Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 25 November – Tuesday, 3 December 2024

Virtual Hearing

Name of Registrant:	**Bernard Roy Watt**
NMC PIN	19B0014O
Part(s) of the register:	Registered Nurse – Adult Nursing RNA – (1 February 2019)
Relevant Location:	Westmorland and Furness
Type of case:	Lack of competence
Panel members:	Konrad Chrzanowski (Chair, Lay member) Elizabeth Coles (Registrant member) Carson Black (Lay member)
Legal Assessor:	Tracy Ayling (25 November 2024) Sean Hammond (26 November – 3 December 2024)
Hearings Coordinator:	Nicola Nicolaou
Nursing and Midwifery Council:	Represented by Stephen Earnshaw, Case Presenter
Mr Watt:	Not present and not represented at the hearing
Facts proved:	Charges 1, 2a, 2b, 2c, 2d(i), 2d(ii), 3a, 3b, 3c, 3d, 3e, 4, 5, and 6
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Watt was not in attendance and that the Notice of Hearing letter had been sent to Mr Watt's registered email address by secure email on 24 October 2024.

Mr Earnshaw, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Watt's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all of the information available, the panel was satisfied that Mr Watt has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Watt

The panel next considered whether it should proceed in the absence of Mr Watt. It had regard to Rule 21 and heard the submissions of Mr Earnshaw who invited the panel to continue in the absence of Mr Watt. He submitted that Mr Watt had voluntarily absented himself.

Mr Earnshaw referred the panel to an email from Mr Watt to the NMC dated 24 October 2024 which stated:

> '[…] *I apologize I cannot attend.'*

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *‘with the utmost care and caution’* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mr Watt. In reaching this decision, the panel has considered the submissions of Mr Earnshaw, the email from Mr Watt dated 24 October 2024 confirming he cannot attend this hearing, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Watt;
- Mr Watt has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Four witnesses are due to attend this hearing to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2022;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Watt in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to Mr Watt at his registered address, he has made no response to the allegations. Mr Watt will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Watt's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Watt. The panel will draw no adverse inference from Mr Watt's absence in its findings of fact.

Details of charges (as amended)

That you, between 1 March 2022 and 20 August 2022 failed to demonstrate the standards, knowledge, skills and judgement required to practise as a Band 5 Registered Nurse in that you:

1. On 4 March 2022 administered an incorrect dose of hypertonic saline to Patient A.

2. On 10 April 2022:

    a) Required prompting to complete observations of patients in your care.

    b) Incorrectly recorded two patients were not on oxygen.

    c) Failed to identify and/or escalate Patient B's oxygen levels had dropped below their target.

    d) In relation to Patient C:

i) Incorrectly recorded you had administered intravenous medication.

ii) Did not provide an explanation to Colleague A when asked about the entry in the patient's records.

3. On or around 1 May 2022:

a) Did not administer Patient D's 10am dose on time.

b) Did not record a G2 pressure ulcer in Patient E's clinical notes.

c) Did not provide an effective handover of Patient E to a colleague.

d) Failed to identify and/or escalate Patient F's oxygen levels had dropped below their target.

e) Required prompting to check patients' allergies and dates of birth when administering medication.

4. On or around 2 May 2022 did not provide an explanation to Colleague B when asked about an entry you made in Patient G's records.

5. On 15 May 2022 did not identify the correct prescribed drug for Patient H during a supervised round.

6. On an unknown date failed to complete observations due for patients in your care before going on your lunch break.

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

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

After the charges were read out, Mr Earnshaw made a request that this case be held partly in private on the basis that Mr Watt's case may make reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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 and when matters relating to [PRIVATE] are raised in order to protect his privacy.

Background

The NMC received a referral on 10 September 2022 from University Hospitals of Morecombe Bay NHS Foundation Trust ('the Trust') raising concerns of alleged near misses and patient safety incidents during Mr Watt's probationary period together with high levels of absence.

The concerns led to Mr Watt's probationary period being extended. An action plan was put in place to support Mr Watt but his supervisors still noted concerns in completing patient observations, even after prompting. They also noted Mr Watt was not always administering medication when it was due, poor knowledge of medicines, a failure to consistently identify the need to escalate and not documenting patient care adequately.

Mr Watt was dismissed by the Trust on the 19 August 2022 for failing his probationary period.

Decision and reasons on amending the charges

After hearing closing submissions from Mr Earnshaw regarding the facts of this case, the panel retired in camera to deliberate on the charges. The panel noticed that there was a typographical error in charges 3 and 4 regarding the dates. The panel was advised by the legal assessor who made reference to Rule 28. The panel were minded to amend the charges to accurately reflect the dates as set out in the documentary and oral evidence of this case.

The proposed amendments are as follows:

Charge 3

> That you, between 1 March 2022 and 20 August 2022 failed to demonstrate the standards, knowledge, skills and judgement required to practise as a Band 5 Registered Nurse in that you:
>
> 3. On **or around** 1 May 2022: […]

Charge 4

> That you, between 1 March 2022 and 20 August 2022 failed to demonstrate the standards, knowledge, skills and judgement required to practise as a Band 5 Registered Nurse in that you:
>
> 4. On **or around** 2 May 2022 did not provide an explanation to Colleague B when asked about an entry you made in Patient G's records.

Prior to making its decision, the panel resumed the hearing to invite Mr Earnshaw to make submissions on amending the charges.

Mr Earnshaw did not object to the panel's proposed amendments of charges 3 and 4 and submitted that he understood why the proposed amendments were required.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment was in the interest of justice as it would be wrong to simply allow these charges to fail because of a minor typographical error. The panel was satisfied that there would be no prejudice to Mr Watt and no injustice would be caused to either party by the proposed amendment being allowed as it did not alter the nature or seriousness of the charges, rather it simply clarified the dates. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mr Watt.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Ward Manager at the time of the alleged incidents.

- Witness 2: Respiratory clinical nurse specialist on the ward at the time of the alleged incidents.

- Witness 3/Colleague A: Respiratory clinical lead on the ward at the time of the alleged incidents.

- Witness 4/Colleague B: Band 5 Staff Nurse on the ward at the time of the alleged incidents.

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 the NMC.

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

Charge 1

1. On 4 March 2022 administered an incorrect dose of hypertonic saline to Patient A.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement which stated:

> '[…] *I went to check the patient's prescription and saw that she was prescribed 3% hypertonic saline which is less common but she was on this at home. Knowing that we only stocked 6% hypertonic saline, I looked in the drug trolley and saw a 6% hypertonic saline pack.*
>
> *I suspected that Bernard had fetched a 6% hypertonic saline pack and used it.*
>
> […]

I asked him if he gave her 3% hypertonic saline. Bernard answered yes. I then asked him where he got the 3% hypertonic saline medication. Bernard said he gave her what was in the drug trolley. I told him that the drug trolley had the 6% hypertonic saline pack.

[…]

If Bernard had continued to give her the 6% hypertonic saline, she could have got really unwell by the end of the day. At worse, her oxygen levels could have dropped significantly and worst case scenario, could've had a respiratory arrest.'

This is corroborated by a file note dated 4 March 2022, which stated:

'Respiratory nurse [Witness 2] *spoke to myself and ward manager* [Witness 1] *this afternoon. She had noticed that a patient she reviewed had been given 6% hypertonic saline nebuliser instead of the prescribed 3% dose.* [Witness 2] *spoke to Bernard about this as he was looking after the patient. He agreed he had given the 6% nebulise instead of the 3%. He told* [Witness 2] *he thought he had given 3% nebules.* […]*'*

This is further corroborated by Witness 1's witness statement which stated:

'On 4 March 2022, Bernard gave hypertonic saline 6% nebuliser instead of the prescribed 3% dose.

[…]

He agreed he had given the 6% nebuliser instead of the 3%. He told [Witness 2] *he thought he had given 3% nebules.'*

The panel determined that Witness 2 was credible and reliable. It was of the view that the evidence produced by Witness 2 was consistent across her witness statement, file note, and oral evidence. The panel also determined that Witness 2's evidence is corroborated by Witness 1's witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 2a

2. On 10 April 2022:

    a) Required prompting to complete observations of patients in your care.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement which stated:

> *'On 10th April 2022, I was working with Bernard in the respiratory ward.* […] *We aim to start observations at 10am and complete them by 11am. I checked the patients' records at 11am and noticed that Bernard hadn't completed his observations for any of his 5 patients. I therefore reminded him to complete the observations'*

This is corroborated by Witness 1's witness statement which stated:

> *'At 11am,* [Witness 3] *had to remind Bernard that the 10am observations still needed to be performed.'*

This is further corroborated by an action plan that contains the following criteria:

> *'Independently manages own workload to ensure patients vital signs are monitored correctly and at the correct times'*

The action plan states that on 25 July 2022, 26 July 2022, 31 July 2022, 1 August 2022, and 5 August 2022, Mr Watt failed to achieve this criteria and needed prompting on multiple occasions.

The panel was of the view that the evidence produced by Witness 3 was consistent across her witness statement and oral evidence. The panel also determined that Witness 3's evidence is corroborated by the action plan, and Witness 1's witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 2b

2. On 10 April 2022:

   b) Incorrectly recorded two patients were not on oxygen.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement which stated:

> *'When Bernard completed the observations, I looked at his notes on the patient's charts and noticed mistakes for 2 patients. He had written that 2 of the patients weren't on oxygen when they were.* […]*'*

This is corroborated by Witness 1's witness statement which stated:

> *'*[Witness 3] *checked the observations and found the mistakes on two of the patients' charts. He had documented that there both were not on oxygen when they were.* […]*'*

This is further corroborated by the action plan which sets out a number of actions that Mr Watt was required to undertake regarding oxygen therapy, but that on multiple dates from 25 July 2022 to 5 August 2022, he failed to undertake these actions.

The panel was of the view that the evidence produced by Witness 3 was consistent across her witness statement and oral evidence. The panel also determined that Witness 3's evidence is corroborated by the action plan, and Witness 1's witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 2c

2. On 10 April 2022:

   c) Failed to identify and/or escalate Patient B's oxygen levels had dropped below their target.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement which stated:

> *'one of the patients was on 5 litres of oxygen had her saturations at 88%. Her saturation target was 92% and above. Despite this, Bernard hadn't escalated it to me. Bernard should have escalated it because the patient was below target and already on 5 litres of oxygen. There was no harm as a result but there was a risk of the patient lacking oxygen which can potentially cause a cardiac arrest. The patient would also be at risk of falling due to lack of oxygen.'*

This is corroborated by Witness 1's witness statement which stated:

> '[…] *one of the two ladies was on 5l of oxygen with saturations of 88% when her target saturation were 92% and above. He hadn't escalated this to* [Witness 3]*'*

This is further corroborated by the action plan which sets out two criteria regarding the identification, understanding, and communication of clinical concerns relating to the National Early Warning Score (NEWS) escalation, but that on multiple dates from 25 July 2022 to 5 August 2022, Mr Watt was inconsistent in escalating concerns with the patient's NEWS score.

The panel was of the view that the evidence produced by Witness 3 was consistent across her witness statement and oral evidence. The panel also determined that Witness 3's evidence is corroborated by the action plan, and Witness 1's witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 2d(i)

2. On 10 April 2022:

   d) In relation to Patient C:

      i) Incorrectly recorded you had administered intravenous medication.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement which stated:

> '[…] *I looked at the prescription chart before preparation for an intravenous* (IV) *antibiotic for a patient. I noticed that Bernard had already signed at 14:04 stating the medication had been given 11:22.*
>
> […]
>
> *The patient was due to have an IV dose at 13:57. I ended up not giving the medication dose as I wasn't confident about Bernard's answer. He could've given an oral tablet, I didn't know for sure. If Bernard had given the medication, then there would have been a risk of an overdose if I had*

> *administered the IV dose.* […] *Bernard hasn't done the IV course and therefore needed someone else to administer the Intravenous antibiotic'*

This is corroborated by Witness 3's oral evidence when she said:

"I asked him numerous times […] *but still it was just a blank facial expression saying he hadn't given it."*

This is further corroborated by Witness 1's witness statement which stated:

> *'*[Witness 3] *noticed that it had been signed for already by Bernard at 1404 saying it had been given at 11:22am.* [Witness 3] *reported that this wasn't true. When* [Witness 3] *asked him about this, Bernard couldn't tell him* [sic] *why he had documented this'*

The panel was of the view that the evidence produced by Witness 3 was consistent across her witness statement and oral evidence. The panel also determined that Witness 3's evidence is corroborated by Witness 1's witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 2d(ii)

2. On 10 April 2022:

    d) In relation to Patient C:

    ii) Did not provide an explanation to Colleague A when asked about the entry in the patient's records.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement which stated:

> '[…] *Knowing Bernard couldn't give intravenous antibiotic, I asked him if he could tell me what happened. Bernard said no he hadn't given them the intravenous antibiotic. I asked why he had signed that he had. Bernard maintained that he didn't give the IV antibiotic medication to the patient but couldn't explain how he ended up signing that he did. […] I explained to Bernard that I needed to give intravenous antibiotic to the patient and I needed to know if he had given it to patient otherwise there would be a risk of an overdose. I asked him if he gave the medication orally and he said he didn't. The patient was due to have an IV dose at 13:57. I ended up not giving the medication dose as I wasn't confident about Bernard's answer. He could've given an oral tablet, I didn't know for sure. If Bernard had given the medication, then there would have been a risk of an overdose if I had administered the IV dose.'*

This is corroborated by Witness 3's oral evidence when she said:

> *"I asked him numerous times* […] *but still it was just a blank facial expression saying he hadn't given it."*

This is further corroborated by Witness 1's witness statement which stated:

> *'On 13 April 2022,* [Witness 3] *(Registered Nurse) reported that he* [sic] *went to check the prescription chart in preparation to make up an Intravenous antibiotic for a patient that was to be given 4 times a day.* [Witness 3] *noticed that it had been signed for already by Bernard at 1404 saying it had been given at 11:22am.* [Witness 3] *reported that this wasn't true. When* [Witness 3] *asked him about this, Bernard couldn't tell him [sic] why he had documented this'*

The panel was of the view that the evidence produced by Witness 3 was consistent across her witness statement and oral evidence. The panel also determined that Witness 3's evidence is corroborated by Witness 1's witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 3a

3. On or around 1 May 2022:

   a) Did not administer Patient D's 10am dose on time.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement which stated:

> *'On 1st May 2022, I was doing medication rounds with Bernard at 10am. I later checked the records at around 12pm lunchtime and noted that Bernard had forgotten to give medication to a patient. I don't remember what medication it was but it was controlled drugs. When I mentioned it to him, Bernard asked me should I just sign for it even though he hadn't given the medication. Bernard looked like he was panicking. I said no, give them the medication and then sign for it.'*

This is corroborated by Witness 4's file note dated 1 May 2022 which stated:

> *'Bernard did not recognise a CD* [Controlled Drug] *was due at 10:00am. When it came to lunch time administration, he said shall I just sign for it. I said no as it has not been given.* […]*'*

Witness 4 also produced a written note on an unknown date which stated:

> *'Bernard forgot about a CD which was due to be given'*

This is further corroborated by Witness 1's witness statement which stated:

> '[Witness 4] *informed me that Bernard did not recognise that an analgesic medication was due at 10:00am for a patient on 1 May 2022. At lunch time, Bernard asked* [Witness 4] *whether he should just sign for it when prompted*

that this had not been administered yet. [Witness 4] *advised that we do not sign for medications that have not been administered. This raised concerns as if not promoted, would Bernard just have signed for medications not given therefore potentially harming patients.'*

The panel was of the view that the evidence produced by Witness 4 was consistent across her witness statement, file note dated 1 May 2022, and written note. The panel also determined that Witness 4's evidence is corroborated by Witness 1's witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 3b

3. On or around 1 May 2022:

   b) Did not record a G2 pressure ulcer in Patient E's clinical notes.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement which stated:

> *'On 1 May 2022, a sister (name not remembered) received a handover from Bernard at Westmorland General Hospital (WGH). She wasn't happy to accept the handover due to a lack of detail in the notes. The sister asked Bernard to pass the handover to another colleague. Bernard approached me to do the handover. The sister told me there wasn't enough detail in the notes. Bernard failed to mention that the patient had a G2 pressure ulcer. The sister said to me I don't know what's going on with the patient, referring to the patient with the G2 pressure ulcer.'*

This is corroborated by Witness 4's file note dated 1 May 2022 which stated:

> *‘On the Saturday Bernard was asked to Handover a patient to WGH. When I spoke to the Sr* [sister] *about his handover she was not happy to accept the handover due to lack of detail. Bernard for example did not handover the patient had a G2 pressure ulcer.’*

Witness 4 also produced a written note on an unknown date which stated:

> *‘Bernard handed over a pt* [patient] *to WGH. RGN* [Registered General Nurse] *was not happy to accept handover due to lack of detail.’*

This is also corroborated by Witness 4’s oral evidence when she said that the sister receiving the handover was unsure of *“what was going on with the patient, what the plan was, and also their skin condition”.*

This is further corroborated by Witness 1’s witness statement which stated:

> *‘On 1 May 2022,* [Witness 4] *was asked to handover a patient to Westmorland General Hospital (WGH). When* [Witness 4] *spoke to the Sr (name unknown) she was not happy to accept the handover due to lack of detail. Bernard didn’t make it known that the patient had a G2 pressure ulcer.’*

The panel was of the view that the evidence produced by Witness 4 was consistent across her witness statement, file note dated 1 May 2022, written note, and oral evidence. The panel also determined that Witness 4’s evidence is corroborated by Witness 1’s witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 3c

3. On or around 1 May 2022:

    c) Did not provide an effective handover of Patient E to a colleague.

This charge is found proved.

In reaching this decision, the panel took account of the same documentary evidence as charge 3b i.e., Witness 4's witness statement which stated:

> *'On 1 May 2022, a sister (name not remembered) received a handover from Bernard at Westmorland General Hospital (WGH). She wasn't happy to accept the handover due to a lack of detail in the notes. The sister asked Bernard to pass the handover to another colleague. Bernard approached me to do the handover. The sister told me there wasn't enough detail in the notes. Bernard failed to mention that the patient had a G2 pressure ulcer. The sister said to me I don't know what's going on with the patient, referring to the patient with the G2 pressure ulcer.'*

This is corroborated by Witness 4's file note dated 1 May 2022 which stated:

> *'On the Saturday Bernard was asked to Handover a patient to WGH. When I spoke to the Sr* [sister] *about his handover she was not happy to accept the handover due to lack of detail. Bernard for example did not handover the patient had a G2 pressure ulcer.'*

Witness 4 also produced a written note on an unknown date which stated:

> *'Bernard handed over a pt* [patient] *to WGH. RGN* [Registered General Nurse] *was not happy to accept handover due to lack of detail.'*

This is also corroborated by Witness 4's oral evidence when she said that the sister receiving the handover was unsure of *"what was going on with the patient, what the plan was, and also their skin condition".* Witness 4 also said that a handover for this patient was important *"because it means that the next ward could either get a mattress ready* […] *or just be aware so that as soon as the patient arrives, they're giving good pressure area care".*

This is further corroborated by Witness 1's witness statement which stated:

‘On 1 May 2022, [Witness 4] *was asked to handover a patient to Westmorland General Hospital (WGH). When* [Witness 4] *spoke to the Sr (name unknown) she was not happy to accept the handover due to lack of detail. Bernard didn’t make it known that the patient had a G2 pressure ulcer.’*

The panel was of the view that the evidence produced by Witness 4 was consistent across her witness statement, file note dated 1 May 2022, written note, and oral evidence. The panel also determined that Witness 4’s evidence is corroborated by Witness 1’s witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 3d

3. On or around 1 May 2022:

    d) Failed to identify and/or escalate Patient F’s oxygen levels had dropped below their target.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4’s witness statement which stated:

‘On 1 May 2022, I noticed a patient’s oxygen had dropped to 91%, the target sats [saturations] *for the patient was 94%. Bernard was responsible for observing the patient and should have responded.* […] *Bernard didn’t do anything, he had just moved on. When I spoke to him about this, he had no idea about the patient’s sats and how to escalate. I asked him what he should have done and he didn’t know. I tried to support Bernard by going through the observation policy, he obviously would have had training on this as well. If that patient was left as he was, it could even have potentially lead* [sic] *to their death.’*

In her oral evidence, Witness 4 said that escalating concerns was *"part of deteriorating patient policies that we have in our trust. It would be* […] *escalated appropriately to prevent deconditioning and deterioration of a patient."* When asked by the panel if a registered nurse would be expected to recognise the potential consequences of not escalating a deteriorating patient, Witness 4 said *"definitely, yeah.* […] *we use the NEWS score system for our observations and it would trigger a three in one parameter which would require an immediate action from it and that would be for a registered nurse."*

This is corroborated by Witness 4's file note dated 1 May 2022 which stated:

> *'On the Saturday Bernard did not act upon a patient with sats of 91% on 35%VFM. Target sats >94%. I was the one that noticed when checking his obs* [observations]. *He had no awareness that patient was scoring high and what his patients target sats were. I asked what he thought he should do and he did not know. Unable to escalate signs of deterioration.'*

Witness 4 also produced a written note on an unknown date which stated:

> *'Bernard did not action upon a pt's sats being 91% on 35%VFM – Target >94. Needed me to prompt + act by increasing O2 and informing medics.'*

This is further corroborated by Witness 1's witness statement which stated:

> *'On 1 May 2022,* [Witness 4] *informed that Bernard didn't respond to a patient with sats of 91% on 35% oxygen. The Target sats for the patient was 94%.* [Witness 4] *noticed when she checked the patient's observations. Bernard had no awareness that patient was scoring high and what his patients target sats were.* [Witness 4] *asked what he thought he should do and he didn't know. The patient was displaying signs of deterioration but Bernard was unable to escalate signs of deterioration. There was no harm to the patient as* [Witness 4] *was supervising Bernard. However there was a potential of harm. Failure to escalate an acutely unwell patient can lead to significant deterioration and failure to rescue.'*

The panel was of the view that the evidence produced by Witness 4 was consistent across her witness statement, file note dated 1 May 2022, written note, and oral evidence. The panel also determined that Witness 4's evidence is corroborated by Witness 1's witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 3e

3. On or around 1 May 2022:

    e) Required prompting to check patients' allergies and dates of birth when administering medication.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement which stated:

> *'Bernard would often not check a patient's ID by asking questions. This did improve after prompts. There were some areas of improvement such as his general communication with patients.'*

This is corroborated by Witness 4's file note dated 1 May 2022, which stated:

> *'Bernard did not check patient allergies and DOB* [date of birth] *when giving meds* [medications]. *Needed promoting* [sic] *on both days and did check correctly after prompts.'*

Witness 4 also produced a written note on an unknown date which stated:

> *'Needs to check a pt's ID band (DOB). This did improve after prompts.'*

In her oral evidence, Witness 4 spoke about the importance of using the five R's policy (right person, right medication, right route, right dose, right time) when administering medication, she said that *"there was just not that awareness from Bernard."*

This is further corroborated by Witness 1's witness statement which stated:

> *'On 1 May 2022* […] *while supervising Bernard,* [Witness 4] *noticed that he didn't check a patient's allergy and their date of birth when giving medications. Bernard needed prompting. There was no harm to the patient because* [Witness 4] *was supervising Bernard. The risk of harm to the patient could have been a severe drug interactions, adverse side effects or even death in extreme cases. The standard for administering medication is right time, right dose, right drug, right patient, and right route.'*

The panel was of the view that the evidence produced by Witness 4 was consistent across her witness statement, file note dated 1 May 2022, written note, and oral evidence. The panel also determined that Witness 4's evidence is corroborated by Witness 1's witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 4

4. On or around 2 May 2022 did not provide an explanation to Colleague B when asked about an entry you made in Patient G's records.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement which stated:

> *'On the following day, I reminded Bernard not to forget to administer the controlled drugs to the patients. When I looked at the records, I noticed that Bernard had written 'patient refused with capacity' for one of the patient's* [sic].

> *Knowing that patient, I thought it was quite strange for him to refuse his pain killer medication. I checked with the patient and he said he was in pain and wanted his pain killer. I asked Bernard to give me an explanation but he wasn't able to give me an answer. He shrugged his shoulders and said nothing. I'm not sure if Bernard even spoke to the patient.'*

This is corroborated by witness 4's file note dated 1 May 2022, which stated:

> *'The following day I prompted him not to forget his CD. He then had signed 'pt refused with capacity'. When I asked the patient, he wanted his pain relief. Bernard could not answer why he put refused with capacity on chart'*

In her oral evidence, Witness 4 said that when she asked Mr Watt why he documented that the patient refused his medication when he didn't, Mr Watt shrugged his shoulders and *"wasn't able to give me an answer".*

This is further corroborated by Witness 1's witness statement which stated:

> *'The following day* [Witness 4] *prompted Bernard not to forget the patient's medication. Bernard signed 'pt refused with capacity'. When* [Witness 4] *asked the patient, he said he had wanted his pain relief. [Witness 4] asked Bernard why he put 'pt refused with capacity' on chart. Bernard was unable to explain why. There was no harm to the patient as* [Witness 4] *picked up the error. Had* [Witness 4] *not picked up the error, the patient would not have had his pain controlled. Again, this raises questions as to whether this would also be the case with other medications.'*

The panel was of the view that the evidence produced by Witness 4 was consistent across her witness statement, file note dated 1 May 2022, and oral evidence. The panel also determined that Witness 4's evidence is corroborated by Witness 1's witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 5

5. On 15 May 2022 did not identify the correct prescribed drug for Patient H during a supervised round.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement which stated:

> *'On 15 May 2022, I was working with Bernard. He proceeded to take out medication for a patient who was prescribed oxycodone. However, instead of taking out oxycodone, Bernard took out temazepam tablets.* […] *I explained the seriousness of giving a wrong medication by telling him that a patient could fall unconsciousness* [sic] *or have an allergic reaction. I was giving general information and not information relating to this particular patient but Bernard didn't appear to recognise or understand the seriousness.'*

This is corroborated by Witness 4's file note dated 15 May 2022, which stated:

> '[…] *Just wanted to give you further feedback from my shift with Bernard today. We went into the back room with a laptop with meds chart Infront of us. I let him take the lead. He proceeded to get out the incorrect drug. I waited for him to check the px chart and realise but there was no awareness of the error. When I told him he had made the mistake and got the incorrect drug there was still little awareness of the seriousness. The patient had been prescribed Oxycodone MR but Bernard had got out temazepam tablets.'*

Witness 4 also provided a written noted dated 15 May 2022 which stated:

> *'medications unable to sign off due to mistake with CD – Bernard did not realise he was getting the incorrect drug out until I told. Good practice with taking laptop into treatment room but more awareness needed.'*

In her oral evidence, Witness 4 explained that Mr Watt *“didn’t really understand or comprehend the seriousness”* of giving a patient the wrong medication.

This is corroborated by Witness 1’s witness statement which stated:

> *‘*[Witness 4] *(Registered Nurse) reported that Bernard proceeded to take out temazepam tablets for a patient instead of Oxycodone MR on 15 May 2022. She allowed him to take the lead and waited for him to check the meds chart. When she informed him about the mistake, there wasn’t awareness about the seriousness. There was no harm to the patient as Bernard was being supervised by* [Witness 4], *and the wrong medication was not administered. There was a risk of harm if Bernard had administered the wrong medication, as the patient may have been allergic to the medication that want* [sic] *not prescribed for them, or inappropriately sedated. Temazepam is a sedative and oxycodone is an analgesic. Also, the patient pain control would not have been appropriately managed.’*

The panel was of the view that the evidence produced by Witness 4 was consistent across her witness statement, file note dated 15 May 2022, written note dated 15 May 2022, and oral evidence. The panel also determined that Witness 4’s evidence is corroborated by Witness 1’s witness statement. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 6

6. On an unknown date failed to complete observations due for patients in your care before going on your lunch break.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4’s witness statement which stated:

'There was generally a lack of awareness and responsibility from Bernard. On one occasion (date not remembered), Bernard was about to go on his lunch break without completing or delegating his patients' observations. There were 6 patients in total. They were due to be completed and recorded before he went for his lunch. I did the observations for him but told him about the responsibility of ensuring they were done before leaving.'

This is corroborated by an action plan that contains the following criteria:

'Independently manages own workload to ensure patients vital signs are monitored correctly and at the correct times'

The action plan states that on 25 July 2022, 26 July 2022, 31 July 2022, 1 August 2022, and 5 August 2022, Mr Watt failed to achieve this criteria and needed prompting on multiple occasions.

This is further corroborated by Witness 4's written note on an unknown date which stated:

'Bernard did not recognise he needed to do obs prior to going on his lunch break – needed prompting'

The panel was of the view that the evidence produced by Witness 4 was consistent across her witness statement, written note, and oral evidence. Therefore, on the balance of probabilities, the panel found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether Mr Watt's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely, kindly 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 a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, Mr Watt's fitness to practise is currently impaired as a result of that lack of competence.

Submissions on lack of competence

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

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

Mr Earnshaw submitted that over the course of a relatively short period of time, Mr Watt made a number of significant mistakes which are indicative of a lack of competence. He submitted that when looking at the range and breadth of the charges found proved by the panel, Mr Watt had not been completing any of the basic tasks that are fundamental to nursing practice. Mr Earnshaw further submitted that the tenor of the evidence from all of the witnesses heard in this hearing was that none of the tasks were difficult for a Band 5 registered nurse to complete.

Mr Earnshaw submitted that this was not a one-off incident, and that Mr Watt continued to make mistakes over a period of time. He further submitted that despite

Mr Watt’s probationary period being extended, it did not seem to have made any difference regarding his performance.

Mr Earnshaw submitted that the facts found proved show that Mr Watt’s competence at the time was below the standard expected of a Band 5 registered nurse.

Submissions on impairment

Mr Earnshaw 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Earnshaw provided the following written submissions in relation to impairment:

> *‘10. There is no statutory definition for impairment. The panel has to look forward and consider, in light of what has happened, whether the Registrant’s fitness to practice is impaired (Cheatle v General Medical Council [2009] EWHC 645 (Admin)). There has been almost no engagement whatsoever from the registrant to assist. There has been no reflection from the registrant and no attempts to understand the effect of his lack of competence.*
>
> *11. The panel is obliged to consider the Registrant’s competence in light of all the relevant factors known to the panel and whether the this is ‘easily remediable’ (Cohen v General Medical Council [2008] EWHC 581 (Admin)). It is submitted it is not. The probation period was extended for this very reason but failed to have any effect.*
>
> *12.The Panel will also need to consider whether or not there is a risk of the Registrant behaving in a similar way in the future. In making that assessment, the Panel may wish to consider any remorse/ insight, any training taken to remediate areas of professional deficiencies; and reflection on harm to patients*

and nursing profession. None of that applies here. Each witness explained that there was a real risk to patients if this behaviour continued.

13. In the Fifth Shipman Inquiry Report 2004 (paragraph 25.50), Dame Janet Smith identified the appropriate test for health care regulators considering fitness to practice. Of the 4 points it is submitted two apply. A medical professional's fitness to practice will be impaired where he or she:

i) Presents a risk to patients: it is submitted this is the position here;
ii) Has breached one of the fundamental tenets of the profession;'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

'1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively

6 Always practise in line with the best available evidence
To achieve this, you must:
6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work cooperatively
To achieve this, you must:
8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

13 Recognise and work within the limits of your competence

To achieve this, you must:

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

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

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

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:

18.1 prescribe, advise on, or provide medicines or treatment, […] *if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs*

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel bore in mind, when reaching its decision, that Mr Watt should be judged by the standards of a reasonable Band 5 registered nurse and not by any higher or more demanding standard.

The panel determined that these were basic nursing tasks that should comfortably sit in the skills set of a qualified Band 5 nurse. It determined that whilst no harm was caused to patients, as Mr Watt was being supervised by other registered nurses, had he not been supervised, there would be a significant risk of harm to patients.

The panel also noted that Mr Watt had initially failed his probationary period, and as a consequence, his probationary period was extended and a development plan was put in place. The panel determined that Mr Watt failed to address the issues in the development plan, and consequently failed his probation and was dismissed from the trust on 19 August 2022. The panel took account of the letter from the Trust to Mr Watt dated 19 August 2022 which stated:

> '[…] *Fundamentally, during your probationary period your performance and capability still does not meet the expected standards of a registered nurse. […] Having considered all of this information, my decision today is to terminate your contract during your probationary period due to your failure to satisfactorily complete a probationary period'*

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mr Watt's practice was below the standard that one would expect of the average registered nurse acting in Mr Watt's role.

In all the circumstances, the panel determined that Mr Watt’s performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Mr Watt’s fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 February 2024, 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. Nurses must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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

> *‘In determining whether a practitioner’s fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence*

in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) […]*'*

The panel determined that patients were put at significant risk of harm as a result of Mr Watt's lack of competence, and that the only reason no actual harm was caused was because he was being supervised by other registered nurses. Mr Watt's lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mr Watt has not demonstrated an understanding of how his actions put the patients at a risk of harm, and he has also not demonstrated an understanding of why what he did was wrong and how this impacted negatively on the reputation of the nursing profession.

The panel determined that Mr Watt has not provided any evidence to demonstrate that he has taken steps to strengthen his practice, or that he has undertaken any relevant training since the incidents occurred in 2022. The panel took into account that Mr Watt was a qualified nurse, and had worked at a different trust previously, and was supported by his development plan and extended probationary period, as well as receiving supervision from his colleagues, but that this did not improve his clinical practice.

The panel also took account of the completed regulatory concerns response form that was returned to the NMC by Mr Watt on 15 November 2022. In the form, Mr Watt denied the following regulatory concern:

> *'Concern 1: Lack of competence – in that you failed to demonstrate the standards of knowledge, skill and judgement to practise without supervision in the following areas:*
>
> *a. Knowledge of medicines and administering medicines when due*
> *b. Communication with patients*
> *c. Making adequate clinical records*
> *d. Patient observations*
> *e. Identifying a need for escalation/ escalating patients where indicated'*

In light of this, the panel determined that Mr Watt has not demonstrated any insight into his failings and determined that it is highly likely that the facts found proved would be repeated in the future if a finding of current impairment was not made. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that, in this case, a finding of impairment on public interest grounds was also required. The panel determined that a reasonable member of the public, who knew the circumstances of this case, would be concerned to learn that a registered nurse could not successfully complete basic tasks that are fundamental to nursing practice. The panel also determined that a finding of no impairment would undermine public confidence in the nursing profession and the NMC as the regulator.

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

Sanction

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

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

Submissions on sanction

Mr Earnshaw informed the panel that in the Notice of Hearing, dated 24 October 2024, the NMC had advised Mr Watt that it would seek the imposition of a suspension order for a period of 12 months if it found Mr Watt's fitness to practise currently impaired.

Mr Earnshaw submitted that taking no further action or imposing a caution order would be inappropriate given the finding of lack of competence and current impairment. Mr Earnshaw further submitted that a conditions of practice order is also not appropriate or proportionate as Mr Watt has not demonstrated any insight or reflection into his failings, and also as he lives in the Philippines and has not engaged with the NMC regarding this process. Mr Earnshaw therefore submitted that a suspension order is the only appropriate and proportionate sanction in this case.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of insight into failings
- A pattern of incompetence over a period of time
- Conduct which put patients at risk of suffering harm.
- Lack of engagement with the NMC regarding this process

The panel considered references made to [PRIVATE], and whether these may have amounted to a mitigating factor in relation to his practise. However, the panel, whilst accepting there were some [PRIVATE], considered that these were linked to his attendance record and not to his clinical practise. In the circumstances, the panel found that there were no mitigating factors in this case.

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

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

The panel next considered whether placing conditions of practice on Mr Watt's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG.

The panel determined that Mr Watt has demonstrated general incompetence in relation to his nursing practise. The panel also took into account that Mr Watt is not currently living in the United Kingdom and has not been engaging with the NMC regarding this process. The panel has no confidence that Mr Watt would comply with conditions, were they to be imposed. It therefore determined that it is not possible to formulate workable conditions in this case. Furthermore, such an order would not protect the public or meet the public interest in this case.

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

- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel went on to consider whether a striking-off order would be proportionate in this case. Given this is a lack of competence case, a striking-off order is not available to the panel until Mr Watt has been subject to a substantive order for a period of two years. Therefore, the least restrictive sanction the panel can impose at this time is a suspension order.

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

The panel noted the hardship such an order will inevitably cause Mr Watt. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of Mr Watt's lack of competence.

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

The panel is of the view that the period of suspension will afford Mr Watt the opportunity to reflect on whether he wishes to return to nursing practice in the United Kingdom, and to take steps to strengthen his practice.

Any future panel reviewing this case would be assisted by:

- Evidence of training undertaken in relation to:
    a. Knowledge of medicines and administering medicines when due
    b. Communication with patients and colleagues
    c. Making adequate clinical records
    d. Patient observations
    e. Identifying a need for escalation/escalating patients where indicated

- A reflective statement from Mr Watt demonstrating his understanding of what he has done wrong, and any insight into his failings.
- Mr Watt’s engagement in the process and attending a future review hearing.

This will be confirmed to Mr Watt in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Earnshaw. He invited the panel to impose an interim suspension order for a period of 18 months to allow time for any possible appeal. Mr Earnshaw submitted that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest.

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 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 to allow time for any possible appeal.

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

That concludes this determination.