating to the Trust;

- Witness 9: Senior Nurse to a team of Community Learning Disability Nurses at the Trust at the time of the allegations relating to the Trust. At the time of the incident in June 2020, Witness 9 was redeployed to swab testing teams in care homes, supporting with coordination of teams for the months of June and July 2020.

- Witness 10: Nurse Manager at the Home at the time of the allegations relating to the Home;

- Witness 11: Staff Nurse at the Home at the time of the allegations relating to the Home;

- Witness 12: Deputy Nurse Manager at the Home at the time of the allegations relating to the Home;

- Witness 13: Area Nurse Manager for the Home at the time of the allegations relating to the Home;

- Colleague A: Staff Nurse at the Home at the time of the allegations relating to the Home.

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Mr Hamill on your behalf, and made the following findings:

Charge 1

1. On an unknown date, between 2019 and 29 January 2020, without clinical justification, asked Service User 1 about:

Charge 1a

a) her sex life with her husband;

In relation to charges 1a, b and c, the panel took account of the following evidence:

- Service User 1's written statement and oral evidence
- Witness 4's written statement, and oral evidence
- Entry in Service User 1's progress notes of discussion 29 January 2020 made by Community Mental Health Nurse (CMHN), whose supervisor was Witness 4
- Witness 5's written statement and oral evidence, Witness 5's email summarising

the ‘tripartite meeting’ of 29 January 2020

- Record of supervision meeting between you, Witness 4 and Witness 5 dated 21 February 2020
- Letter dated 17 April 2020 from Witness 6 to you
- Service User 1’s clinical records obtained by the NMC from the Trust at the Panel’s request comprising of 2 pages of “Progress notes” and 8 pages containing copies of letters to Service User 1 from you confirming appointments, 1 letter to Service User 1 confirming discharge from the CMHT, 1 Letter to the GP confirming Discharge from CMHT and a letter to the GP
- Your oral evidence and diary entries provided by you.

In her oral and written evidence, Service User 1 was very clear that her recollection was that she met you on one occasion only between July and August 2019. In her oral evidence to the panel, she referenced that this meeting took place just before she went on holiday, and in the year before Covid. She described how her husband had taken her to the appointment in the late morning.

Further, Service User 1 referenced that it was before she had returned to work in December 2019. Service User 1 was asked whether she could have been mistaken about the timing of the meeting, but she said that she was “*sure*” of her recollection. She was also questioned about whether she could have been mistaken that she met you on one occasion, but she said that she was “*100% clear*” that she met you once.

On 29 January 2020 Service User 1 attended a routine meeting with a CMHN having been referred back to the CMHT. Service User 1 recounted that the nurse remonstrated with her for her lack of engagement with the service previously which had led to the Service User 1 being discharged in November 2019. Service User 1 told a CMHN on 29 January 2020 about a meeting with you, explaining that this was the reason that she had stopped engaging with the service. The details of the conversation were recorded in handwriting by the CMHN in Service User 1’s “progress notes”. The notes do not record any date of this

alleged incident. The CMHN called Witness 4 who was her supervisor to come to talk to Service User 1. Witness 4 recounted the following in her written evidence:

> *"I did speak to the service user briefly on that day to reassure her and to thank her for bringing it to our attention. She reported she would meet with me further and more formally but attempts to do this were unsuccessful"*

In her oral evidence, Witness 4 confirmed that she had not taken any notes of the discussion herself. Service User 1 was asked whether she made a formal complaint and confirmed that she 'wasn't well at the time and didn't want to make a formal complaint'. Witness 5 spoke about this in her written evidence stating that Service User 1 'would not engage in a formal complaint'.

On the same day, the 29 January 2020, Witness 4 and Witness 5 held a meeting with you to discuss the working relationship between Witness 4 and you. There was no note of the complaint by Service User 1 being mentioned at that meeting, even though the complaint was made the same day. When questioned, Witness 4 confirmed that the meeting was about resolving issues between her and you and so it would not have been appropriate for Service User 1's complaint to have been discussed.

On 21 February 2020, Witness 4 and Witness 5 held a supervision meeting with you. This covered many other unrelated issues causing concern about your performance but included a reference to complaints, as follows:

> *"Gareth advised one formal complaint and 2 others reporting they will be going formal".*

Witnesses 4 and 5 both stated that Service User 1's complaint would have been one of the complaints referred to. However, neither Witness 4 nor Witness 5 could recall discussing the details of the complaint recorded on 29 January 2020, with you.

The allegation was further referenced in documentation prepared by the Trust on 26 February 2020. The document referred to as a screening tool was prepared to assess whether an investigation into several concerns should take place under the Trust's disciplinary policy and the Nursing and Midwifery Code of Practise. However, this investigation did not take place with the reason documented as follows:

> *"Date employee was advised verbally of the investigation; 26/02/20 attempted to inform G McG but he left the meeting."*
>
> *"Did not proceed to investigation due to his retirement."*

In the Trust's letter to you regarding concerns about your practice dated 17 April 2020, there is reference to "three complaints by service users" as one of the concerns. There was no further detail documented.

You say that you were never told about the complaint made by Service User 1 and did not know about it until the NMC made you aware of the allegations.

In her written evidence Witness 4 said that she was not aware of any issues between you and service users, until the issue with Service User 1 was brought to her attention. Witness 4 confirmed that she had witnessed you with service users on a few occasions and had no issues with you. She gave evidence that you appeared to have a good level of rapport and professionalism in your dealings with service users.

In oral evidence, Witness 4 stated that she had reviewed Service User 1s records and concluded that there was no clinical justification in Service User 1s history that would have justified the questions alleged in charge 1a, b, c. When asked about this, Witness 4 stated that she would have reviewed Service User 1's notes and information on EPEX – electronic record of notes.

The panel was not provided with any records of appointments or clinical records for Service User 1 other than the diary entries that you provided and the note from the CMHN documenting Service User 1's complaint dated 21 January 2020. The panel noted that neither Witness 4 nor Witness 5 had been asked to provide any of Service User 1's records by the NMC. Having heard the NMCs evidence, the panel requested that the NMC obtain whatever records the Trust had for Service User 1 between 2018 - March 2020 as it was concerned that important evidence could be missing.

The panel was subsequently provided with 2 pages of "progress notes" that covered the period 2 October 2017 to 1 November 2019. The first entry recorded by you was on 29 June 2018 indicating that Service User 1 had not attended a scheduled appointment. Subsequent entries in your handwriting, record that you met Service User 1 on 9 October 2018 and 13 March 2019. The entries on these dates do not disclose any information or reference the questions as alleged in charges 1a, b, or c.

The progress records also showed appointments for the 15 August 2018, 7 November 2018 and 1 February 2019, where you have recorded that Service User 1 did not attend. The panel was also provided with copies of appointment letters for the 9 October 2018, 7 November 2018 and 1 February 2019 but not the appointments for 15 August 2018 or 13 March 2019.

A final entry in the 2 pages of progress notes dated 1 November 2019 indicated that Service User 1 did not attend the appointment and was discharged from the Trust. The panel was provided with copies of the letters confirming the discharge to Service User 1 and her GP. The panel did not see a letter inviting Service User 1 to the appointment on 1 November 2019. Service User 1 recollected in her written evidence that she was sent some letters and was called by you trying to arrange appointments after July / August 2019 but that she ignored them and declined to meet you. She recalled taking a phone call from you when she was at work, and you asking her if she could come in to see you. She said that she could not come and said, '*something about being too busy'*. Service User 1

then recounted you telling her that she would be "*Struck off the Trust's books*" to which she replied "*ok no problem*" or words to that effect.

In your oral evidence, prior to the panel requesting the extra records from the Trust you told the panel that you had met with Service User 1 on multiple occasions, the first being in June 2018. You denied that the conversation ever took place, as alleged. In your oral evidence you referred to Service User 1 as a sporadic attender. You referred the panel to your diary entries which showed a meeting was held on 28 June 2018.

The panel noted the documentary evidence before it in Service User 1's progress notes, recorded by you, of two meetings between you and Service User 1: the first was on 9 October 2018 and second on 13 March 2019. These meetings coincided with diary entries supplied by you and the appointment letters provided by the Trust. The panel concluded that the documentary evidence supported your account that Service User 1 attended appointments with you on more than one occasion.

There was no documentary evidence that you and Service User 1 met between 2019 and 29 January 2020 other than the meeting on 13 March 2019. Neither was there evidence that you met Service User 1 in June 2018, which you initially indicated in your oral evidence.

The panel noted that there was no documentary evidence or records which supported a meeting taking place between Service User 1 and you between July and August 2019, as alleged by Service User 1. The panel noted the clear evidence from Service User 1 as regards to her memory of a meeting with you sometime in July/August 2019. However, the documentary evidence before the panel did not support Service User 1's memory. The panel considered whether or not this meeting could have occurred on either 9 October 2018 or 13 March 2019. However, the panel concluded that this was unlikely because Service User 1 was very clear that the meeting took place in either July or August 2019, and not on any other date.

The panel noted that Service User 1 stated that she met you for the first and only time in the period July - August 2019. However, the documentary evidence suggested that this was incorrect, as there was evidence that two meetings took place in October 2018 and March 2019. The panel considered this to be a significant inconsistency in light of Service User 1's evidence on this issue.

The NMC submitted that to suggest that the alleged incident did not occur because it was not recorded, was incorrect. The NMC further submitted that Service User 1 said that she had one meeting with you. However, the records showed two meetings, and the NMC submitted that there was not a big difference. The panel disagreed with this and considered the divergence between Service User 1's recollection of the meeting and the evidence of the written records to be very significant.

The panel was mindful of the NMC guidance regarding Burden of Proof (DMA - 6) and took this into account when considering the difference between Service User 1 evidence and the documentary evidence before it.

The panel considered that the NMC had not discharged its burden of proof in respect of this charge. The panel noted the inconsistencies arising from Services User 1's account, allied with the lack of supporting documentary evidence in respect of this charge. Service User 1's records were only requested from the Trust after the panel had requested them. Upon receipt of the records, it was evident that they did not support the allegations made in this charge.

Taking all of the evidence into account the panel found that this charge was not proved on the balance of probabilities.

The panel therefore found charge 1a not proved.

Charge 1a NOT proved.

Charge 1b

b) going onto on-line dating sites;

The panel bore in mind its conclusions above in respect of the inconsistency of Service User 1's account and the lack of documentary evidence to show when the consultation between you and Service User 1 took place.

The panel however considered that both you and Service User 1 accepted that a conversation occurred in respect of Service User 1's use of online dating sites.

Service User 1 gave evidence that you asked her about using online dating sites and that she thought it was inappropriate for him to ask this question, as he knew you were married and had no reasons for doing so. You told the panel in your oral evidence that you told her that using online dating sites was risky behaviour.

You told the panel that the use of online dating sites had been raised by Service User 1 when you both met. You explained that during the consultation Service User 1 mentioned her use of online dating sites when in a hyper-manic state. Your evidence was that you advised her to stop using them. The panel considered the evidence of Witness 4 who explained that there was nothing in the historic records that she viewed at the time of the complaint by Service User 1 that would justify asking questions about using online dating sites. However, the panel did not have any documentary evidence about this alleged conversation.

In the absence of any other independent evidence to the contrary, the panel accepted your account that Service User 1 discussed her hyper mania with you and said that she would access online dating sites when she was hyper manic. You told the panel that you advised her not to do this. In these circumstances, the panel considered that your discussion around using on-line dating sites clinically justified.

The panel was mindful of the NMC guidance regarding Burden of Proof. The panel was not satisfied on the balance of probabilities that this charge was found proved.

Charge 1b NOT proved.

Charge 1c

c) whether she ever met strangers for sex or words to that effect.

Service User 1 in her oral and written evidence alleged that when you met her you asked '*do you ever meet strangers for sex*' or words to that effect. Service User 1 alleged that this was one of the first questions that you asked her in the meeting that she recalled occurring in July or August 2019.

You told the panel that you deny asking Service User 1 whether she ever met strangers for sex or words to that effect.

The informal complaint, made by Service User 1, and recorded by the CMHN on 29 January 2020 made no reference to you asking her whether she ever met strangers for sex.

The panel noted its previous determination about the significant inconsistencies in Service User 1's accounts around the date of the alleged meeting, and the fact that she was clear in her evidence that she had only ever met you once. This was not accepted by the panel in view of the documentary evidence to the contrary. The informal complaint of 29 January 2020 made no mention of this specific allegation. The first time it was raised was in the witness statement prepared by Service User 1 for this hearing. Therefore, the panel concluded that, on an unknown date between 2019 and 29 January 2020, without clinical justification, you did not ask Service User 1 whether she ever met strangers for sex, or words to that effect.

Taking all of the evidence into account the panel considered that the NMC had not discharged its burden of proof. Therefore, on the balance of probabilities, it found charge 1c not proved.

Charge 1c NOT proved.

Charge 2

2. By your conduct at Charge 1 above you sexually harassed Service User 1 in that:

    a) it was unwanted; and
    b) it was sexual in nature; and
    c) it had the purpose or effect of:
        i) violating Service User 1's dignity; or
        ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for Service User 1

As the panel found charge 1a - 1c not proved, it follows that charge 2a- 2c)i) - ii) is not capable of being found proved.

Charge 3

3. Your actions in Charge 1 above were a breach of professional boundaries.

As the panel found charge 1 not proved, it follows that charge 3 is not capable of being found proved.

Charge 4

4. On unknown dates between 2019 to 9 March 2020, you:

Charge 4a

a) failed to respond to Service User 2's telephone calls and/or messages;

In relation to charge 4a the panel took account of the following evidence: Service User 2's formal complaint dated 9 March 2020, the community Psychiatric Nurse's note in relation to Service User 2 dated 14 May 2020, Witness 4's notes of a discussion on 27 May 2020, the Trust's response to the formal complaint 4 June 2020, Witness 4's written statement and oral evidence and your oral evidence and diary entries for that time period.

It was clear to the panel that you were the key worker responsible for responding to Service User 2's requests for telephone calls and/or messages. The panel took account of the complaint raised by Service User 2 dated 9 March 2020, setting out that you did not contact her between 7 July 2019 to 9 March 2020.

In your oral evidence you acknowledged that there had not been any contact between you and Service User 2 between 7 July 2019 and 9 March 2020. **[PRIVATE].**

Witness 4 recalled speaking to Service User 2 on 27 May 2020 but at this point a formal investigation into the complaint had not begun. The panel heard that Witness 4 accepted the validity of Service User 2's complaint and escalated it to the Trust's director of mental health, who subsequently acknowledged the complaint on 4 June 2020 and apologised for any distress caused.

Your diary showed an absence of any entries between 9 July 2019 and 9 March 2020. You were unable to provide the panel with an explanation for this, but you gave evidence that Service User 2 was engaging with the Trust's recovery college (a step-down facility) from July 2019. The panel however, had no evidence to support your account that Service User 2 was engaging with the recovery college from July 2019.

On the basis of the evidence before it, the panel considered that the complaint and accounts of the discussions with Service User 2 were credible. The complaint was recorded contemporaneously, the notes from Witness 4 were contemporaneous and the panel found Witness 4's oral evidence to be clear and credible. Witness 4 took the complaint sufficiently seriously that a new key worker was assigned to Service User 2 and the complaint was escalated to the Trust's director of mental health for a response Therefore, on the balance of probabilities, the panel determined that you failed to respond to Service User 2's telephone calls or messages as set out in the charge.

Charge 4a proved

Charge 4b

b) did not telephone Service User 2 back after informing her you would do so.

Service User 2 complained that she spoke to you on the telephone and that you agreed to call her back, but you did not do so. In your oral evidence you acknowledged that you did not contact Service User 2 for a period of 10 months. However, you suggested that in your experience no service user would be left for 10 months without them being contacted by an alternative key worker, if not yourself.

It was clear to the panel that you were the key worker responsible for responding to Service User 2's requests for telephone calls and/or messages. There was no evidence before the panel that this responsibility had been passed to anybody else or that another key worker had been assigned to support Service User 2. The panel heard that Witness 4 accepted the validity of Service User 2's complaint about your lack of contact and escalated it to the Trust's director of mental health who responded to Service User 2.

All the evidence before the panel showed that Service User 2 attempted to contact you, but you did not return her calls. Based on the evidence before it, and on the balance of

probabilities, the panel was satisfied that you did not call Service User 2 back as set out in the charge.

Charge proved.

Charge 5

5. On unknown dates between 2018 – June 2020, you failed to: **(proved in its entirety by admission)**
    a) Fully complete and/or record initial assessments for one or more service users including but not limited to those in Schedule 1; **(Proved by admission)**
    b) complete and/or record risk assessments of one or more service users including but not limited to those in Schedule 2; **(Proved by admission)**
    c) complete and/or record care/management plans assessments for one or more service users including but not limited to those in Schedule 3; **(Proved by admission)**
    d) update the Epex system following consultations with service users; **(Proved by admission)**
    e) make contemporaneous notes and/or did not mark retrospective entries as retrospective in service users' records; **(Proved by admission)**
    f) keep service users' records updated; **(Proved by admission)**
    g) left gaps in the running records of service users; **(Proved by admission)**
    h) failed to provide information to onward stakeholders. **(Proved by admission)**

Charge 6

6. You failed to maintain proper file management by: **(proved in its entirety by admission)**
    a) Not setting up case files for service users; **(Proved by admission)**

b) Using post it notes and loose papers to record patient notes on; **(Proved by admission)**
c) Failing to keep service users records in a secure locked manner. **(Proved by admission)**

Charge 7

7. Your actions in Charge 6 above put confidential information at risk of being lost and/or confidentiality being breached. **(proved in its entirety by admission)**

Charge 8

8. You lost and/or failed to report and/or escalate the loss of notes/files for: **(proved in its entirety by admission)**
   a) Service User 16; **(Proved by admission)**
   b) Service User 17. **(Proved by admission)**

Charge 9

9. Your actions in charge 8 above: **(proved in its entirety by admission)**
   a) Put Service Users 16 and/or 17 at risk of harm; **(Proved by admission)**
   b) Breached confidentiality; **(Proved by admission)**
   c) Breached data protection; **(Proved by admission)**
   d) Breached information governance provisions; **(Proved by admission)**
   e) Were a breach of the duty of Candour. **(Proved by admission)**

Charge 10

10. On or around 22 June 2020, you failed to follow Covid infection prevention controls by:

Charge 10a

a) not using the outside changing area to put on PPE;

In relation to charge 10a, the panel took account of the written and oral evidence of Witness 7, Witness 8, Witness 9, as well as your oral evidence. The panel also took account of documentary evidence set out in emails which discussed the initial complaint.

It is not disputed that you were allocated to the Covid infection swabbing team. The panel heard evidence that you had gone through the relevant training and that this was your first swabbing duty.

Witness 7 told the panel that you arrived late and entered the Home to get changed. She told the panel that she had no recollection of there being an outside changing area.

In your oral evidence, you told the panel that you recalled that some female colleagues arrived in their scrubs or got changed in their cars. You were clear that, there was no outside changing area, and you were directed to a staff area by the home manager to get changed.

In view of the oral evidence the panel heard from both Witness 7 and you, it was not clear that there was an outside changing area. The panel concluded that you were directed to, and used a staff area to get changed, and therefore did not enter the Home where the residents lived. Therefore, the panel was satisfied on the balance of probabilities, that you did not fail to use the outside changing area to put on PPE, as set out in the charge. The panel found charge 10a not proved.

Charge 10a not proved.

Charge 10b

b) entering the Home without wearing PPE.

For the purpose of charge 10b, the panel interpreted the Home as the area where the residents resided and had access to.

The panel heard oral evidence from both you and Witness 7 that you were directed to a staff area which was part of the building that contained the Home but was used exclusively by staff and not by residents. The panel considered that if you entered a staff area where there was no requirement to wear PPE, and there was no evidence to show that there was an outside changing area, then it could not find charge 10b proved.

Charge not proved.

Charge 11

11. On or around 22 June 2020, did not work co-operatively with colleagues by:

Charge 11a

a) Not following instructions regarding the swabbing process;

In relation to charge 11a, the panel took account of Witness 7's written and oral evidence. Witness 7 worked directly with you on the shift in question. The panel heard oral evidence from Witness 6, 8 and 9 and had access to their witness statements. The panel was also provided with a series of email exchanges that related to the allegation set out in the charge.

Witness 7 was an experienced member of the Covid 19 swabbing team and had been 'swabbing' for approximately three months. She had a good recall of events, and her written and oral evidence was consistent. She told the panel that you did not follow

instructions, and that you had to be constantly reminded about how the swabbing process was to be conducted including the requirement to regularly change gloves. She confirmed that this was the first time that she had experienced difficulties with a colleague on the swabbing team. She told the panel that you would “roll your eyes” and were reluctant to do things in the way that you had been trained.

Witness 7 raised her concerns with her duty supervisor who escalated the issue to her line manager, Witness 9. Although Witness 6, 8 and 9 did not directly observe your alleged behaviour the allegations complained about were the subject of a series of emails between them. The first of these was an email from Witness 9 on the day of the shift, after Witness 7 had reported her concerns to her supervisor. These concerns were subsequently escalated for investigation.

In oral evidence you told the panel that the first you heard about the concern with your alleged behaviour was when you heard from the NMC. You told the panel that you followed the instructions regarding the swabbing process and that no issues were raised with you about your conduct on the day. The panel considered that Witness 7’s concerns were sufficiently serious that she raised them with her duty supervisor on the same day and the matter was escalated to other, more senior, members of staff. The panel found the evidence of Witness 7 to be consistent and reliable and considered that there was no reason as to why Witness 7 would have fabricated the allegation against you. Overall, the panel preferred the evidence of Witness 7 as opposed to your version of events.

The panel preferred the evidence of Witness 7 and on the balance of probabilities it considered it more likely than not that you failed to follow instructions regarding the swabbing process.

Charge 11a proved.

Charge 11b

b) Not helping to clean down the mobile swabbing unit.

The panel took account of the written and oral evidence of Witness 7, who told it that you left early and did not assist in cleaning down the mobile swabbing unit. She told the panel that there was an expectation that everyone would stay to clean up. During her oral evidence Witness 7 asserted that although the incident occurred some time ago it stood out in her mind. In reference to your conduct, she told the panel that there was "*a reluctance on your part to do what we were doing as a team*" The fact you left early was another concern which she had raised with her supervisor at the end of the shift.

You told the panel that you had been authorised to leave early by the coordinator, who arrived at the end of the shift. You said the reason for this was because you lived the furthest away and therefore had the furthest to travel. However, the panel had no evidence to support this. Witness 7 was unable to recall such a conversation taking place and told the panel that you simply left. You also told the panel that you were not 'thrilled' to have been assigned to the swabbing team. In view of your lack of enthusiasm, and the evidence of Witness 7, the panel considered it more likely than not that you sought to leave as quickly as possible.

For the same reasons as documented on the decision for charge 11a above, the panel considered the evidence of Witness 7 to be clear and credible. This concern was raised by Witness 7 with her supervisor on the day of the allegation and the panel had no reason to suspect that Witness 7 had any reason to fabricate her evidence. The panel preferred Witness 7's account of events, that you left the site early and did not help to clean down the mobile swabbing unit.

In view of this evidence, and on the balance of probabilities, the panel considered it more likely than not that you did not help to clean down the mobile swabbing unit.

Charge 11b proved.

Charge 12

12. On or around 22 June 2020, informed at least one other person that you were a band 8a qualified nurse when you were not.

The panel had regard to the written statements and oral evidence of Witness 7, Witness 8 and Witness 9, as well as your oral evidence.

The panel bore in mind that the allegation had been reported by Witness 7, who was the only witness to the conversation. Witness 7 in her written statement said that she had never met you before the swabbing shift and had not met you since. [PRIVATE]. In oral evidence you stated that Witness 7 had commented to you that she was aware of you from the Trust's coordinator's office. You told the panel that Witness 7 could have been mistaken in thinking that you had claimed to be a Band 8a. You said that it would have been 'foolish' and 'embarrassing' for you to have made such a claim. There was no other evidence before the panel to assist it.

Witness 7's written statements set out the following:

> *"I don't know anything about the registrant or his substantive role or banding, just that he was also deployed to the swabbing team* [PRIVATE]*. The registrant told me that he was a band 8a. Within NHS, within the trust there is a banding system. Band 8a would be equivalent to my manager's manger, directorate level. Band 8a is pretty high up…*
>
> *…The context in which the registrant disclosed his banding was very strange. It wasn't during a discussion of 'what do you do?' It wasn't asked of him, we didn't discuss his background. It was during general chit chat and he volunteered the information."*

Witness 7 was questioned about this allegation and was asked whether she could have been mistaken. However, she had a clear recollection which the panel considered to be credible. In oral evidence Witness 7 was clear that she would not have misinterpreted you and that she had a good understanding of nursing grades in the Trust.

The panel could see no reason as to why Witness 7 would fabricate such an allegation and then raise it with her supervisor if it was not true. The panel considered Witness 7 to be a credible and reliable witness. On the balance of probabilities, the panel preferred the evidence of Witness 7 and considered it more likely than not that you informed at least one other person that you were a band 8a qualified nurse, as set out in the charge.

Charge 12 proved.

Charge 13

13. Your actions in Charge 12 above were dishonest in that you sought to misrepresent your level of seniority.

The panel bore in mind that you have been a nurse for 30 years and therefore you would have been familiar with and would have understood what the job grading structure for nurses was and what each grade meant in terms of seniority. The panel was not provided with any evidence that you were previously appointed as a Band 8a. The panel could not identify any legitimate reason why you would have claimed to have been a Band 8a or told Witness 7 that you held such a grade.

The panel considered that Witness 7 provided credible evidence that you had told her that you were a Band 8a. The panel considered that you would have known that it was dishonest of you to misrepresent yourself as a Band 8a in a clinical setting when you did not hold this grade. An ordinary decent person would interpret your misrepresentation as being dishonest.

On balance, the panel was satisfied that there was sufficient evidence to show that you were dishonest in that you sought to misrepresent your level of seniority, as set out in the charge.

Charge 13 proved.

Charge 14

Whilst working as a registered nurse at Chester Nursing Home:

14. On or around 18 December 2020 you:

Charge 14a

a) failed to administer Lansoprazole to Residents A and B;

The panel had regard to the MAR charts for resident A and B covering December 2020, as well as Colleague A's written statement and oral evidence, Witness 10's written statement and oral evidence, Witness 13's written statement and oral evidence, and the document referred to by Witness 13 which summarised the errors made by you.

During oral evidence from the witnesses, the panel heard differing accounts as to whether you had received an induction in the care home. Witness 10 stated that you received a two-day induction and that you would have been expected to be administering medication under supervision. You told the panel that you were administering drugs from 8:30am on your first day, and that you received no paperwork setting out details of your induction and what had been covered.

Witness 10's written statement set out the following:

"On 18 December 2020 the registrant failed to give 'Lansoprazole' to two patient. He had signed for the medication on the MAR chart to show it had been administered to the residents but he had not administered the medication. This was a relatively minor error and it occurred on the day after he had commenced his employment at the home."

In response to questions by the panel, you confirmed that it was your signature on the MAR charts for Residents A and Resident B and you maintained that you had not failed to administer the Lansoprazole.

In oral evidence you told the panel that you were confident that you had administered the Lansoprazole, and you recalled that the tablets were difficult to break into two parts. You told the panel that, as a rule, you would not sign a MAR chart until after you had administered the medication. You also told the panel that you did not think it possible that you could have missed a medication dose.

Witness 13 confirmed in oral evidence that she had raised these errors with you during a meeting on 22 December 2020 and had discussed a synopsis of errors made by you which were later documented. This showed that Witness 13 had discussed the errors with you on 22 December 2020. Witness 13 confirmed that she had personally audited the MAR charts and that she had circled the entries which related to these errors.

Witness 10 confirmed in his written and oral evidence that he was aware that Witness 13 had discussed the errors with you in your meeting on 22 December 2020. Witness 10 had subsequently discussed the errors with you in a meeting on 30 December 2020. The notes of the meeting on 30 December 2020 were not explicit, and simply stated the following:

'I explained some of the medication notification required should medication not be given/if errors occur etc.'

You do not recall the errors being mentioned at this meeting and asserted that you had never seen the notes of the meeting which had been provided to the panel.

Resident A's MAR chart showed a drug count on 17 December 2020 and on the 19 December 2020. The drug count indicated that when the Lansoprazole had been counted on 19 December 2020 by Colleague A, an extra half dose remained, and it had therefore not been administered on 18 December 2020.

You told the panel that you recalled administering this medication to Resident A because you had to cut it in two, and you were also aware that it was a boxed medication. When asked if you could have made a mistake or missed it accidentally, you insisted that the medication was administered and signed for. In your oral evidence you stated that if the medication was signed for then it was administered.

The panel found the evidence of Colleague A to be consistent, clear and credible. When taken alongside the evidence shown in the MAR chart and the evidence provided by Witness 13 the panel preferred the evidence of Colleague A.

Resident B's MAR chart showed a drug count on 19 December 2020 and a drug count on the 21st of December 2020. The MAR chart drug count on 21 December 2020 indicated that when the Lansoprazole had been counted on 21 December 2020 by Colleague A, an extra half dose remained, and it had therefore not been administered on 20 December 2020.

You told the panel that you recalled administering this medication to Resident B because you had to cut it in two, and you were also aware that it was a boxed medication. When asked if you could have made a mistake or missed it accidentally, you insisted that the medication was administered and signed for. In your oral evidence you stated that if the medication was signed for then it was administered.

The panel found the evidence of Colleague A to be consistent, clear and credible. When taken with the evidence provided by the MAR chart and the evidence provided by Witness 13 it preferred the evidence of Colleague A.

Therefore, from the evidence before it, the panel considered it more likely than not that you failed to administer Lansoprazole to Residents A and B, as set out in the charge.

Charge 14a proved.

Charge 14b

b) signed one or more MAR charts to show the medication had been administered.

The evidence considered in charge 14a was also applicable for charge 14b. You confirmed in your oral evidence that you signed the MAR charts for Resident A and B indicating that you had administered the medication. The panel concluded that your signature on the MAR charts clearly showed that the medication had been administered by you.

Therefore, from the evidence before it, the panel determined that it was more likely than not that you signed one or more MAR charts to show the medication had been administered, as set out in the charge.

Charge 14b proved.

Charge 15

15. Failed to follow safety procedures in respect of insulin pens, in that:

Charge 15a

a) between 17 and 30 December 2020, you left a needle on an insulin pen;

The panel took account of the written and oral evidence of Witness 10, along with the notes of a meeting between Witness 10 and you on 30 December 2020.

Witness 10 recalled the incident clearly in his oral evidence. You, however, had no recollection.

When questioned about the procedure for handling needles, Witness 10 told the panel that the disposable needles were separate from the insulin pen and should be removed and replaced after use. You also confirmed to the panel that it was standard practice to discard used needles once removed from insulin pens.

Witness 10's written statement set out the following:

> *"At this meeting we also discussed insulin pens. There had been an incident where the registrant had left a needle on an insulin pen. There is a sharps bin on the medication trolley so the needles can be disposed of straight away. I reminded him that the needles for the insulin pens are only to be used once and discarded."*

When questioned about this Witness 10 told the panel that needles had to be replaced every time, there was no reason not to replace them, and that he had documented a meeting discussing the issue with you on 30 December.

You told the panel that you were not aware of the incident and that the meeting on 30 December was a general discussion, and that you were not advised that you needed to do anything differently.

The only evidence offered by the NMC in respect of this charge, was Witness 10's witness statement and the non-specific notes of the meeting on 30 December 2020. The panel did

not consider that this evidence was specific and detailed enough to discharge the burden of proof in this allegation.

Charge not proved.

Charge 15b

b) on or around 18 February 2021, left a used insulin needle on an insulin pen.

The panel took account of the written and oral evidence of Colleague A and Witness 10, along with a handwritten and contemporaneous note made by Colleague A on 18 February 2021, and a typed local witness statement from Witness 2 recalling the events of the 17 February 2021, which appeared to be erroneously dated as 8 February 2021.

In oral evidence you told the panel that you had a lot of experience of administering insulin and bloods over a 30-year period. You said that you had no recollection of this incident, and that you had not been working on 18 February 2021. You stated that if you had left the needle on the insulin pen on 17 February 2021 then it would have been discovered by the night staff. During Colleague A's oral evidence, she explained that the insulin was only prescribed to be given in the mornings. Therefore, the night shift staff would not have needed to use the insulin pen and would not have found the needle on the pen.

Colleague A's contemporaneous note made on 18 February stated:

> *"While working I found the used insulin needle left on the pen of … it was loosely screwed on, no caps on it, just the top of the pen was replaced. S/N … witnessed the same."*

You told the panel that you were not aware of the contemporaneous note made by Colleague A on 18 February 2021.

Witness 10's written statement set out the following:

> *"On the next medication round after the registrant, [Colleague A] went into the medication trolley to administer insulin to a resident and found the old needle still on the insulin pen. To administer insulin we use an insulin pen, on the medication trolley there is a separate box of needles. When administering insulin, put a new needle onto the pen, dial the amount of insulin needed, remove the sheath, administer the insulin and then dispose of the needle straight away. The needles are single use needle. There are two needle disposal bins on the medication trolley, one on top of the trolley and a smaller one inside as well...*
>
> *…We didn't investigate this incident in depth. It paled into significance in relation to the other medication error that day where six medications were not administered on 14 February 2021."*

The panel found the evidence of Colleague A to be consistent and credible. In view of the contemporaneous note and the other evidence before it, the Panel was satisfied, on balance, that you left a used insulin needle on an insulin pen, as set out in the charge.

Charge 15b proved.

Charge 16

16. On or around 16 January 2021, you failed to check and/or record the blood glucose levels of Resident F before drawing up the insulin and signing the insulin chart.

The panel took account of the written and oral evidence of Colleague A and Witness 10, along with notes made by Witness 10 on 22 January 2021, and a copy of the contemporaneous hand-written local statement of Colleague A detailing the allegation. The panel also saw the insulin chart relating to the incident.

The panel had sight of notes made by Witness 10 on 22 January 2021 following a telephone conversation between you, Witness 10 and Witness 13 which included the following:

> *'insulin signed for and the resident's BM was not checked. Gareth stated that he had checked the BM and it was low. He had asked [Colleague A] if he should give the insulin and she had said 'no' as the BM was low. Gareth admits having already drawn the insulin up. Gareth told not to draw up insulin in future without knowing the BM and determining it should be given.'*

The meeting notes were signed and dated by you on the 2 February 2021. In your oral evidence you stated that you only signed the notes to confirm that you were at the meeting and had felt pressured into signing.

Colleague A's hand-written statement set out the following:

> *"That shift the registrant had given me an empty sheet with the drawn up insulin. I asked him if he checked the blood sugar as it wasn't recorded on the sheet. If I remember correctly he said he didn't yet but he will. I refused to sign it until he checked the blood sugar level…*
>
> *The registrant had marked initially in the 'Insulin Dosage' column that the insulin had been drawn. I was supposed to countersign the insulin sheet and found he had not checked the blood sugar levels before drawing up the insulin. When the registrant checked the resident's blood sugar levels, he found that they were low and he shouldn't have drawn up the insulin as we didn't end up administering to the resident. I changed the record to 'Omitted'"*

The panel also heard clear oral evidence from Colleague A as to the sequence of events. Colleague A was specific that you *'placed the needle on the pen and expelled units to remove the air'* before Colleague A established with you that you had not checked the

blood glucose levels. On checking the blood glucose levels, they were found to be too low to justify the administration of insulin. Therefore, Colleague A confirmed that she entered the word *'Omitted'* on the insulin chart and referred the panel to the insulin chart which reflected this.

In oral evidence you explained that you would never have drawn up insulin without checking the blood glucose levels first. You told the panel that you felt pressurised into signing the notes of the meeting held on 22 January 2021. You said that the notes that Colleague A wrote describing the events on 16 January 2021 had not been shared with you.

The panel, however, did not find it credible that you would have signed the notes of the meeting held on 22 January 2021 if you disagreed with the contents, especially as they showed that you had made errors, which you claim you had not made. The panel also bore in mind that you had signed the notes sometime after the meeting and therefore you would have had time to reflect and raise any issues or objections about the notes' contents.

The panel found that the contemporaneous hand-written note and oral evidence of Colleague A were consistent and credible. It did not find it credible that you, a very experienced nurse, would sign the notes of the meeting held on 22 January 2021 if you disagreed with the contents. This was especially the case given that the notes were specific in detailing your involvement in the alleged event and your failure to check and or record the blood glucose levels of Resident F before drawing up the insulin and signing the insulin chart.

In view of the evidence before it, the panel was satisfied, on balance, that you drew up the insulin without checking the blood glucose levels, as set out in the charge.

Charge 16 proved.

Charge 17

17. On or around 2 February 2021, you:

Charge 17a

a) Failed to administer Levothyroxine to Resident C;

The panel took account of the written and oral evidence of Colleague A and Witness 10, alongside the notification to the Regulation and Quality Improvement Authority (RQIA), notes made by Witness 10 after a supervised drug round, the local statement of a student nurse, and Resident C's MAR chart.

The panel bore in mind that Witness 10 considered this error sufficiently serious to report it to the RQIA. As a result, a supervised medication round was undertaken on 5 February 2021. Witness 10 provided contemporaneous notes of a meeting held on 5 February 2021 in which it was recorded that you acknowledged that you had made a drug error on 2 February. You maintained that these notes had not been shared with you.

Colleague A's local statement dated 3 February 2021 showed that Resident C's blister pack contained an extra Levothyroxine tablet. The student nurse confirmed that there had been no discrepancies with the drugs on the, 1 February 2021.

In oral evidence you told the panel that Colleague A was mistaken and that you administered the drug and signed the MAR chart. The panel took account of Residents C's MAR chart, which you had signed on 2 February to show that you had administered the medication. However, the panel considered it unlikely that you had administered the medication in view of the discovery of the extra medication in the blister pack on 3 February. The panel concluded from this that the drug had not been administered on 2 February.

You also told the panel that you were unaware of the notification to the RQIA until the referral was made to the NMC. In the hand-written notes of the meeting with Witness 13 on 16 February 2021, which you signed, there was reference to various parties being informed about medication errors, including the RQIA, which would have indicated that you had been made aware of this.

You told the panel that you had requested to see the blister packs containing the medication which you allegedly failed to administer, but these had not been shown to you.

The panel found the evidence of Colleague A to be credible. The panel determined that there was an extra tablet in the blister pack and, as such, this tablet was not administered by you on 2 February 2021. Further, the panel gave weight to the contemporaneous meeting notes provided by Witness 10, which acknowledged that you accepted the error.

On balance, the panel found that you had failed to administer Levothyroxine to Resident C, as set out in the charge.

Charge 17a proved.

Charge 17b

b) Signed the MAR chart that the Levothyroxine had been administered when it had not been;

The panel referred to the evidence in respect of charge 17a. Again, the panel took account of Residents C's MAR chart, which you confirmed in oral evidence that you had signed on 2 February to indicate that you had administered the medication.

In view of the evidence before it, the panel was satisfied, on balance, that you had signed the MAR chart that the Levothyroxine had been administered when it had not been, as set out in the charge.

Charge 17b proved.

Charge 17c

c) administered two doses of Fultium D3 to Resident D instead of one dose;

The panel took account of the written and oral evidence of Colleague A, as well as her local statement date 2 February 2021, and the written and oral evidence of Witness 10, the notification to the RQIA, along with Resident D's MAR chart.

The panel also had sight of contemporaneous notes made by Colleague A setting out that there was a dose of Fultium D3 unaccounted for when she counted the drugs on 3 February. Colleague A also annotated the MAR chart stating '*tablets missing from blister?? Popped x2?? Manager advised to omit for today. Witnessed by x2*'. Both the contemporaneous note and the MAR chart showed that a dose was unaccounted for.

In oral evidence, however, you denied administering two doses of Fultium to Resident D. Your recall of the event was clear, and you were able to provide the panel with a detailed description of the actions that you had taken. You were clear that you did not open two blister packs and present the patient with double the amount of medication. You said that the medication was administered on a spoon, and you explained to the panel that you would have known or realised if there were four tablets on the spoon, and that that would obviously equate to two doses. The panel heard no evidence as to how the medicine should be administered or any evidence to contradict your explanation about administering this medication.

The panel was satisfied that the evidence given by colleague A was credible. However, the panel had not been provided with sufficient evidence to show that it was you that had administered the missing medication. In view of all the evidence the panel heard, including your explanation about the administration of Fultium, it was not satisfied that the NMC has

discharged its burden of proof that you administered two doses of Fultium D3 to Resident D instead of one dose, as set out in the charge, and therefore it found the charge not proved.

Charge 17c not proved.

Charge 17d

d) administered two tablets of Furosemide to Resident E instead of one tablet.

The panel took account of the written and oral evidence of Witness 10, Resident E's MAR chart, the written and oral evidence of Colleague A, and her local written statement.

Colleague A in her local written statement confirmed that she had found that one tablet of Furosemide was missing from the resident's medication. This was reflected by Colleague A's notes on the MAR chart. Again, your recall of the event was clear, and you were able to provide the panel with a detailed description of the actions that you had taken. The panel accepted your oral evidence.

In oral evidence you were clear that you had not given two doses. Initially, when asked about this you contended that the medication was in liquid form. However, the MAR chart showed that the medication was in tablet form, and you maintained that you had not given two doses. The NMC provided the written and oral evidence of colleague A which confirmed that medication missing from the blister pack. This had been documented on the MAR chart by colleague A. However, there were no witnesses, or further evidence before the panel to show that you had administered the missing medication.

In view of the oral evidence the panel heard, it was not satisfied on the balance of probabilities, that you administered two tablets of Furosemide to Resident E instead of one tablet, as set out in the charge, and it found the charge not proved.

Charge 17d not proved.

Charge 18

18. On or around 14 February 2021, you:

Charges 18a)

a) failed to administer the following medications to Resident A:
    i) Aspirin; **Charge proved.**
    ii) Bisiprolol; **Charge proved.**
    iii) Lercandipine; **Charge proved.**
    iv) Levothyroxine; **Charge proved.**
    v) Moxonidine; **Charge proved.**
    vi) Sodium bicarbonate. **Charge proved.**

The panel considered charges 18a)(i) – 18a)(vi) together because they were all alleged to have occurred at the same time and the medications were all linked to Resident A.

The panel took account of the written and oral evidence of Colleague A, Colleague A's local statement dated 15 February 2021, the local statement of Witness 2, the meeting notes of 16 February 2021 of your meeting with Witness 13, Resident A's MAR chart, and the Regulation and Quality Improvement Authority report completed by Witness 12 20th February 2021. The panel also took account of your oral evidence.

Colleague A's written statement set out the following:

> *"The registrant signed for six medications as being aspirin, bisoprolol, lercanidipine, levothyroxine, moxonidine and sodium bicarbonate as being administered but they had not been. I think this medication error was discovered the next day, when I was*

doing the morning medication, none of the tablets were missing from the blister packs. All the medication was for one resident."

Witness 13 confirmed to the panel that you had been working on 14 February, and that you had signed the MAR chart to show that you had administered the medication. The panel had sight of the MAR chart which showed your signature.

The local statement of Colleague A dated 15 February 2021 provided the panel with clear and contemporaneous evidence that the medication remained in the blister packs after they should have been administered from.

The panel also took account of the Regulation and Quality Improvement Authority (RQIA) report completed by Witness 12. Again, the panel noted that the concerns around your medicines management were sufficiently serious to have been reported to the RQIA.

The panel had regard to the local statement of Witness 2 and her notes of a meeting with you on 16 February 2021. The notes showed that Witness 2 had discussed the medication errors with you.

In your oral evidence you told the panel that you worked on the 14 February 2021 and administered the medication to Patient A. You said you would have had no reason to withhold the medication from the patient. You said this patient was well known to you and was a retired nurse who was very particular about her medications and would have been very vocal had you not administered them to her. You told the panel that this incident 'occurred on the 14 February and there was a gap of 48 to 72 hours before it was brought to your attention'. You told the panel that you subsequently requested to see the blister packs containing the medication which you allegedly failed to administer. However, these were not shown to you. In respect of Colleague A' written statement dated the 15 February 2021 you said that this had never been shared with you. You explained that you only signed the meeting notes on the 16 February because you were being threatened with referral to the NMC and your NMC conditions were no longer being supported.

The panel, however, was not persuaded by your evidence and found it unlikely that a nurse with your level of experience would sign meeting notes without indicating or challenging that you disagreed with them. The panel was also satisfied that the contemporaneous record produced by Colleague A accurately reflected what had occurred.

In view of the evidence before it, the panel was satisfied, on balance, that you failed to administer the medications set out in charges 18a)(i) – (vi) to Resident A, and therefore found them all proved.

Charge 18b

b) Incorrectly signed the record that the medications in a) above had been administered.

The panel took account of the evidence summarised in charge 18a above.

Resident A's MAR chart clearly showed that you signed your signature for the administration of the medications set out in 18 a) above. In your evidence, you have confirmed that this was your signature.

The panel found in 18 a) that that the medication remained in the blister packs after they should have been administered. In view of this evidence, the panel was satisfied, on the balance of probabilities, that you incorrectly signed the record that the medications listed in 18 a) above had been administered when they had not, as set out in the charge, and it found the charge proved.

Charge 18b proved.

Charge 19

19. On or around 17 February 2021, failed to record the administration of a new medication namely Cephalexin to Resident F, on:

Charge 19a

a) the MAR chart;

The panel had regard to the written and oral evidence of Witness 10 and Witness 11, as well as the local statement of Witness 11, Resident F's MAR chart and the RQIA report dated 22/02/2021.

Witness 11's written statement set out the following:

> *"When I was doing the evening medications, I found that the space on that resident F's MAR sheet was blank, but there was a time in the time column signed by the registrant indicating a medication had been given. If we start a medication mid cycle (middle of the month) when we start the medication, we draw arrows, from the beginning of the month to the date we start administering the medication, so in this case the arrow would be from 1 February 2021 to 16 February 2021 to indicate that the medication was commenced on 17 February 2021. The times had been filled in and the arrows had been put in and the registrant had signed that the medication had been given at 17:00. He had signed for it. The registrant didn't specify what medication he had administered. We had no idea what medication he had administered to resident F…*
>
> *…If we get a new medication in for a resident, we print out a new computerised prescription sheet. The prescription sheet is signed by two people. When we put new medication on a prescription sheet on the computer, it is second checked by a second nurse and then printed out and put in the resident's file. The registrant*

hadn't recorded the antibiotics on the computerised prescription sheet or on the paper MAR chart, he hadn't recorded it anywhere. On the paper MAR chart, the registrant recorded that he received 15 tablets but didn't say what they were."

In her oral evidence Witness 11 confirmed that on the evening of 17 February, while undertaking the evening medication round, she noticed that Resident F's MAR chart showed that medication had been administered. She gave a clear account in her witness statement about the process that should be followed when a new drug was administered to a resident. She explained that a new computerised prescription sheet should be printed out and should be second checked before being put into the resident's file.

In Witness 11's oral and written evidence, she explained that the MAR chart should contain the name of the medication, the dose and how often it was to be administered. However, all that was recorded on the MAR sheet was the quantity of 15 tablets, and that your initials were next to the entry. In her statement she said that she found a box of Cephalexin with one tablet missing. She also told the panel that she checked the computerised prescription sheet, but the medication had not been recorded.

The panel found the evidence of Witness 11 to be clear and credible. It was consistent with her contemporaneous handwritten local statement which was written on the 20 February 2021. In her local statement Witness 11 said she had been told at handover that Patient F had been prescribed Cephalexin. However, she noticed that it had not been recorded on the MAR sheet and that the computerised prescription sheet had not been updated.

Witness 11 said there was a blank section on the MAR sheet where she assumed it should have been included as you had signed the evening box to say you had administered one tablet. You had also entered 15 tablets into the prescription box, where the label should have been affixed, but had not named the drug or detailed the dispensing instructions. She said she found a box of 15 cephalexin tablets with Resident F's name on

it and with the dispensing instructions. One tablet had been removed from the box. She said she completed the MAR sheet and updated the printed prescription sheet.

You stated in your evidence that you were clear that there would have been entries from you about Resident F's medication in the computerised records system. You suggested to the panel that it would have been helpful to have had those records before the panel.

Witness 10 set out in his written statement:

> *"On 17 February 2021 the registrant administered Cephalexin to patient but didn't record it on the MAR chart or computerised records."*

Witness 10 considered this error sufficiently serious to include it in an RQIA report dated 22 February 2021, as set out in his witness statement.

You told the panel that you ordered the medication and when you received it, instead of you doing handwritten notes about it, you stuck the pre-printed label with the relevant information onto the MAR chart. You accepted that it was your responsibility to apply the label properly. You were certain that the label was stuck to the MAR chart when you administered the drug on 17 February 2021. In your evidence you posed the question as to why you would sign an empty box and from your point of view it would not have made any sense for you to have done so.

There was no evidence before the panel to suggest that the label had been removed. The panel accepted the evidence of Witness 11 who stated that when she looked at the MAR chart there was no label. During your oral evidence you were questioned about this by the panel and agreed that there was nothing to suggest that a label had been torn off the MAR chart.

On balance, the panel considered that you had partly completed the MAR chart in that you signed your initials and recorded the number of tablets. However, the name of the

medication, the dose, and how often it was to be administered were missing and you had signed an empty medication details section. Therefore, the panel determined that you failed to fully record the administration of Cephalexin to resident F on the 17 February 2021.

In view of this evidence, the panel was satisfied, on the balance of probabilities, that you failed to record the administration of a new medication namely Cephalexin to Resident F, as set out in the charge, and it found the charge proved.

Charge 19a proved.

Charge 19b

b) the computerised records.

The panel took account of the oral and written evidence of Witness 11, the local witness statement of Witness 11 dated 20 February 2021, along with your oral evidence.

In her witness statement Witness 11 said that when a new medication was given to a resident a new computerised prescription sheet was printed and this was signed by a second checker. The record was then printed and was placed in the resident's file. She said that you had not recorded the drug on the computerised prescription sheet. In her oral evidence Witness 11 said that she had checked the electronic computerised records and there were no entries from you in respect of the Cephalexin medication.

Witness 11 also recorded the lack of an entry in the computerised records in her contemporaneous handwritten statement dated 20 February 2021. In your evidence you stated that there would have been information on the computerised prescription sheet including the fact that you had ordered the medication and what the resident’s symptoms were. You indicated that it would have been helpful if the panel had had the computerised prescription chart in front of them.

Whilst the panel did not have sight of the computerised records, it found the evidence of Witness 11 clear and consistent, as supported by her contemporaneous statement of 21 February 2021. It was satisfied, on the balance of probabilities, that you failed to record the administration of a medication on the computerised records, as set out in the charge, and it found the charge proved.

Charge 19b proved.

Charge 20

20. On or around 17 February 2021, failed to administer Baclofen to Resident D and/or record the administration of Baclofen on the MAR sheet.

The panel had regard to the written and oral evidence of Witness 10 and, as well as the local statement of Colleague A and Resident D's MAR chart, and your oral evidence.

The panel had sight of Resident D's MAR chart, on which there was no signature to indicate that Baclofen had been administered on 17 February 2021.

Witness 10's written statement set out the flowing:

> *"2021 the registrant administered a dose of Baclofen to a resident without signing the MAR sheet. [Witness 2] noticed the error the next day (18 February 2021) when she was doing the medication round… As the medication wasn't signed for we don't know whether it was given or not. If it's not signed for, we assume it wasn't administered."*

The panel identified an inconsistency in the evidence of Witness 10, who stated that you administered the medication without signing the MAR chart. Witness 10 later said that if the MAR chart was not signed, then the assumption would be that the medication was not

administered. Witness 10 also explained to the panel that Baclofen was a liquid medication and came in a bottle. As a result, it would be difficult to tell from looking at the bottle whether or not a dose had been administered.

Witness 10 told the panel that he knew your signature and had seen from other patient's MAR charts that you had undertaken the lunchtime drug round. You said you would need to see the MAR charts before commenting, but these had not been made available to you. The panel was not provided with other MAR charts on which to confirm Witness 10's assertion. There was no evidence before the panel to prove that you had undertaken that particular drug round or that you had been responsible for administering Baclofen to Resident D.

In your oral evidence you confirmed to the panel that you worked all day that particular day. However, you said that you did not undertake the lunch time medication round and that it was rare for you to do a lunchtime drug round. You said you had done the morning medication drug round, and this took you between 2.5 hours and 3 hours. After doing the morning medication round you said you were then involved with caring responsibilities.

The panel considered the evidence before it to be insufficient to satisfy the NMC's burden of proof. In view of the evidence before the panel, it was not satisfied that there was sufficient evidence for it to find that you failed to administer Baclofen to Resident D and/or record the administration of Baclofen on the MAR sheet, as set out in the charge, and it found the charge not proved.

Charge 20 not proved.

Charge 21

21. On or around 21 February 2021, you:

Charge 21a

a) Failed to give controlled drug MST to resident G;

The panel took account of Witness 10's witness statement and his supplementary witness statement, the RQIA report dated 22 February 2021 and Resident G's MAR chart, and your oral evidence.

Witness 10 told the panel that you administered the drug to Resident G and signed the MAR chart, when you had not administered the drug. The panel had sight of the MAR chart which showed a drug count of 15 for the MST tablets after they had been administered on the previous day, 20 February 2021. On 21 February 2021, your signature appeared on the MAR chart, however, above it there appeared an 'O' which had been struck through, and the MAR chart showed another drug count of 15. The panel interpreted the MAR chart as indicating that no dose of MST had been administered by you on 21 February 2021.

MST was a prescribed drug for Resident G, which had not been prescribed 'as required', and should have been administered. The panel was of the view, that as it had been prescribed by the GP, it should have been administered as prescribed. The panel considered you to be under a duty to administer the MST or to take appropriate action to discuss any issues with the prescriber.

In your oral evidence you told the panel that Resident G appeared over sedated. You confirmed that you made the decision not to administer the drug. You said that you were acting in Resident G's best interests and that your clinical judgment took precedence in the matter. You said that it was your intention to hold back the medication until later in the day when Resident G would be less sedated. You explained that MST can reduce the respiratory rate, and you did not want to cause any harm to the resident. You confirmed that you did not consult anyone else about your decision or contact the resident's GP. In oral evidence you said: *'if I had rung the surgery, I am fairly confident that they [the GP] would have agreed with my decision.'*

The panel noted that there was nothing recorded on the MAR chart explaining your reason for you withholding the medication.

The panel noted that this matter had been referred to the RQIA the same day. The reason for the referral was non-administration of a prescribed controlled drug to Resident G on the 21 February 2021.

Taking all of this evidence into account, the panel was satisfied, on the balance of probabilities, that you failed to give controlled drug MST to resident G, as set out in the charge, and it found the charge proved.

Charge 21a proved.

Charge 21b

b) Incorrectly recorded that you had administered MST to Resident G:

Charge 21b)i)

i) On Resident G's MAR chart;

The panel had regard to the written evidence of Witness 2 and Witness 10, as well as the oral evidence of witness 10 and your oral evidence. The panel also took account of the RQIA referral dated 22 February 2021, Resident G's MAR chart, and your oral evidence.

Witness 10 set out in his written statement that you signed the MAR chart to show that you had administered the medication to Resident G, and then retrospectively altered the MAR chart. Witness 2's local statement stated that she saw you alter the controlled drug book and Resident G's MAR chart as follows:

‘He run to the trolley 2 and I followed him there. He put out the MAR sheet and opened at Resident G medication and he transformed the 1 on top of the MST given on 0 which means on the MAR sheet code, not given, and he put 15 under his signature [sic]*.’*

The panel considered that the ‘O’ on the MAR chart appeared to be a heavily inked alteration of something that had been written there previously. In response to questions during cross-examination by the NMC, you denied altering your entry on the MAR chart. It was put to you by the NMC that you had originally put a 1 in the MAR chart and that you had subsequently altered this by putting a struck through ‘0’ over the number 1. You denied this, indicating that you had originally put a strike through ‘0’ on the MAR chart to show that you had not administered the MST.

The panel had sight of the MAR chart and the contemporaneous local statement of Witness 2 and the evidence of Witness 10. As a result, the panel concluded that it was more likely than not that an alteration had been made by you after Witness 2 discovered that an additional MST tablet was in the stock on the evening on 21 February 2021.

The panel’s view was, on balance, that you signed the MAR chart to show that you administered the MST. Although there was an entry above your signature which was subsequently altered, this did not affect the signature which was the primary indicator confirming that the drug had been administered.

In view of this evidence, the panel was satisfied, on the balance of probabilities, that you signed Resident G’s MAR chart, as set out in the charge, and it found the charge proved.

Charge 21b) i) proved.

Charge 21b)ii)

ii) In the Controlled Drug book;

The panel took account of an extract from the controlled drugs book referencing 21 February 2021 in respect of Resident G, Witness 2's local statement Witness 10's witness statements, the report to the RQIA dated 22 February 2021, Witness 12's local statement dated 22 February 2021, and your oral evidence.

The controlled drug book showed an entry by Witness 2 and another checker at 8:00 AM on the 21st of February 2021 indicating that a stock check was completed and that a stock of 15 tablets was present. The next entry was made by you at 8:00 AM. This records that you had administered the MST to resident G. It was signed by you but there was no record of a second signature. The stock count following this record of administration of MST showed that there were 15 tablets. However, this entry was heavily inked, and it appeared that the number 5 was written over another number. The next entry in the book is recorded as a stock check, signed by you with no second checker at 8:00 PM showing a count of 14 tablets. Further, there were two subsequent entries at 8:00 PM from witness 2 and countersigned by independent checkers showing a stock check of 15 tablets.

In his witness statement Witness10 said that the controlled drug book had been retrospectively altered to show that a drug had not been administered. In his oral evidence Witness 10 said that in circumstances where a mistake was made it should have been flagged to the person working alongside you and this did not happen. In addition, mistakes should be recorded, signed for and dated. He said it was clear to him that the record was retrospectively amended. He questioned why you did not get a colleague to countersign the record.

Witness 2 made a local statement on 21 February 2021, stating that at 18:30 she had checked the MST stock and found that there were 15 tablets present. In this statement she said that the controlled drug register showed that you had administered one tablet in the morning leaving a stock of 14 tablets. Witness 2 explained that when she highlighted this mistake to you, you modified both the MAR sheet and the controlled drug book,

modifying the entries to show that there were 15 tablets and not 14 which was what you had previously recorded.

Witness 2 detailed how she then took the book from you and did not allow you to make any further alterations. Witness 2 recounted that she then phoned Witness 12 to report what had happened. Witness 12 also wrote a contemporaneous local statement on the 22 February 2021 confirming that Witness 2 had phoned him to say that she had found an extra MST tablet in the controlled drugs store. She had explained what had happened and that you wanted to change the count in the Controlled Drug (CD) book because it was incorrect.

In your oral evidence you explained that you mistakenly wrote a count of 14 at 8am on the 21 February 2021. You reiterated that you had not administered the MST to Resident G and that you had written 14 in the stock count in error. You explained that you realised that this was an error and so marked the control book with the word ‘error’. You wrote “ERROR” across both the 8am entry relating to the administration of MST and the subsequent entry which was your stock check at 8pm. However, before you were able to amend the subsequent entry, you alleged that the book was taken from you by a Witness 2, and you were not given an opportunity to amend it. You reiterated that you had not falsified any record, and it was simply a clerical error.

In considering this charge, the panel was persuaded by the evidence from Witness 2, witness 12 and witness 10. You gave evidence that you made a decision not to administer the MST to Resident G based on your clinical judgement. The panel considered that your evidence was not credible that you signed the controlled drug book indicating that the MST had been administered at 8am on 21 February 2021 and immediately altered the stock number to 15 to show that no administration had been made. You gave evidence that this was a simple clerical error. The panel was not satisfied that you would not have indicated in the controlled drug book at the time of entry that this was a clerical error and informed your colleague accordingly. The panel considered that on the balance of probabilities, the explanation offered by Witness 2 where she reported to witness 13 at the

time and which both Witness 2 and Witness 13 captured in their contemporaneous statements was credible.

Therefore, on the balance of probabilities, the panel considered that you Incorrectly recorded that you had administered MST to Resident G in the Controlled drugs book.

In view of this evidence, and on the balance of probabilities, the panel found the charge proved.

Charge 21b)ii) proved.

Charge 21b)iii)

iii) Without a second checker.

The panel took account of an extract from the controlled drugs book referencing 21 February 2021 in respect of Resident G, the written and oral evidence of Witness 10, and your oral evidence.

Again, the panel had sight of the controlled drug book which clearly showed your signature, indicating that you had administered the MST. However, there was no second signature provided by a ‘second checker’ as was required for the administration of controlled drugs. In oral evidence you accepted that there should always be a second checker to sign the entry, but when asked you said that you were not sure why that did not happen on this occasion.

In view of this evidence, and on the balance of probabilities, the panel found the charge proved.

Charge 21b)iii) proved.

Charge 22

22. On or around 21 February 2021, you altered the following records to show that MST had not been administered to Resident G:

Charge 22

a) Resident G's MAR chart;

The panel had regard to the written evidence of Witness 2 and Witness 10, as well as the oral evidence of witness 10 and your oral evidence. The panel also took account of the RQIA referral dated 22 February 2021 and Resident G's MAR chart. The panel also took account of a note of a meeting held on the 22 February 2021 between Witness 13 and Witness 2. The panel also took account of your oral evidence.

In his witness statement Witness 10 said that you signed the MAR chart to show that you had administered MST, a controlled drug, when you had not done so. Witness 10 went on to say that you then retrospectively altered the MAR sheet and the controlled drug book to indicate that the drug had not been administered. He said that the error had been picked up by Witness 2 during the evening medication round. He noted that Witness 2 found there was one more MST tablet in stock than shown on the controlled drug book. He said that this meant the medication had not been given. However, he noted that both the MAR chart and the controlled drug book were signed, indicating that the drug had been administered. In addition, Witness 10 also added that a second checker had not signed the controlled drug book to show that the drug had been administered in line with the home's policy.

Witness 2's local statement indicated that subsequent to the error in the controlled drug book being pointed out to you, you altered the entry on the MAR chart.

In your evidence you said that the MAR chart was correctly recorded and that the change you made was simply to reflect an error on your part. You said you went to correct the controlled drug book but that Witness 2 had removed it with the result that you did not have the opportunity to make the necessary amendment. It was put to you that Witness 2 saw you alter the MAR chart and the controlled drug book and that was the reason why Witness 2 had removed it from you. You denied altering any records and said that a colleague who was there at the time could verify that you did not alter anything.

The panel took account of minutes of a meeting between Witness 13 and a senior carer at the Home. The senior carer, when questioned about the incident on 21 February 2021, said of the MAR sheet '*I was upstairs when he checked, and he did not change/have a pen in his hand'*. However, she did not see the controlled drugs register.

The panel gave careful consideration to Resident G's MAR chart and the manner in which it appeared to have been completed. The panel considered that the 'O' on the MAR chart appeared to be a heavily inked alteration of something that had been written there previously. Because of the nature of the 'O' with a line through it appearing to be written over something else on the MAR chart, the panel considered it to have been altered. The panel found that this was done by you after Witness 2 found an extra MST tablet, which indicated that you had not administered the tablet in the first place.

The panel did not give weight to the account of the senior carer, during the home's investigation, when it was recorded in the minutes that she did not see you with a pen in your hand at the drug trolley/cabinet/MAR chart. This evidence was untested during the hearing and was not supported by any other evidence, documentary or otherwise.

The panel was of the view that the MAR chart had clearly been altered. In view of the contents of the chart, which you have denied amending, the panel did not find your denial credible. It preferred the detailed and consistent evidence of Witness 2 that you altered the MAR chart as set out in her local statement, the interview with Witness 13 on 22 February 2021, and her report of the events by way of telephone call to Witness 12 just after the

incident occurred. Furthermore, the incident was considered sufficiently serious to be included in the RQIA report made by Witness 10.

In view of this evidence, and on the balance of probabilities, the panel found the charge proved.

Charges 22a proved

Charge 22b

b) The Controlled drug book.

The panel had regard to the local statement of Witness 2, the record of the phone call by Witness 12 with Witness 2 on 21 February 2021, the written and oral evidence of Witness 10, as well as your oral evidence. The panel also took account of the RQIA referral dated 22 February 2021, the controlled drug book entries relating to Resident G on 21 February 2021. The panel also took account of a note of a meeting held on the 22 February 2021 between Witness 13 and Witness 2. The panel also took account of your oral evidence.

In her local statement, dated 21 February 2021, Witness 2 set out that she looked at the controlled drug book at 6:30pm and saw that the previous stock count showed that 14 MST tablets should have been in the stock. She claimed that you altered the drug count within the controlled drug book from ‘14’ to ‘15’ after she had found that there was an extra tablet a brought it to your attention. The meeting minutes between Witness 13 and Witness 2 set out the following:

> *“I [Witness 2] went to countersign the drugs and there were 15. I stated why write 14 when there is 15. He became agitated and stated that he had given it. Blamed the night nurse. He stated he is being blamed. I saw Gareth change 14 to 15 tablets”*

You told the panel that you did not make any alteration to the controlled drug book. You maintained that you had written ‘error’ next to that entry, because it was a clerical entry indicating a drug count of 15 at 8am on that day.

The panel preferred the detailed and consistent evidence of Witness 2 that you altered the controlled drug book as set out in her local statement, the interview with Witness 13 on 22 February 2021, and her report of the events by way of a telephone call to Witness 12 just after the incident occurred. Furthermore, the incident was considered sufficiently serious to be included in the RQIA report made by Witness 10.

Your evidence regarding the entries made by you in the controlled drug book, was that this was a simple clerical error. The panel found that the entry was heavily inked and that the number five had been written over another number. The panel was of the view that the controlled drug book had clearly been altered by you and the panel did not accept your evidence, that it was a simple clerical error, as being credible.

Taking all of the evidence into account, and on the balance of probabilities, the panel found the charge proved.

Charge 22b proved

Charge 23

23. Your actions in Charge 22 above were dishonest in that you sought to conceal your error(s) as set out in Charge 21 above.

In considering this charge the panel directed itself to the test for dishonesty as set out by the Supreme Court in the case of *Ivey v Genting* Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67. The panel therefore firstly considered your knowledge and belief as regards your entries in Resident G’s MAR chart and controlled drug book. The panel was in no doubt that the controlled drug book had been altered by you to reflect the fact that an MST

tablet had been found to be unaccounted for. The panel could see that the number 14 was changed to number 15 and the word ‘error’ was added. In addition, there was no evidence that a second checker had signed the controlled drug book as was the requirement for controlled drugs in the Home. You gave evidence that you understood that there should always be two checkers when controlled drugs were being administered or a stock check was being undertaken. Eventually, the controlled drug book was updated by Witness 2 and the correct number of MST tablets recorded.

In respect of the MAR chart, the panel noted its previous finding that you had retrospectively altered the chart. The panel’s view was, on balance, that you signed the MAR chart to show that you administered the MST when you had not done so. Although there was an entry above your signature which was subsequently altered, this did not affect the signature which was the primary indicator confirming that the drug had been administered.

The panel reached the view that you modified the entries to conceal that you had made those errors. No notes were made by you at the time regarding your alleged clinical justification for withholding the medication on the MAR chart, and you did not discuss it with colleagues on duty. The panel concluded the evidence you gave that you had decided not to administer the MST, due to your clinical judgement, was untruthful. Further, it considered that this explanation was provided with the intention of justifying your error, along with the subsequent alterations that you made to the MAR chart and controlled drugs book.

The panel concluded that you knew what you were doing and that you were acting dishonestly. The panel considered that your conduct was dishonest and would be considered dishonest by the objective standards of ordinary decent people.

Taking account of all the evidence, and on the balance of probabilities, the panel found the charge proved.

Charge 23 proved

Fitness to practise

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

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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Mr Kabasinskas invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code)' and highlighted the following standards which the NMC considered you to have breached: 1.2, 1.4, 2.1, 3.3, 4.1, 7.4, 8.1, 8.2, 8.4, 8.5, 8.6, 9.2, 9.3, 10.1, 10.2, 10.3, 10.4, 10.5, 10.6, 14.1, 14.2, 14.3, 19.1, 20.1 and 20.3.

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

Mr Kabasinskas submitted that whilst charges 5 – 7 are capable of remediation, charges 8 – 9 involve a breach of duty of candour and therefore are the most serious category of concerns to put right. He submitted that charges 14 – 19 amounts to a pattern of behaviour, related to your clinical practice, and suggest an attitudinal issue.

Mr Kabasinskas told the panel that many of the facts found proved raise serious questions about your trustworthiness and may indicate a deep-seated attitudinal problem. He highlighted that attitudinal issues are more difficult to put right.

Mr Hamill provided the panel with detailed written submissions and a bundle including your CV, two reflective statements, evidence of three modules of online training of unspecified lengths or assessment, CPD certificates from 2017 to 2020, and five testimonials. The panel took all of this information into account.

In respect of misconduct, Mr Hamill accepted that the panel will likely find the admitted or proved charges as amounting to misconduct. Further, he accepted that at least some of the panel's findings will likely give rise to a public confidence issue in respect of your behaviour.

Mr Hamill highlighted that you are a person of good character with a clear regulatory and criminal record. He submitted that you have expressed remorse, as set out in the two reflective pieces, and that your genuine remorse showed a proper acceptance of the failings which have been found proved.

In respect of current impairment, Mr Hamill accepted that the concerns are serious and therefore a finding of impairment is likely to be necessary on public confidence grounds. However, the concerns can, at least in part, be addressed and will be addressed if you were afforded an opportunity to do so.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council (No 2)* [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Khan v Bar Standards Board* [2018] EWHC 2184 (Admin), *Schodlok v General Medical Council* [2013] EWHC Civ 769 (Admin), *Ahmedsowadi v General Medical Council* [2021] EWHC 3466 (Admin), *Meadows v General Medical Council* [2007] 1 All ER 1, *Cohen v General Medical Council* [2008] EWHC 581 (Admin), *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Zygmunt v General Medical Council* [2008] EWHC 2643 (Admin), and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Gra nt* [2011] EWHC 927 (Admin).

Decision and reasons on misconduct

In coming to its decision, the panel had regard 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.'*

The panel also had regard to the terms of the Code. It reached the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to breaches of the Code, specifically the following areas:

1. Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion
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
2.6 recognise when people are anxious or in distress and respond compassionately and politely

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

To achieve this, you must

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

4. Act in the best interests of people at all times

8. Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
8.2 maintain effective communication with colleagues

8.4 work with colleagues to evaluate the quality of your work and that of the team
8.5 work with colleagues to preserve the safety of those receiving care

9. Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance
9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10. Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
10.5 take all steps to make sure that records are kept securely
10.6 collect, treat and store all data and research findings appropriately

13. Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

14. Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm
14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

18. Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

19. Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
19.3 keep to and promote recommended practice in relation to controlling and preventing infection
19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

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
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel considered the allegations individually and collectively to be sufficiently serious to amount to misconduct.

In respect of charge 4, the panel bore in mind that Service User 2 was in a state of distress and was reliant on you as her key worker. As a registered nurse, the panel expected that you would have responded to their calls/messages. The panel reached the view that your failure to respond or follow up on Service User 2's calls/messages did fall short of what would be proper in the circumstances. The panel decided that your failure was serious and amounted to misconduct.

Charge 5 relates to a range of clinical record keeping and information sharing failures and there are numerous failures on your part which were repeated over an extended period of time. You were aware of your failures and the panel considered that you should have alerted your supervisor to your omissions. Your failures set out in charges 5a – 5h were neither isolated nor one-off incidents, rather they were routine failures which created the potential for serious harm to patients in your care. The result of your failures was that accurate patient records were not available for your colleagues to rely upon in order to provide continuity of care.

The panel was of the view that you demonstrated disregard regarding the requirements of your role in relation to record keeping. Accurate note/record keeping, and information sharing are basic aspects of nursing practice, and the panel had serious concerns about the failures in regard to your record keeping. The panel reached the view that your behaviour set out in charge 5 amounted to misconduct.

The panel reached the view that your actions set out in charge 6 demonstrated poor practice and amounted to misconduct. You were under an obligation to set up and maintain service user records and ensure they were properly filed and securely stored. Your failure in respect of charge 6 led to the patient records not being properly filed,

organised and easily accessible for your colleagues to access, therefore creating potential detriment to the care provided to the patients. The panel considered your failures to be serious and amounted to misconduct.

In relation to charges 8 and 9, the panel was of the view that your behaviour demonstrated an alarming disregard for patients in your care and was a flagrant failure to prioritise their care over a two-year period. Your failure to keep patient records safe, and your subsequent failure to escalate the loss of these records, had the potential to prevent the continuity of care to those patients and demonstrated a lack of candour on your part.

In respect of charge 11, the panel considered that you, an experienced nurse, failed to follow policies and work collaboratively with colleagues to prevent the spread of Covid-19, at a time when no vaccine was available. Your actions in the circumstances put staff at risk which had the potential to place vulnerable residents at risk. The panel considered that your failure to follow policies and work collaboratively amounted to misconduct.

In relation to charge 12, the panel reached the view that by misrepresenting your banding, leading colleagues to believe that you were more senior than you were, you created a situation where colleagues may have depended on your experience and false seniority at a critical time during the pandemic. The panel reached the view that your misrepresentation created potential to undermine effective patient care and amounted to misconduct.

The panel concluded that charge 13, which related to dishonesty demonstrated a breach of your duty of professional candour. Your misrepresentations were misleading and although they did not result in tangible gain for you, they had the potential to diminish your colleagues trust in you. Therefore, the panel considered that this amounted to misconduct.

Charge 14 relates to a prescribed medication which you failed to administer but signed to indicate that it had been administered. Your false recording would have misled your colleagues and potentially undermined the care provided to the resident. The panel

concluded that the fact that the medication was prescribed, and should have been given, made this a serious incident and amounted to misconduct.

Charge 15b relates to you leaving a used needle on an insulin pen. The panel reached the view that whilst this amounted to poor practice, it was not sufficiently serious to amount to misconduct.

In relation to charge 16, if Colleague A had not intervened, then Resident F could have been caused actual harm. You drew up the insulin and signed the insulin chart without checking the resident's blood glucose levels which was not the correct procedure. You then asked Colleague A to counter sign the insulin chart. However, Colleague A ascertained that you had not yet checked Resident F's blood sugar levels and therefore refused to sign the chart until you had. On checking the blood sugar level, it was found that the insulin should be withheld. The panel considered this to be poor practice and, given the potential risk to the patient, serious enough to amount to misconduct.

Charge 17 relates to a medication which you failed to administer but signed to indicate that it had been administered. Again, your false recording would have misled your colleagues and potentially undermined the care provided to the resident. The panel also considered this to be poor practice and to be serious enough to amount to misconduct.

In relation to Charge 18, the panel considered that the medication in question was prescribed medication, and that each of the six tablets required a signature on the MAR chart. They were not administered, and you falsely recorded that they were. Not only were they not administered, but your false recording would have misled your colleagues and potentially undermined the care provided to the resident in the future. The panel considered this to be poor practice and, given the potential risk to the resident, serious enough to amount to misconduct.

Charge 19 includes two instances of record keeping failures. Although the medication was administered, your omission to enter records onto the MAR chart and the computer

system, created potential to mislead your colleagues and potentially undermined the care provided to the patient in the future. Given the potential risk to the patient, the panel determined that your failure did amount to misconduct.

In relation to charge 21a) and 21b) i – iii), you failed to administer a prescribed drug. You made the decision, without consulting with the prescriber, to withhold this medication. You also falsely recorded on the MAR chart and in the Controlled Drug book that you administered the medication and the entry in the controlled drug book was made without a required second checker. The panel considered you to have demonstrated a flagrant disregard for the Home's medicines management systems and policies on 'second checkers' relating to controlled drug administration. The panel considered that this amounted to misconduct.

At charge 22, after a colleague noted a mismatch between the record in the controlled drug book and the number of tablets available. You then amended your previous erroneous entries in the residents MAR chart and their controlled drug book. The panel considered its previous conclusions that you deliberately amended the entries, and this was not simply a clerical error. You amended the entries without informing your colleague or manager of your initial errors. The panel considered that this could have misled your colleagues and led to a breakdown in professional trust and confidence between colleagues. The panel considered this to be serious enough to amount to misconduct.

At charge 23, the panel noted its previous conclusions that you modified the entries to conceal your errors and cover up your mistakes rather than being open and honest. The panel was of the view that you knew what you were doing and that you were acting dishonestly. The panel considered that honesty is a fundamental tenet of the profession and a failure to act openly and honestly has the potential to harm the trust in the profession and bring the profession into disrepute. The panel considered this amounted to misconduct.

The panel considered the charges found proved in their entirety, and observed patterns of behaviour, including medication administration and recording errors, record keeping deficiencies, a lack of candour, dishonesty, and flagrant disregard for patient care and safety.

There are two instances of dishonesty in this case, the most serious being at charge 23. The panel considered that the dishonesty allegations, alongside some of the charges found proved that demonstrate a flagrant disregard for patient care and safety, indicate a pattern suggestive of a deep-seated attitudinal concerns.

For the reasons set out above, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to 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, 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. 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.'*

The panel finds that patients were put at risk of physical and psychological harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not consider charges relating to dishonesty to be serious. The concerns are wide ranging in nature and demonstrate a pattern of poor practice and a deep-seated attitudinal concern which shows a disregard for patient care and safety.

The panel was of the view that whilst not impossible, the misconduct in this case is difficult to remediate. The panel therefore carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice.

The panel took account of your reflective statements, your CV, five references and testimonials, and certificates of training relating to Infection Control in Health Care, Medication Management and Administration, Understanding Duty of Care and Safety Responsibilities.

Regarding insight, the panel considered your reflective statements to demonstrate only limited insight and remorse. Your statement included the following:

> "*I was and am deeply regretful for any injury caused to SU's and any other parties affected. I fully understand the impact this has had on SU's, colleagues and the profession. I would like to apologise to anyone affected."*

The panel concluded that whilst you accepted responsibility and expressed regret, your reflective statement demonstrated a limited appreciation of what you should and could have done differently in the future. Further, your reflection appeared to be general and

lacking in detail and did not sufficiently address the nature and gravity of the concerns and the impact on service users. As such, the panel considered your insight was limited.

The panel took account of your CV, and the training certificates you provided. The panel considered the online training you have undertaken to be insufficient to adequately address the breadth, nature and seriousness of the concerns identified. Furthermore, it acknowledged that you have not been working in a clinical setting since March 2021 and will therefore not have had an opportunity to strengthen your clinical practice.

The panel also took account of the references and testimonials you provided. Whilst the testimonials are positive, they do not address the issues giving rise to these proceedings and some of them speak to your character or nursing practice prior to the incidents. The panel has therefore been able to attach limited weight to the testimonials in its deliberations.

The panel concluded that there is a high risk of repetition based on your limited insight, limited remorse, and your negligible remediation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel considered 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 concluded that public confidence in the profession would be undermined if a finding of impairment were 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 has considered this case very carefully and has 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 Kabasinskas invited the panel to impose a striking-off order.

Mr Kabasinskas submitted that the aggravating features include lack of insight into the failings, a pattern of misconduct over a period of time, and conduct which put patients at risk of suffering harm. He further submitted that some of the incidents took place whilst you were subject to an interim conditions of practice order, which is a further aggravating feature.

Mr Kabasinskas submitted that the mitigating features include your early admissions to some of the charges as well as [PRIVATE]. He told the panel that, although this is not a mitigating feature, the panel should note that you have been fully engaged with the NMC proceedings.

Regarding the test of seriousness, Mr Kabasinskas submitted that your case falls within the most serious category and referred the panel to the NMC's guidance '*Considering sanctions for serious cases*' (Reference: SAN-2). He said that honesty is of central importance and deliberately breaching duty of candour and dishonesty involving misrepresentation was very serious. Further, he submitted that the nature of your rejected

defence, with regard to charges 12 and 13, should also be included as an aggravating feature, when applying the test from *Sawati v General Medical Council* [2022] EWHC 283 (Admin).

In relation to the type of order the panel can impose, Mr Kabasinskas submitted that taking no further action and a caution order would not be the appropriate sanctions because of your lack of insight, lack of remorse and lack of any steps you have taken to strengthen your practice, which in consequence means that there remains a risk of repetition of misconduct.

In relation to conditions of practice order, Mr Kabasinskas submitted that whilst some of the charges are linked to your clinical concerns and conditions for those incidents could be formulated. However, this order is not appropriate for the most serious charges such as dishonesty and attitudinal concerns and on public protection ground. Such an order is also not in the public interest. Mr Kabasinskas told the panel that further misconduct, such as medication administration errors, had taken place whilst you were under an interim conditions of practice order.

In relation to a striking-off order, Mr Kabasinskas told the panel that this was the most serious sanction available to the panel. He submitted that this order was the appropriate and proportionate order as the concerns raised are fundamentally incompatible with you being on the NMC register. He submitted that alongside the clinical concerns, there are concerns about breach of duty of candour, dishonesty and attitudinal concerns which are difficult to remediate.

Mr Kabasinskas referred the panel to the NMC's guidance on 'Striking-off order' (Reference: SAN-3e). He submitted that the regulatory concerns do raise fundamental questions about your professionalism, and that public confidence in the nursing profession would not be maintained unless you were struck off from the register. He further submitted that the striking-off order is the only sanction which is sufficient to protect patients and

members of the public, as well as maintain professional standards in the nursing profession.

Mr Kabasinskas submitted that there were multiple incidents of misconduct, that there are attitudinal concerns, that the concerns include a lack of candour and two instances of dishonesty and that there is no evidence before the panel that the risk of repetition is low. He submitted that there is insufficient evidence of insight and any steps you have taken to remediate the concerns.

Mr Hamill provided the panel with written submissions as well as oral submissions. He submitted that a suspension order would be the most appropriate and proportionate order as your case involves serious failings. Mr Hamill told the panel that you accept the panel's findings and wish for an opportunity to reflect on these serious findings and in turn allow you to properly address those findings.

Mr Hamill acknowledged that the panel may find the follow aggravating features: a pattern of misconduct over a period of time and conduct which put patients at risk of suffering harm.

Mr Hamill submitted that the mitigating features include: your engagement with the NMC and the substantive hearing; a significant number of admissions made; some, albeit limited, insight; **[PRIVATE].**

Mr Hamill said that an interim conditions of practice order had been imposed on your registration and that this was replaced by an interim suspension order. He submitted that you have not had an opportunity to demonstrate safe nursing practice since you were suspended.

In relation to the guidance provided by the NMC in respect of seriousness, Mr Hamill submitted that the most serious types of concerns identified are not engaged but accepted that there are findings of dishonesty and a breach of the duty of candour which are

serious. He also submitted that one should view the case “in the round” and not take the approach that any serious misconduct would justify the severest of sanctions.

Mr Hamill submitted that attitudinal and honesty issues are undoubtedly serious and difficult to address. However, they can be addressed, and you have started to take steps to demonstrate this such as undertaking relevant training, demonstrating some remorse and insight (albeit limited). In relation to a risk of repetition, Mr Hamill submitted that these are findings which can be addressed albeit that they have not yet been and therefore there is risk of repetition. However that you should be given an opportunity to address these findings against you.

Mr Hamill submitted that there are two findings of dishonesty. He said that the first (misrepresentation of banding) is clearly a less serious type of dishonesty and that it does not engage any of the more serious features of dishonesty. Further, he accepted that the dishonesty does engage all of the criteria for less serious incidents (other than being outside professional practice). He accepted that the second incident is more serious as a breach of candour is engaged. He submitted that it is arguable that this was one off, spontaneous conduct and arose in clearly difficult circumstances in which your judgment was clouded.

In respect of the breach of the duty of candour, Mr Hamill submitted that, while there has been a failure by you, you were not solely responsible for the failings identified. It was further submitted that the panel should not consider your “rejected defence” as an aggravating factor. Mr Hamill submitted that your case was put on the basis that the witness was simply mistaken, and you had not put to the witness that she was lying or making this up. In respect of the second allegation of dishonesty, Mr Hamill submitted that the panel rejected the account given by you of this being a mistake. He submitted that this is a case where you were simply not believed as opposed to a case of intrinsic dishonesty.

Mr Hamill also provided oral submissions. He submitted that much of the misconduct occurred during Covid-19 which was a challenging time for the nursing profession.

Mr Hamill accepted the panel's findings on the fact that you have demonstrated attitudinal concerns. However, he suggested that a holistic or "in the round" rather than checkbox approach should be adopted.

Mr Hamill invited the panel to impose a suspension order for a period that the panel sees as appropriate. He submitted that a striking-off order would be disproportionate in all the circumstances.

The panel accepted the advice of the legal assessor who referred the panel to the cases of: *Sawati v General Medical Council* [2022] EWHC 283 (Admin) and *Khetyar v General Medical Council* [2018] EWHC 813 (Admin).

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of misconduct over a period of two years in three separate work settings
- The majority of the charges found proved put patients/residents at risk of suffering harm as a result of your failure
- Limited insight into your failings
- A lack of candour in respect of your poor record keeping and your failure to report lost patient files in a timely manner

The panel noted Mr Kabasinskas' submission on rejected defence of dishonesty. Having considered the guidance on rejected defence: '*Factors to consider before deciding on sanctions*' (Reference: SAN-1) and '*Considering sanctions for serious cases*' (Reference: SAN-2), the panel rejected this submission.

The panel also took into account the following mitigating features:

- Early admissions to some of the charges

The panel noted that you have worked for over 30 years as a registered nurse with no regulatory findings.

The Panel acknowledged Mr Hamil's submission in respect of you having no relevant previous fitness to practice history. The Panel considered the NMC Guidance on this issue and noted its findings in respect of your deep-seated attitudinal concerns. In the circumstances the panel considered that your absence of a fitness to practise history was not a relevant consideration in this case.

[PRIVATE].

The panel also noted that you have been consistently and positively engaging with the NMC proceedings.

The panel first considered the seriousness of the case. It took into account the NMC's guidance on '*How we determine seriousness*' (Reference: FTP-3):

> *'Some behaviours are particularly serious as they suggest there may be a risk to people receiving care; examples include:*
>
> - *conduct or poor practice which indicates a dangerous attitude to the safety of people receiving care* […]'

It also took into account the guidance on ‘Serious concerns which are more difficult to put right’ (Reference: FTP-3a)

- *‘breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records,* […] *or otherwise contributing to a culture which suppresses openness about the safety of care’*

The panel was of the view that your misconduct constituted significant and wide-ranging failures in three separate work settings. It determined that the charges found proved are serious and included dishonesty, lack of candour and professional misconduct which put patients/residents at a direct risk of harm. The panel considers that the online training you have undertaken is insufficient, as it does not adequately address the breadth, nature and seriousness of the charges proved. Furthermore, your reflections appear to be general and lacking in detail and do not sufficiently address the nature and gravity of the charges proved, and the impact on service users.

The panel next considered the type of order it should impose. It 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.

The panel 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 found proved in this case. The misconduct, which included lack of candour and two instances of dishonesty, was not something that the panel considers in this case could be addressed through conditions. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of the charges found proved and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel considered the bullet points set out in the SG on suspension orders and noted that only one of the factors was present:

- *No evidence of repetition of behaviour since the incident;*

The panel noted that this was not a single instance of misconduct but rather a sustained pattern of misconduct over a lengthy period of time affecting vulnerable service users under your care. It found that you had failed to demonstrate sufficient insight into the severity of your actions and also failed to strengthen your nursing practice. It also found that your misconduct could have caused harm to service users. Although there is no evidence of repetition of the concerns since the incident, the panel had found that your actions are suggestive of deep-seated attitudinal concerns which heightens the significant risk of repetition. The panel further noted that you had not worked as a registered nurse since March 2021, and you had not provided any evidence that demonstrates sufficient insight into your actions and how you have strengthened your nursing practice. Therefore, the panel was not satisfied that a period of suspension would serve any useful purpose.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

Accordingly, the panel determined that a period of suspension would not be a sufficient, appropriate or proportionate sanction. It would neither protect the public nor satisfy the public interest consideration in this case.

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 considered that the regulatory concerns raised fundamental questions about your professionalism and striking off was the only sanction which would maintain public confidence and sufficiently protect patients, members of the public and maintain professional standards.

The panel noted the NMC Guidance on '*Considering sanctions for serious cases*' (Reference: SAN-2). The panel determined that the serious, numerous and wide-ranging nature of the charges raises fundamental questions about your professionalism, especially in light of the findings of dishonesty and lack of candour.

Your actions were a significant departure 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 case demonstrate that your actions were serious, and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Kabasinskas. He submitted that an interim suspension order should be imposed for a period of 18 months to cover the 28-day appeal period and the subsequent period, should an appeal be lodged. He submitted that this is necessary for the protection of members of the public and otherwise in the public interest.

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

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

If no appeal is made, then the interim suspension order will be replaced by the substantive 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.