Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 1 July 2024 – Thursday, 4 July 2024

Virtual Meeting

Name of Registrant:	**David Christopher Allen**
NMC PIN	81H0290S
Part(s) of the register:	RN1: Adult nurse, level 1 (11 May 1996) RN7: General nurse, level 2 (28 January 1984)
Relevant Location:	Wakefield
Type of case:	Misconduct
Panel members:	Simon Banton (Chair, lay member) Melanie Lumbers (Registrant member) Alison Lyon (Lay member)
Legal Assessor:	Sean Hammond
Hearings Coordinator:	Max Buadi (1 July 2024) Catherine Blake (2 – 4 July 2024)
Facts proved:	Charges 1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 4, 5.1, 5.2, 6.1, 6.2, 7.1, 7.2, 8.1, 8.2, 9, 10.1, 10.2, 11.1, 11.2, 11.3, 12.1, 12.2, 12.3, 13, 14.1, 14.2, 15.1,15.2, 15.3, 16.1, 16.2, 17.1, 17.2, 18, 19, 20, 21.1, 21.2, 21.3, 22.1, 22.2.1, 22.2.2, 22.2.3, and 23.
Facts not proved:	Charge 15.4
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mr Allen's registered email address by secure email on 16 May 2024. The notice informed Mr Allen that his case would be heard at a meeting on or after 20 June 2024 and that he could make written submissions and provide evidence until 14 June 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually. The panel had before it an email from Mr Allen sent by him on 23 May 2024 to the Nursing and Midwifery Council (NMC) in which, following his receipt of the Notice of Meeting, he stated he would not be responding.

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

Decision and reasons to redact certain information as private

The panel noted that, as this is a Substantive Meeting it will take place entirely in private and without a transcript, an application under Rule 19 is therefore not necessary. However, for the purposes of this determination, there may be cause for the panel to refer to [PRIVATE]. In such event, the sensitive information will be marked private and removed from the public reasons in order to protect Mr Allen's privacy.

Decision and reasons amending the charge

The panel of its own volition determined to amend the wording of charge 14.1.

The proposed amendment was to amend the date in the charge which would provide clarity and more accurately reflect the evidence. It was of the view that that there can be no prejudice to Mr Allen because the proposed amendment was not substantive.

Proposed Amendment

"That you, a registered nurse:

*14.1 did not record in the groups and relationship table the DCA entry dated ~~26/07/19~~ **26/07/18**."*

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 was in the interest of justice. The panel was satisfied that the amendment did not affect the substance of the charge and there would be no prejudice to Mr Allen and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment to ensure clarity and accuracy.

The panel also noted that there are a few typographical errors in the charges. It determined that amending these errors would not alter the substance of each charge and so decided to correct the typographical errors in order to ensure clarity and consistency. These amendments are as follows in bold.

Details of charge (as amended)

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

1. In relation to case 1

1.1 did not record in the groups and relationship table the DCA entry dated 26/07/18.

1.2 recorded an entry in the groups and relationship table dated 6/06/18 which does not correspond to any date in the DCA entry.

2. In relation to case 2

2.1 did not record in the groups and relationships table the DCA entry dated 27/07/18.

2.2 recorded an entry in the groups and relationship table dated 18/05/18 which does not correspond to any date in the DCA entry.

3. In relation to case 3

3.1 did not record in the groups and entry table the DCA entry dated 27/07/18.

3.2 recorded an entry in the groups and relationship table dated 1/06/18 which does not correspond to any date in the DCA entry.

4. In relation to case 4 did not record in the groups and relationship table the DCA entry dated 26/07/18.

5. In relation to case 5

5.1 did not record in the groups and entry table the DCA entry dated 26/07/18.

5.2 recorded an entry in the groups and entry table dated 1/06/18 which does not correspond to any date in the DCA entry

6. In relation to case 6

6.1 did not record in the groups and relationship table the DCA entry dated 10/05/18.

6.2 recorded an entry in the groups and relationship table dated 18/04/18 which does not correspond to any date in the DCA entry.

7. In relation to case 7

    7.1 did not record in the groups and entry table the DCA entry dated 10/05/18.
    7.2 recorded an entry in the groups and entry table dated 17/04/18 which does not correspond to any DCA entry.

8. In relation to case 8

    8.1 did not record in the groups and relationship table the DCA entry dated 27/07/18.
    8.2 recorded an entry in the groups and relationship table dated 7/06/19 which does not correspond to any date in the DCA entry.

9. In relation to case 9 did not record in the groups and relationship table the DCA entry dated 26/07/18.

10. In relation to case 10

    10.1 did not record in the groups and relationship table the DCA entry dated 26/07/18.
    10.2 recorded an entry in the groups and relationship table dated 7/06/18 which does not correspond to any date in the DCA entry.

11. In relation to case 11

    11.1 did not record in the groups and relationship table the DCA entry dated 09/02/18.
    11.2 did not record in the groups and relationships table the DCA entry dated 26/07/18.
    11.3 did not record any partner details.

12. In relation to case 12

12.1 did not record in the groups and relationship table the DCA entry dated 29/03/18.

12.2 did not record in the groups and relationship table the DCA entry dated 27/07/18.

12.3 recorded an entry in the groups and relationship table dated 6/07/18 which does not correspond to any date in the DCA entry.

13. In relation to case 13 did not record in the groups and relationship table the DCA entry dated 27/07/18.

14. In relation to case 14

14.1 did not record in the groups and relationship table the DCA entry dated 26/07/18.

14.2 recorded an entry in the groups and relationships table dated 26/06/18 which does not correspond to any date in the DCA entry.

15. In relation to case 15 did not record in the groups and relationships table one or more of the following DCA entries dated

15.1 22/08/17

15.2 29/03/18

15.3 10/05/18

15.4 12/09/18

16. In relation to case 16

16.1 **did** not record that you had informed the patient that they had tested positive for gonorrhoea.

16.2 **did** not record in the entry dated 14/08/18 any evidence of prescription and/or administration of treatment in the record.

17. In relation to case 17

    17.1 **did** not record and or inform the patient that they had tested positive for gonorrhoea.
    17.2 did not record the DCA entry dated 12/09/18 regarding result management and partner notification in the groups and relationships table.

18. In relation to Patient A documented that partner notification had been completed.

19. Documented that partner notification had been completed for any or all of cases 1-18 above **when** it had not.

20. Your actions **as** specified at charge 19 **were** dishonest in that you sought to create the impression that partner notification had been done when you knew it had not.

21. On 9 October 2018 breached information governance in that you sent a text message to a patient containing one or more of the following details:

    21.1 the **patient's** date of birth
    21.2 the **patient's** name
    21.3 the **patient's** appointment details

22. Used social media to post one or more of the following inappropriate comments/details regarding your colleagues
    22.1 In relation to **Colleague** 1 […] posted 'you're a vile evil cow'
    22.2 In relation to Colleague 2 posted one or more of the following
        22.2.1 referred to her as a **vile** bastard
        22.2.2 referred to her as a homophobic man hater
        22.2.3 revealed details of her personal life

23. Your posts referred to at any or all of charges 22 intended to cause **Colleagues** 1 and or 2 distress and or alarm.

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

Background

On 13 March 2019 the NMC received a referral from the Director of Nursing and Quality Assurance at Spectrum Community Health. At the time the concerns were raised, Mr Allen was working as a Band 7 Senior Health Advisor at Wakefield Integrated Sexual Health Services.

[PRIVATE].

An internal formal investigation was completed in December 2018. On 17 January 2019, a meeting was held in relation to the following concerns:

- An audit on patient records showed a number of instances of incorrect coding, entered by Mr Allen in relation to patient treatments.
- Information Governance breach – on 9 October 2018, Mr Allen sent a text message to a patient which included their date of birth, name and appointment details.

Witness 4 and Witness 1, both peers of Mr Allen, discovered some discrepancies in the coding of patients on the Genitourinary Medicine Clinic Activity Dataset (GUMCAD). Concerns had previously been raised in relation to compliance checks on patients following treatment for infection and contacting patients' partners regarding testing and treatment.

Witness 1 and Witness 2, who is a Consultant in sexual health, conducted a review of the patient records for 50 patients who had been diagnosed with gonorrhoea from April 2018 to September 2018 to establish whether Mr Allen had *'manipulated the data'* when completing the notes and subsequently claimed to have carried out the interventions. They identified a number of cases in which Mr Allen made errors or omissions in patient records.

Witness 1 informed the NMC that the management of the results/partner notification entry is made by ticking a box in the sexual health template on SystmOne. She stated the standard practice would then be to make a corresponding entry in another part of the patient records to detail what action had been taken. She stated *'ticking the above box when there is no evidence in the notes to support that any partner notification update has been done may be interpreted as an attempt to increase/meet KPI without doing the*

required work or intervention'. The NMC say that by doing this, the registrant has acted dishonestly.

On 9 October 2018, Mr Allen breached information governance in that he sent a text message to a patient containing one or more of the following details: the patient's date of birth, the patient's name and the patient's appointment details.

Mr Allen resigned during the investigation and left his employment on 18 February 2019. Subsequently, the investigation was not completed.

[PRIVATE].

In December 2019, Mr Allen made two public Facebook posts. One of these posts mentioned Witness 3, the Integrated Sexual Health Cluster Manager, by name and was *'particularly offensive'*.

In February 2021, Mr Allen made a further public Facebook post that was *'abusive'* and directed at his former colleagues. Mr Allen, on 15 March 2021, repeated this when he posted further *'inappropriate and abusive'* comments.

On 24 June 2021, Mr Allen contacted Witness 5, Clinical Nurse specialist, via Facebook messenger to inform her that he had set up a new Facebook profile as his previous account had been hacked. Mr Allen explained that he *'put the initials of people at Gateway, messaging service, who he thought were bullies'.*

On 20 September 2021, Mr Allen advised the NMC that he volunteers in a non-health related setting.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case including the representations made by the NMC and from Mr Allen in his Case Management Form (CMF).

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 accepted the advice of the legal assessor and had regard to the guidance issued by the NMC.

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

- Witness 1: Band 7 Health Adviser;
- Witness 2: Consultant in Sexual Health;
- Witness 3: Integrated Sexual Health Cluster Manager;
- Witness 4: Spectrum CIC as a Health Adviser.
- Witness 5: Clinical Nurse Specialist in Sexual Health;

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

Charge 1

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

1. In relation to case 1
   1.1 did not record in the groups and relationship table the DCA entry dated 26/07/18.

1.2 recorded an entry in the groups and relationship table dated 6/06/18 which does not correspond to any date in the DCA entry.

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*
>
> *I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:*
>
> - *Case 1 NHS 7171560147 dob 20/07/94:*
>
> *Read coded entries in record show patient chlamydia and gonorrhoea results filed on 21/05/18. DCA (David) entry 26/07/18 states partner notification progress update within 12 weeks of first PN discussion. Usual practice would be to review any entries in the 'Groups and relationships' section of the SystmOne record, add any new information or note no new information available and date this accordingly. Corresponding groups and relationships table shows last entry 06/06/18 which does not correspond with the date of any DCA entry in the record. There is no entry in the table that matches the date of the DCA entry in the patient record…"*

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 26 July 2018 with the name “ALLEN, David (Community Nurse).” It further noted that under the sub-heading “Partner Notification/Public Health Management of results” Mr Allen had entered, “PN – Progress update within 12 weeks after first PN Discussion: Yes”.

The panel took account of the Groups and Relationship’s table, and noted that there are entries made for 24 March 2017, 10 November 2017 and 24 November 2017. However, there is no corresponding entry in relation to the aforementioned record made on 26 July 2018.

The panel also noted that on the Groups and Relationship’s table, in the entry dated 24 November 2017, Mr Allen has entered, “contact GC, screened and treated epidemiologically, 06/06/18”. However, when the panel took account of the aforementioned patient record, it could not find a corresponding entry for 6 June 2018.

The panel took account of Mr Allen’s CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2’s witness statements.

The panel therefore find these sub-charges proved.

Charge 2

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

2. In relation to case 2

2.1 did not record in the groups and relationships table the DCA entry dated 27/07/18.
2.2 recorded an entry in the groups and relationship table dated 18/05/18 which does not correspond to any date in the DCA entry.

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*
>
> *I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:*

- *Case 2 NHS 6376386830 dob 18/03/98:*

Entry 22/05/18 documenting gonorrhoea diagnosis and treatment. DCA entry 27/07/18 regarding management of results and PN progress update. No DCA entry in groups and relationships table for that date. Entry in table 18/05/18 does not correspond to a DCA entry in the patient record…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 27 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there are entries made for 7 June 2013, 27 March 2015, two entries for 18 May 2018 and an entry for 19 November 2018. However, there is no corresponding entry in relation to the aforementioned record made on 27 July 2018.

The panel took account of the Groups and Relationship's table and the two entries dated 18 May 2018. However, when the panel took account of the aforementioned patient record, it could not find a corresponding entry for 18 May 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore find these sub-charges proved.

Charge 3

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

3. In relation to case 3

    3.1 did not record in the groups and entry table the DCA entry dated 27/07/18
    3.2 recorded an entry in the groups and relationship table dated 1/06/18 which does not correspond to any date in the DCA entry.

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*

I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:

- *Case 3 NHS 6013670773 dob 10/12/96:*

Entry dated 24/05/18 showing positive gonorrhoea result filed. DCA entry 27/07/18 regarding management of results and partner notification update. No entry in groups and relationships table for that date. Entry in the table for 01/06/18 does not correspond to any DCA entry in the patient record…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 27 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there are entries made for 14 June 2017, 18 September 2017 and 1 June 2018. However, there is no corresponding entry in relation to the aforementioned record made on 27 July 2018.

The panel took account of the Groups and Relationship's table and the entry dated 1 June 2018. However, when the panel took account of the aforementioned patient record, it could not find a corresponding entry for 1 June 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was

also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 4

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

4. In relation to case 4 did not record in the groups and relationship table the DCA entry dated 26/07/18.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*
>
> *I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:*

- *Case 4 NHS 4161065728 dob 11/06/93:*

Entry 31/05/18 showing negative gonorrhoea and chlamydia result filed in record. No partner notification necessary. DCA entry 26/07/18 regarding management of results and partner notification. No entry on that date in the groups and relationships table…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 26 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there are entries made for 14 November 2011, 22 May 2017 and 21 May 2018. However, there is no corresponding entry in relation to the aforementioned record made on 26 July 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds this charge proved.

Charge 5

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

5. In relation to case 5

5.1 did not record in the groups and entry table the DCA entry dated 26/07/18.
5.2 recorded an entry in the groups and entry table dated 1/06/18 which does not correspond to any date in the DCA entry

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*
>
> *I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:*
>
> - *Case 5 NHS 4160439497 dob 15/02/81*

Entry 01/06/18 showing positive gonorrhoea result filed. DCA entry 26/07/18 regarding management of results and partner notification. No entry in groups and relationship template on that date. Entry in table dated 01/06/18 does not correspond to a date that DCA was in the patient record…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 26 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there are entries made for 30 June 2015 and 1 June 2018. However, there is no corresponding entry in relation to the aforementioned record made on 26 July 2018.

The panel took account of the Groups and Relationship's table and the entry dated 1 June 2018. However, when the panel took account of the aforementioned patient record, it could not find a corresponding entry for 1 June 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 6

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

6. In relation to case 6

    6.1 did not record in the groups and relationship table the DCA entry dated 10/05/18.
    6.2 recorded an entry in the groups and relationship table dated 18/04/18 which does not correspond to any date in the DCA entry.

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*

I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:

- *Case 6 NHS 4123739334 dob 26/04/89*

Entry 03/04/18 showing gonorrhoea and chlamydia infection results filed. DCA entry 10/05/18 regarding management of results and partner notification. No entry in groups and relationship table on that date. Entries in table dated 18/04/18 do not correspond to a date that DCA was in the patient record…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 10 May 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there are two entries made for 18 April 2018 and another for 22 January 2020. However, there is no corresponding entry in relation to the aforementioned record made on 10 May 2018.

The panel took account of the Groups and Relationship's table and the two entries dated 18 April 2018. However, when the panel took account of the aforementioned patient record, it could not find a corresponding entry for 18 April 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was

also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 7

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

7. In relation to case 7

    7.1 did not record in the groups and entry table the DCA entry dated 10/05/18.
    7.2 recorded an entry in the groups and entry table dated 17/04/18 which does not correspond to any DCA entry.

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment*

and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).

I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:

- *Case 7 NHS 6439747045 dob 13/01/01*

Entry 24/04/18 showing positive chlamydia and positive gonorrhoea results filed. DCA entry 10/05/18 regarding management of results and partner notification. No entry in groups and relationship table on that date. Entry in table on 17/04/18 does not correspond to a date that DCA was in the patient record…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 10 May 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there is an entry made for 17 April 2018. However, there is no corresponding entry in relation to the aforementioned record made on 10 May 2018.

The panel took account of the Groups and Relationship's table and the sole entry dated 17 April 2018. However, when the panel took account of the aforementioned patient record, it could not find a corresponding entry for 17 April 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential

weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 8

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

8. In relation to case 8

    8.1 did not record in the groups and relationship table the DCA entry dated 27/07/18.
    8.2 recorded an entry in the groups and relationship table dated 7/06/19 which does not correspond to any date in the DCA entry.

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*

…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).

I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:

- *Case 8 NHS 6069188454 dob 19/10/82*

Entry 07/06/18 showing positive gonorrhoea results. DCA entry 27/07/18 regarding management of results and partner notification. No entry in groups and relationships table on that date. Entry in table dated 07/06/19 does not correspond to a date that DCA was in the patient record…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 27 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there is one entry made for 7 June 2018. However, there is no corresponding entry in relation to the aforementioned record made on 27 July 2018.

The panel took account of the Groups and Relationship's table and the entry dated 7 June 2018. However, when the panel took account of the aforementioned patient record, it could not find a corresponding entry for 7 June 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 9

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

9. In relation to case 9 did not record in the groups and relationship table the DCA entry dated 26/07/18.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…

…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).

I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:

- *Case 9 NHS 6370419842 dob 08/01/98*

Entry 05/06/18 showing positive gonorrhoea result. DCA entry 26/07/18 regarding results management and partner notification. No entries in groups and relationships table – this is a screenshot as unable to print this part of the record if there are no entries…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 26 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

However, the panel noted that in the corresponding Groups and Relationship's table there is no entry in relation to the aforementioned record made on 26 July 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds this charge proved.

Charge 10

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

10. In relation to case 10

    10.1 did not record in the groups and relationship table the DCA entry dated 26/07/18.
    10.2 recorded an entry in the groups and relationship table dated 7/06/18 which does not correspond to any date in the DCA entry.

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…

…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).

I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:

- *Case 10 NHS 4126822771 dob 15/11/80*

Entry 06/06/18 showing positive gonorrhoea result. Two DCA entries dated 26/07/18 regarding results management and partner notification. No entries in the groups and relationships table on that date. Entry in the table dated 07/06/18 does not correspond to a date that DCA was in the patient record…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 26 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there was an entry made for 7 June 2018. However, there is no corresponding entry in relation to the aforementioned record made on 26 July 2018.

The panel took account of the Groups and Relationship's table and the entry dated 7 June 2018. However, when the panel took account of the aforementioned patient record, it could not find a corresponding entry for 7 June 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 11

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

11. In relation to case 11

    11.1 did not record in the groups and relationship table the DCA entry dated 09/02/18.
    11.2 did not record in the groups and relationships table the DCA entry dated 26/07/18.
    11.3 did not record any partner details.

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this

decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*
>
> *I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:*
>
> - *Case 11 NHS 7073974966 dob 04/07/82*
>
> *Entry 16/01/18 showing positive gonorrhoea result. DCA entry 09/02/18 regarding results management and partner notification. No entry in groups and relationships table on that date. New episode 13/06/18. Entry 18/06/18 showing further positive gonorrhoea result. DCA entry 26/07/18 regarding results management and partner notification. No entry in groups and relationships table on that date. No partner details in table at all…"*

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there are entries made on 9 February 2018 and 26 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that, for both entries, under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there are two entries made for 3 April 2018 and an entry for 8 January 2020. However, there is no corresponding entry in relation to the aforementioned record made on 9 February 2018 or 26 July 2018.

The panel took account of the Groups and Relationship's table. It noted that under the sub heading "Type", the entry for 3 April 2018 had "GP" listed, the second entry for 3 April 2018 had "Friend" listed and the entry for 8 January 2020 had "GP". The panel noted that there is no entry that indicated a record for a "Partner".

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 12

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

12. In relation to case 12

12.1 did not record in the groups and relationship table the DCA entry dated 29/03/18.

12.2 did not record in the groups and relationship table the DCA entry dated 27/07/18.

12.3 recorded an entry in the groups and relationship table dated 6/07/18 which does not correspond to any date in the DCA entry

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*
>
> *I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:*
>
> - *Case 12 NHS6004269786 dob 22/07/97*
>
> *Entry 15/03/18 showing positive chlamydia result. Entry 19/03/19 regarding partner notification by staff member... Corresponding entry in groups and relationships table with details. DCA entry 29/03/18 regarding results management and partner notification. No entry in groups and relationships table on that date. New episode*

03/05/18. Positive gonorrhoea result coded 28/06/18. DCA entry 27/07 /18 regarding results management and partner notification. No entry in groups and relationship table on that date. Entry in table 06/07/18 does not correspond to a date when DCA was in that patient record…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 29 March and 27 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that, for both entries, under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there are entries made for 19 March 2018 and 6 July 2018. However, there is no corresponding entry in relation to the aforementioned record made on 29 March 2018 and 27 July 2018.

The panel took account of the Groups and Relationship's table and the entry dated 6 July 2018. However, when the panel took account of the aforementioned patient record, it could not find a corresponding entry for 6 July 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 13

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

13. In relation to case 13 did not record in the groups and relationship table the DCA entry dated 27/07/18.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*
>
> *I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:*
>
> - *Case 13 NHS6391638772 dob 02/05/99*
>
> *Positive gonorrhoea result filed 02/07/18. DCA entry 27/07/18 states notes accessed for pn /entry re results management and partner notification. No entries at*

all in the groups and relationships table. Again this is presented as a screenshot because the table cannot be printed out if there are no entries in it…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 27 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

However, the panel noted that in the corresponding Groups and Relationships table there is no entry in relation to the aforementioned record made on 27 July 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds this charge proved.

Charge 14

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

14. In relation to case 14

    14.1 did not record in the groups and relationship table the DCA entry dated 26/07/18.
    14.2 recorded an entry in the groups and relationships table dated 26/06/18 which does not correspond to any date in the DCA entry.

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*
>
> *I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:*

- *Case 14 NHS 4980185398 dob 22/04/53*

  Entry 25/06/18 showing positive gonorrhoea and chlamydia results. DCA entry 26/07/19 regarding results management and partner notification. No entry in groups and relationships table on that date. Entry in table dated 26/06/18 does not correspond to a date when DCA was in the patient records…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 26 July 2018 with the name "ALLEN, David (Community Nurse)." It further noted that under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationship's table, and noted that there are entries made for 26 May 2011 and 26 June 2018. However, there is no corresponding entry in relation to the aforementioned record made on 26 July 2018.

The panel took account of the Groups and Relationship's table and the two entries dated 26 June 2018. However, when the panel took account of the aforementioned patient record, it could not find a corresponding entry for 26 June 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 15

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

15. In relation to case 15 did not record in the groups and relationships table one or more of the following DCA entries dated

    15.1 22/08/17
    15.2 29/03/18
    15.3 10/05/18

These sub-charges are found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*

I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:

- *Case 15 NHS 4126888993 dob 16/03/88*

DCA entries 22/08/17, 29/03/18, 10/05/18…regarding results management and partner notification with no corresponding entries in the groups and relationships section of the record…"

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there are entries made on 22 August 2017, 29 March 2018 and 10 May 2018 with the name "ALLEN, David (Community Nurse)." It further noted that, for the three entries, under the sub-heading "Partner Notification/Public Health Management of results" Mr Allen had entered, "PN – Progress update within 12 weeks after first PN Discussion: Yes".

The panel took account of the Groups and Relationships table, and noted that there are entries made for 31 July 2017, 18 April 2018 and 14 August 2018. However, there is no corresponding entries in relation to the aforementioned records made on 22 August 2017, 29 March 2018 and 10 May 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 15.4

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records

15. In relation to case 15 did not record in the groups and relationships table one or more of the following DCA entries dated

    15.4 12/09/18

This sub-charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*
>
> *I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:*
>
> - *Case 15 NHS 4126888993 dob 16/03/88*

DCA entries…12/09/18 regarding results management and partner notification with no corresponding entries in the groups and relationships section of the record…"

Witness 2 corroborated this in her own witness statement.

The panel, however, had before it only three of what it ascertained to be six entries on the Groups and Relationships record. It could not verify if any of those unseen entries related to the DCA entry on 12 September 2018. In the absence of this part of the patient's record, the panel found this charge not proved.

The panel therefore finds this sub-charge not proved.

Charge 16

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records:

16. In relation to case 16
    - 16.1 did not record that you had informed the patient that they had tested positive for gonorrhoea
    - 16.2 did not record in the entry dated 14/08/18 any evidence of prescription and/or administration of treatment in the record.

This charge is found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…

…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).

I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:

…

- *Case 16 NHS 6338700108 dob…*

Patient had positive gonorrhoea result but no evidence in notes of patient being informed of this result. Entry 14/08/18 states patient treated as a contact of gonorrhoea but no evidence of prescription or administration of treatment in the record. Patient was an index case and not a contact. Records reviewed by clinical lead 05/12/18 following concerns re DCA and patient identified as having untreated gonorrhoea – recalled and treated but was 17 week gestation at this point.'

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry made on 6 August 2018 with the name "ALLEN, David (Community Nurse)" that gonorrhoea had been detected. It further noted that for this entry, there was no mention that the patient was informed of the diagnosis.

The panel placed significant weight on the entry in the patient record dated 5 December 2018 by Witness 2, which stated that, following the record's review, she identified 'Not had GC Rx – please recall and offer treatment'.

The panel took account of the Groups and Relationships table, and noted that there is no corresponding entry in relation to the aforementioned record made in August 2018.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 17

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records:

17. In relation to case 17

    17.1 did not record and or inform the patient that they had tested positive for gonorrhoea
    17.2 did not record the DCA entry dated 12/09/18 regarding result management and partner notification in the groups and relationships table.

This charge is found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

Witness 1 in her witness statement stated:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patients back in for treatment, partner tracing and liaise with other clinics regarding results…*
>
> *…The Health Adviser (David) would be expected to manage the positive STI results for chlamydia and gonorrhoea. This includes filing the results correctly and in a timely manner, and informing the patient of their results and arranging treatment and appropriate follow-up including test of cure (i.e. repeat testing to ensure the infection has resolved).*
>
> *I thereafter checked the information passed from [Witness 2], who extracted the following data regarding errors or omissions made by David:*
>
> *…*
>
> - *Case 17 NHS 4746991901 dob…*
>
> *Result filed 14/08/18 by DCA shows positive gonorrhoea result on a pharyngeal swab, filed by DCA with comment 'pharyngeal GC treat as negative'. Subsequent result shows rectal chlamydia, patient informed by DCA and recalled for chlamydia treatment only. No evidence of patient being informed of positive gonorrhoea result. Patient eventually treated for gonorrhoea 04/09/18 when named by another patient as a contact of infection. DCA entry 12/09/18 regarding result management and partner notification with no corresponding entry in the groups and relationships table on that date."*

Witness 2 corroborated this in her own witness statement.

The panel took account of the relevant patient record referred to in the witness statements of Witness 1 and Witness 2. It noted that there is an entry on 14 August 2018 that the patient had tested negative for chlamydia but positive for gonorrhoea. It further noted that for this entry and throughout the patient record, there was no mention that the patient was informed of the diagnosis and no further action recorded. The panel found that there was no corresponding entry to the aforementioned record made on 14 August 2018 and the entry in it dated 21 August 2018 is unrelated to the events of the earlier date.

The panel took account of Mr Allen's CMF which is signed and dated on 6 September 2023. In it, there is no indication from Mr Allen that he disputed the evidence of Witness 1 and Witness 2. Additionally, it noted that Mr Allen, in his CMF had admitted these charges.

The panel bore in mind that both Witness 1 and Witness 2 had undertaken a review of 50 patient records, which, given their contemporaneous nature, the panel afforded evidential weight, between the time frame of April to September 2018. It accepted the evidence of Witness 1 and Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the patient records corroborated the details in Witness 1 and Witness 2's witness statements.

The panel therefore finds these sub-charges proved.

Charge 18

That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records:

18. In relation to Patient A documented that partner notification had been completed.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF.

The panel had regard to the record for Patient A which contained an entry on 1 October 2018 that a notification to the partner of Patient A was to be through the patient himself. The partner was noted on the groups and relationships table on the same date. However, the record indicates that it was not until 16 October 2018 that the partner was contacted and made aware that he may have an STI. That notification was conducted by Witness 4.

In her meeting notes dated 12 December 2018, Witness 4 details the process of indexing a patient who has tested positive for an STI:

> *"[Witness 4] confirmed that Patient A was the index patient. RB explained that the process is that if the Chlamydia test is positive the patient is the index patient. The HA then supports the index to ensure their partner/s is/are treated. If the partner attends, they are a contact of Chlamydia. If the contact is then found to be Chlamydia positive the index then becomes a contact too. This can then all be coded accordingly. In order to code this on the record, the partner needs to be screened, if this occurred outside the clinic at a GP practice or another service, the HA would need to verify this by contacting the service and checking attendance. [Witness 4] would not take the patients [sic] word for it as the duty would be with the index patient. [Witness 4] confirmed that she could not find this verification recorded in Patient A's records."*

It is a near contemporaneous report so the panel placed significant weight on this evidence, which is reiterated in Witness 4s statement:

> *"When a patient is treated for an infection a compliance check is made by the Health Advisor a week later to check that medication has been taken correctly and advice followed so that the patient has been successfully treated. The duty of care of the Health Advisor is to the index patient, the patient who is first diagnosed with the infection. After that partner notification is carried out to break the chain of infection by ensuring any of the index patient's partners have themselves been successfully treated and cured. It would be normal for partner treatment to be*

verified by the health advisor who may phone the partner to confirm that treatment had been given (with the consent of the index) or to verify using our own patient records or to contact another sexual health clinic to verify an attendance and or treatment."

The panel considered the patient record for Patient A and noted that *"Partner Notification"* is starred due to it concerning public health information. However, there is no other information in the record that Patient A's partner was notified. It noted that the test result was communicated to Patient A by phone, but there is no confirmatory record of Patient A's partner being contacted and informed of the positive test by any method.

The panel concluded that Mr Allen did not follow the correct procedure in notifying Patient A's partner, but made an incorrect entry in Patient A's record that he had.

The panel therefore finds the charge proved.

Charge 19
That you a registered nurse

On one or more of the following occasions made incorrect entries and/or omitted information in the following patient records:

19. Documented that partner notification had been completed for any or all of cases 1-18 above when it had not.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2 and the response from Mr Allen in the CMF, as they relate to the previous charges, as well as the witness statement of Witness 4.

Witness 4 in her witness statement stated:

"One of these compliance check was made to a female partner who had no idea if her partner had been treated for chlamydia and in fact had not been treated

despite 'partner treated by GP' being the entry recorded in the index patients notes.

Another patient who was an index patient for Gonorrhoea had 'index states partner treated but unable to verify'. This was very unusual as the health advisor would normally do a thorough follow up to ensure partners were notified and treated. This is a public health duty to break the chain of infection. In some records there was no evidence that a compliance check had been done.

Specific targets for health advising and partner notification are audited each year and these are reported on a monthly basis. This audits the amount of Chlamydia tests taken, the amount of positive patients and how many partners need to be informed. The national target is 0.6 and if one month the figure dropped to 0.5 I would usually ask for all the patient notes to be sent so I can check what has happened to cause the shortfall.

David's PN figures had been very poor, but after I had shown him how to correctly code they improved dramatically and were then been reported as 1.0 instead of the sometimes 0.2. It became apparent that David was coding all CT/GC positive patients as contacts as well, even if there was no evidence of their partners having a CT/GC diagnosis. This I believe was to improve the PN outcome figures."

The panel considered the evidence of Witness 4 and was satisfied that it was cogent and reliable. It noted that their statement was supported by exhibits to explain the write ups, that this evidence is consistent across the other evidence in the bundle, and is supported by Witness 2. The panel further noted that Witness 4 first provided this evidence on 1 September 2018, having been part of the compliance audit, and that their account is a near contemporaneous report of the events referred to in this charge.

The panel therefore finds the charge proved.

Charge 20

Your actions as specified at charge 19 were dishonest in that you sought to create the impression that partner notification had been done when you knew it had not.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1, Witness 2, Witness 4, and the response from Mr Allen in the CMF.

The panel recognised that it must consider and make a separate decision in respect of whether each of the factual charges found proved amounted to dishonesty. The panel bore in mind the seriousness of the allegation of dishonesty and the potential impact on the registrant's future. It was mindful that the more serious the allegation the more cogent the evidence required to find it proved on the balance of probabilities.

In reaching its decisions, the panel had regard to the NMC Guidance regarding dishonesty (DMA-8) and applied the test of dishonesty as set down in the case of *Ivey v Genting Casinos Ltd t/a Crockfords [2017] UKSC 67.*

The panel noted that this is the only charge Mr Allen denies in the CMF signed and dated 6 September 2023.

The panel determined that the following evidence was relevant to its decision making in relation to the issue of dishonesty in respect of all of charges 1-18.

Witness 1 in her statement states:

> *"The key aspects of the role of health advisor is partner notification, stop the spread of infections, code correctly on the system, contribute to KPI' s, get patient's [sic] back in for treatment, partner tracing and liaise with other clinics regarding results. It was not easy to mis-code as this is a key role of the Health Advisor, either someone has an infection or they don't and you cant code until you have the results. It is just a case of ticking a box, but the box cant be ticked until the results have been received."*

The panel noted Witness 1's further statement, implying that Mr Allen did not notify the relevant partners in order to meet a KPI (key performance indicator):

> *"Ticking the above box when there is no evidence in the notes to support that any partner notification update has been done may be interpreted as an attempt to increase/ meet a KPI without doing the required work or intervention."*

This is corroborated by Witness 4's statement.

The panel also noted the following from Witness 2's statement:

> *"I had asked David to look again at partner notification as this had gone from 30% to 100% over a 1 month period. I questioned whether this was right and checked with Kay Matthewman, (Performance and Information Analyst, Spectrum CIC) who confirmed yes, it was 100%. I informed David I would need to talk about this with him as I felt that it was unlikely that these figures were correct, [PRIVATE]. When a review of the notes was done it was found that David had coded people as partner notification complete when there was no evidence in the record of this being the case. I didn't know if this was deliberate or indicative of where his head was at the time."*

This reportedly rapid increase in partner notification was supported in the statement of Witness 4:

> *"David's PN figures had been very poor, but after I had shown him how to correctly code they improved dramatically and were then been reported as 1.0 instead of the sometimes 0.2. It became apparent that David was coding all CT/GC positive patients as contacts as well, even if there was no evidence of their partners having a CT/GC diagnosis. This I believe was to improve the PN outcome figures"*

The panel had regard to the statement of Witness 2, in which she speculated as to why these errors were made:

> *"These errors were coding issues. This could have been due to the volume of work, trying to work too quickly or it may have been that David was cutting*

corners. In David's defence I had felt that there was too much work for a single Health Adviser and I had flagged this issue up about David needing help, but this was not put in place. When I asked David, he had always said his workload was acceptable and manageable. David was not unsupported but there was a need to be more proactive in future.

[PRIVATE]"

However, the panel has seen no explanation from Mr Allen to explain these errors.

The panel also noted the following, also from Witness 2's statement:

"I had heard second-hand reports that David's behaviour had been erratic and that he had been rude to staff, unpleasant about staff and had outbursts of temper whilst I had been away. This was out of character, but he had done it before. When I raised the issue with David about a case of syphilis that was untreated and asked why this hadn't been treated. David responded, "fucking hell, I knew you'd ask that". This was out of character for David to swear at me or at work."

The panel was of the view that this interaction indicated that Mr Allen was conscious of the fact that this error could become an issue, and that he knew something was wrong.

Having regard to the above, the panel considered the first limb of the test in *Ivey.* It was satisfied that in relation to each of charges 1-18 Mr Allen did not complete the partner notification and that he knew he had not done so. Furthermore, the panel was satisfied that, in relation to each charge, Mr Allen had falsely indicated he had contacted the partner of the infected patient when he had not done so. The panel was satisfied that at the time he did this, Mr Allen knew that his actions were capable of creating a false and misleading impression that the mandatory partner notification process had been completed when it had not.

The panel next considered the second limb of *Ivey*. In so doing, the panel considered whether there was another innocent explanation for Mr Allen's conduct that pointed away from him having behaved dishonestly.

The panel considered the evidence before it and noted that Mr Allens conduct occurred over a significant period of time and affected a large number of patients. To the panel, this indicated a repeated and sustained pattern of behaviour as opposed to isolated mistakes or errors.

While there is some evidence that Mr Allen was subject to high caseload, there is no evidence that this was a significant contributory factor negatively affecting his performance.

The panel also noted that Mr Allen had received some support in the use of SystmOne, particularly in regards to previous inaccuracies in the proper coding of patient records. It has seen evidence that partner notification is an expected part of the role, and noted that Mr Allen was at the time an experienced practitioner who had undergone additional SystmOne training. It accepted the evidence that Mr Allen had previously completed SystmOne inputs correctly.

[PRIVATE].

The panel noted that there was some evidence that Mr Allen's behaviour had been out of the ordinary, however the panel was satisfied that it was more likely than not, applying the standards of ordinary decent people, that in relation to each of the charges he acted dishonestly.

The panel concluded that it was most likely that Mr Allen knowingly recorded partner notifications when he had not done so, that this was dishonest and that his reasons for doing so was to improve the associated KPIs.

The panel therefore finds the charge proved in relation to all charges 1 to 18.

Charge 21

That you a registered nurse

21. On 9 October 2018 breached information governance in that you sent a text message to a patient containing one or more of the following details:

    21.1 the patient's date of birth
    21.2 the patient's name
    21.3 the patient's appointment details

This charge is found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 2, and the response from Mr Allen in the CMF.

The panel took account of the SystmOne patient record, which contained clear evidence of the text sent to the patient on 9 October 2018 against the name "ALLEN, David (Community Nurse)" that listed their name and date of birth, as well as the time and date of their appointment at the clinic.

Mr Allen accepted in the CMF that he sent the text, there is no suggestion that this text could have been sent by anyone else.

In meeting notes dated 17 January 2019, Witness 2 stated the following regarding the clinic's text reminder practice:

"…they would send more of a generic message unless the patient had specifically asked but then this should be documented in the notes…

…

"…it would normally be a generic text from systmone [sic], and they wouldn't normally send such a text with those details as outlined ..."

The panel determined that the text message sent by Mr Allen was a clear breach of information governance by incorrectly divulging private patient information via text messaging.

The panel therefore finds these sub-charges proved.

Charge 22

That you a registered nurse

22. Used social media to post one or more of the following inappropriate comments /details regarding your colleagues
    - 22.1 In relation to Colleague 1 […] posted 'you're a vile evil cow'
    - 22.2 In relation to Colleague 2 posted one or more of the following
        - 22.2.1 referred to her as a vile bastard
        - 22.2.2 referred to her as a homophobic man hater
        - 22.2.3 revealed details of her personal life

This charge is found proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 4 and Witness 5, and the response from Mr Allen in the CMF.

The panel saw screenshots of the post made by a Facebook user named 'David Allen' which states '[Colleague 1], your [sic] a vile evil cow'.

The panel also saw screenshots of comments left by the same Facebook user, in which someone with the same initials as Colleague 2 (Witness 4) is referred to as a 'homophobic man hater' and 'vile', and that the post stated that Mr Allen had witnessed this person have daily arguments with their husband on the phone.

The panel also took into account that Mr Allen has accepted in the CMF that he made these posts on social media.

On the evidence before it the panel was satisfied that Mr Allen did use social media to call Colleague 1 a 'vile evil cow', and also to accuse Colleague 2 of being a 'homophobic man hater' and a 'vile bastard', and to publicly reveal details of their private life.

The panel therefore finds the charge proved.

Charge 23

Your posts referred to at any or all of charges 22 intended to cause Colleagues 1 and or 2 distress and or alarm.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 4 and Witness 5, and the response from Mr Allen in the CMF.

The panel saw evidence from the witnesses about how they felt after viewing the posts

- Witness 4/Colleague 2

"The posts made me feel very upset (I cried when I read them) I was extremely distressed. I worried re my personal and professional reputation. They are very untrue and incorrect, they made me feel that I had to justify my values and morals…it was unprovoked, unjustified and outrageous lies."

- Witness 5

  "The following day I spoke with [Witness 4] and informed her of the post. I sent her the screenshot and she was shocked and upset that comments referring to her were posted so publicly."

The panel took into account that Witness 5 reported the post to the platform and blocked Mr Allen. Witness 5 stated *"the post shocked me and I took a screenshot and reported it to Facebook. I also blocked David".* The panel were of the view that this speaks to the impact Mr Allen's post had on her.

The panel was satisfied on the evidence before it that Mr Allen's conduct at charge 22 did cause distress and alarm to Colleagues 1 and 2.

The panel noted Witness 5's statement states that Mr Allen contacted her after the posts were made to say that his previous Facebook account had been hacked, but no other evidence beyond his own assertion has been provided that this was the case, or whether this impacted on his responsibility for the posts in question.

The panel took account of Mr Allen's comments in the CMF in relation to charge 22. It found that his opinions of Colleague 1 and Colleague 2 have not changed since making the posts and they remain vitriolic. The panel found that, given the nature of the language used and that he posted publicly in a forum that his colleagues would see, Mr Allen's actions were deliberate and intended to cause distress and alarm to the colleagues named.

The panel therefore found the charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Allen'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 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, Mr Allen's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2018)' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Mr Allen's actions amounted to misconduct. In particular, the NMC submitted that he had breached the following sections of the Code: 1.2, 6.2, 10.1, 10.2, 10.3, 13.3, 20.1, 20.2, and 20.10.

The NMC reminded the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper

standards and maintain public confidence in the profession and in the NMC as a regulatory body. In this, the panel was referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).*

The NMC invited the panel to find Mr Allen's fitness to practise impaired on the ground of public protection. The NMC submitted that Mr Allen's conduct fell far short of what would have been expected of a registered nurse and demonstrated *"deficiencies in record keeping in relation to the coding of diagnoses of sexually transmitted diseases, and associated follow up care and partner notification could have resulted in a real risk of harm to patients."*

The NMC further submitted that Mr Allen's fitness to practise was impaired on the ground of public interest due to his *"inappropriate use of social media, by posting in appropriate content of Facebook in relation to colleagues demonstrate a flagrant departure from the standards expected of a registered nurse and a breach of the fundamental tenets of the profession. Mr Allen's posts caused colleagues to feel distress which is a failure to uphold professional standards and maintain public confidence."*

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

The panel was of the view that Mr Allen's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Allen's actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

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*

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

5.1 *respect a person's right to privacy in all aspects of their care*

6 Always practise in line with the best available evidence

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

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.

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

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

19.3 *keep to and promote recommended practice in relation to controlling and preventing infection*

20 Uphold the reputation of your profession at all times

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*

20.5 *treat people in a way that does not … cause them upset or distress*

20.10 *use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times*

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

The panel considered each charge separately, identifying whether each amounted to serious misconduct. The panel determined the conduct found proved at charges 1 to 21 to be extremely serious. It concluded that Mr Allen's poor practise led to patients not receiving care, and that the patients' partners were not notified which delayed them receiving care. The panel concluded that these deficiencies in record keeping demonstrated a dangerous attitude towards his work, especially in light of the public health implications, and created a real risk of harm to the public. The panel also noted that, given Mr Allen was a healthcare professional working in a sensitive environment and with vulnerable patients, such poor practise was reckless and would, if known, undermine the public's confidence in the service. The panel was of the view that this could discourage people from seeking the services of sexual health clinics, which presents a risk to public health.

The panel was of the view that such sustained dishonesty as found proved at charge 20 was extremely serious and Mr Allen's actions created a significant risk of harm to patients and the public.

The panel further noted that Mr Allen was an experienced nurse who was familiar with his practice and had worked in sexual health clinics for many years prior to the allegations. The panel found no contextual reasons to excuse his conduct at charges 1 to 21.

Regarding charges 22 and 23, the panel was of the view that Mr Allen's conduct at these charges was serious. The panel considered such conduct to be intimidatory and distressing, and indicated a disregard for colleagues.

Accordingly, the panel found that Mr Allen's 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, Mr Allen'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. 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* [2011] EWHC 927 (Admin) in reaching its decision. In paragraph 74, she said:

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds all four limbs engaged and that patients were put at risk of serious harm as a result of Mr Allen's misconduct. Mr Allen's misconduct 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 find charges relating to dishonesty extremely serious.

The panel applied the test from *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and was satisfied that the misconduct in this case is capable of being addressed, however with difficulty. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Allen has taken steps to strengthen his practice. The panel has not seen any evidence of remediation or additional training from Mr Allen. Regarding insight, the panel has only before it very limited evidence of reflection from Mr Allen. It also noted that Mr Allen does not address the impact of his actions on colleagues and patients, nor does he provide any information as to how he would behave in future.

The panel considered this to be a failure by Mr Allen to accept responsibility for his actions. The panel further noted that Mr Allen maintains his vitriolic opinions towards Colleague 1 and Colleague 2. The panel was concerned that this suggests deep-seated attitudinal issues.

Having regard to the finding that Mr Allen was dishonest, the panel considered that this misconduct was extremely serious but not impossible to remediate, with these charges all relating to clinical practice. However, given his lack of insight, the panel was not satisfied that Mr Allen has taken any steps to address the misconduct in this case. It noted his comments in the CMF form dated 9 September 2023, *"I did not intentionally falsify any records"* but did not consider this sufficient to remediate the dishonesty.

The panel is of the view that there is a risk of repetition based on Mr Allen's lack of insight and remediation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required. It noted that Mr Allen was a healthcare professional working in a sensitive environment with vulnerable patients. The panel found that his misconduct could undermine public confidence in the service. The panel therefore 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 Mr Allen's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Allen's 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 Mr Allen off the register. The effect of this order is that the NMC register will show that Mr Allen has 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.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 16 May 2024, the NMC had advised Mr Allen that it would seek the imposition of a striking off order if the panel found his fitness to practise currently impaired.

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

Decision and reasons on sanction

Having found Mr Allen'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:

- That Mr Allen's misconduct put patients and the wider public at potential risk of harm
- That Mr Allen's misconduct intimidated and distressed his colleagues
- That Mr Allen's misconduct was repeated over a significant period of time and involved numerous instances of misconduct

- That Mr Allen has not provided evidence of insight or reflection

The panel also took into account the following mitigating features:

- That Mr Allen has made admissions to all charges except charge 20
- That there are potential factors that may, in part, explain Mr Allen's misconduct

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, nor would it protect the public 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 Allen'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 Allen's 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 Mr Allen's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Given that dishonesty was found proved, the misconduct identified in this case was not something that can be addressed through retraining. The panel was not satisfied that Mr Allen has indicated a willingness to engage with retraining nor to develop his insight further. It has not heard any information that Mr Allen is currently working in a clinical environment or intends to do so in future. The panel also noted that some of Mr Allen's misconduct occurred outside of professional practice. The panel therefore concluded that the placing of conditions on Mr Allen's practice would not adequately address the seriousness of this case and would not protect the public.

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

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

Based on the charges found proved in this case, none of the above factors are satisfied. Mr Allen's misconduct comprised numerous instances of clinical misconduct over many months. The panel has seen extremely limited evidence of insight and reflection from Mr Allen, nor evidence of a willingness to develop insight further. 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 Mr Allen's actions is fundamentally incompatible with him remaining on the register.

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

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

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

Mr Allen's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this case demonstrate Mr Allen's sustained dishonesty over a long period of time which places patients and the wider public at risk of harm. To allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing 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. The panel noted the adverse effect that removing Mr Allen from the register may have on him. However, having regard to the matters it identified, in particular the effect of Mr Allen's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, 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 standards of behaviour required of a registered nurse.

This will be confirmed to Mr Allen in writing.

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 Mr Allen's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC, who submitted that, *"if a finding is made that Mr Allen's fitness to practise is impaired on a public protection and*

public interest grounds, and a restrictive sanction imposed, we consider an interim order is necessary in the same terms as the substantive order for a period of 18- months. This will cover the initial period of 28-days before the sanction comes into effect and any period if Mr Allen decides to lodge an appeal."

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 to allow time for any appeal to be determined.

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

That concludes this determination.