Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 22 July 2024 – Thursday, 25 July 2024

Virtual Hearing

Name of Registrant:	**Samantha Jane Dixon**
NMC PIN	08A2250E
Part(s) of the register:	Adult Nurse – Level 1 (24 October 2008)
Relevant Location:	Sunderland
Type of case:	Misconduct
Panel members:	Gregory Hammond (Chair, Lay member) Patricia Ford (Registrant member) June Robertson (Lay member)
Legal Assessor:	William Hoskins
Hearings Coordinator:	Zahra Khan
Nursing and Midwifery Council:	Represented by Sean White, Case Presenter
Ms Dixon:	Present and not represented at the hearing
Facts proved by admission:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

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

At the outset of the hearing, Mr White, on behalf of the Nursing and Midwifery Council (NMC), made a request that this case be held partly in private on the basis that proper exploration of your case involves [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You supported the application.

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

The panel determined to go into private session in connection with [PRIVATE] as and when such issues are raised in order to [PRIVATE].

Details of charge

That you, a registered nurse:

1) Whilst employed by South Tyneside and Sunderland NHS Trust ('the Trust'), worked for ProHealth Care Agency and/or University Hospital of North Tees [PRIVATE] from the Trust, on one or more of the dates, on one or more occasion, set out in Schedule 1.

2) Your conduct as alleged in charge 1 was dishonest in that you knew that you should not work elsewhere [PRIVATE] from the Trust.

3) Between 1 January 2019 and 31 December 2020, did not inform ProHealth Care Agency and/or University Hospital of North Tees Trust that you were subject to restrictions placed on you by the Trust.

4) Your conduct as alleged in charge 3 was dishonest in that you represented to your employment agency and/or University Hospital of North Tees that your registration was not subject to restrictions when you knew it was.

5) Whilst employed by the Trust, made the following medication errors:

   a) On 29 July 2017, gave Gentamicin to the wrong patient.
   b) On 1 February 2018, failed to document that you had disposed of bottles of Oramorph.
   c) On 29 April 2018, administered 1gm of Paracetamol when 500mg was prescribed to an unknown patient.
   d) On 8 May 2018, administered a 1 litre bag of saline without a prescription to an unknown patient.
   e) On 30 July 2018, administered intravenous antibiotics to the wrong patient.
   f) On 23 October 2018, administered Gentamicin intramuscularly when it had been prescribed to an unknown patient to be given intravenously.
   g) On 31 May 2019, administered a PEJ feed at the incorrect dose volume of 100ml per hour rather than 45ml per hour to an unknown patient.

6) Whilst working for University Hospital of North Tees, on or before16 September 2019, incorrectly told an unknown patient that Morphine was no longer prescribed for them, even though it was on the patient's chart.

7) Whilst employed by Spire Healthcare, made the following errors:

   a) On 19 April 2023, failed to identify that medication needed to be administered by IV and not orally for an unknown patient.

b) On an unknown date between April and May 2023, asked a band 5 nurse to sign off a control drug when you knew you needed to ask a more senior colleague.
c) On 12 May 2023, admitted an unknown patient to the ward with an incorrect name on their wrist band.

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

Schedule 1

17 July 2019
23 July 2019
24 July 2019
25 July 2019
30 July 2019
01 August 2019
10 April 2020
11 April 2020
12 April 2020
13 April 2020
14 April 2020
19 April 2020
20 April 2020
21 April 2020
22 April 2020

Background

By way of background, the Agreed Statement of Facts between you and the NMC is as follows:

'1. The Registrant self-referred to the NMC on 12 October 2021, relating to incidents at South Tyneside & Sunderland NHS Foundation Trust (the 'Trust') and subsequently at Spire Healthcare.

Charges

*2. The Registrant admits the following charges, but does **not** admit that her practise is impaired…*

Facts

3. The Registrant joined the NMC register on 24 October 2008.

4. The Registrant was employed by the Trust since August 2008 as a Band 5 staff nurse. She was required to perform all the duties of a nurse of that band including administering medication.

5. The Registrant has [PRIVATE]. The Registrant described that at this time, the Stroke unit closed at the Trust where she was working and she was moved to Ward 3. The Registrant described that [PRIVATE].

6. Within a 2 year period from 2017, the Registrant made a number of medication errors:

a) On 29 July 2017 the Registrant gave Gentamicin to the wrong patient.

b) On 1 February 2018, the Registrant failed to document that she had disposed of bottles of Oramorph.

c) On 29 April 2018, the Registrant administered 1gm of Paracetamol when 500mg was prescribed to a patient.

d) On 8 May 2018, the Registrant administered a 1 litre bag of saline without a prescription to a patient.

7. On 30 July 2018 the Registrant administered intravenous antibiotics to an incorrect patient. This error led to the first internal investigation to be carried out.

8. An investigation report was produced for August-September 2018. It was noted during this investigation that the Registrant had made 4 further previous medication errors (above referenced) since July 2017. The Registrant acknowledged and reflected on the medication errors she had made. An action plan was put in place and the Registrant was put under supervision. The Registrant completed the action plan on 23 October 2018 and was given permission to re-commence independent drug rounds.

9. Later that same day, the Registrant gave intravenous antibiotics (Gentamicin) intramuscularly even though the prescription clearly stated for the drug to be administered intravenously.

10. On 31 October 2018, due to the volume of errors made by the Registrant, a decision was made to [PRIVATE].

11. On 16 November 2018, [PRIVATE].

12. On 7 January 2019, [PRIVATE].

13. A second investigation report was completed in February 2019 in relation to:

- The drug error referenced at para 9 above. That over the last year the Registrant has had 6 medication errors and her practice has not improved.

- That the Registrant failed to adhere to the Trust Policy on Medicine Management and the Administration and checking of Medication.

This led to a disciplinary hearing taking place on 29 April 2019. There was no dispute with the Registrant over the medication errors occurring. The Registrant was issued with a final written warning for a period of 24 months and was put on a formal action plan for the next 6 months whereby the Registrant would continue to be supervised when giving medications during the 6 month period as well as having monthly review meetings with her Ward manager and a face-to-face meeting review with the Registrant's Matron at 3 months.

14. The Registrant was [PRIVATE].

15. On 31 May 2019 the Registrant administered a PEJ feed at the wrong rate, despite not being able to undertake any unsupervised medication administration as per the recent disciplinary action plan.

16. This error was discovered by deputy Ward manager, [PRIVATE], and raised as a concern as it happened so soon after the disciplinary plan had been put in place. [PRIVATE] had been working on shift with the Registrant at the time of the incident. [PRIVATE] confirmed that the Registrant had not been asked to carry out the set up of the PEJ feed at handover and it was not until the Registrant had approached her to tell her she had set this up that she knew she had done it but she was too busy at the time to question why she had done it. She only become aware of the error when a staff nurse informed her of such. [PRIVATE] spoke with the Registrant about this and it was the Registrant's view that setting up a PEJ feed didn't fall within her restrictions. [PRIVATE] informed her that it did as a PEJ feed was prescribed.

17. On 5 June 2019 the Registrant spoke with [PRIVATE], Ward manager, about the 31 May 2019 drug error. The Registrant was asked if [PRIVATE]. The Registrant said [PRIVATE]. The Registrant was also asked if [PRIVATE]. The Registrant was reminded that she must not carry out any PEJ feeds and continue not to complete medications as per the recent disciplinary action plan. See paragraphs 25-26 below for further detail.

18. From June to November 2019, the Registrant had [PRIVATE].

19. Whilst the Registrant was being investigated, she worked for ProHealth Care Agency (the 'Agency') whilst [PRIVATE] from the Trust on several occasions between July 2019 – April 2020 and she was dishonest in doing so. There was also a specific additional layer of dishonesty that occurred on one occasion in April 2020 when the Registrant contacted the Trust to say that [PRIVATE].

20. The Registrant also did not declare the restrictions on her working practice to the Agency. In the Registrant not telling the Agency about the restrictions on her practice she was putting patients and the Agency at risk. The Registrant acted dishonestly; by deliberately choosing not to tell the Agency she had restrictions on her practice she misrepresented to the Agency that she was able to practice unrestricted, when she knew she was not able to. See paragraph 27 for further details.

21. On or before 16 September 2019, whilst working for University Hospital of North Tees, the Registrant incorrectly told a patient that Morphine was no longer prescribed for them, even thought it was on their chart.

22. On 30 September 2019, the Registrant [PRIVATE].

23. On 18 October 2019, the Registrant had a meeting [PRIVATE] and she was advised that the PEJ feed incident on 31 May 2019 was to be investigated and if

any further restrictions, in addition to the supervision of medications would be implemented, and that she may move to another ward whilst the investigation was undertaken.

24. A further meeting was held on 14 November 2019 and the Registrant was informed she was moving to Ward 20 [PRIVATE] and that she wouldn't be undertaking any supervised administration of medication for the foreseeable future. During this meeting the Registrant was urged to seek representation.

25. On 22 January 2020, an investigatory meeting was held to discuss the PEJ incident and the Registrant admitted her error and took responsibility for this. As the Registrant was subject to the disciplinary action plan in relation to the administration of medications, [PRIVATE] was asked in an interview, held also on 22 January 2020, how the Registrant came to put up the PEJ feed by herself and whether the Registrant had been asked to do this. Ms Burdis explained that it was just something the Registrant did herself. [PRIVATE] advised that the Registrant had previously stated that a PEJ feed was not a medication and that the Registrant had been informed that it was as it is a prescribed feed. [PRIVATE] confirmed that the Registrant was not asked to draw up the feed as she was not signed off as being fit to undertake medication administration, as she had to be supervised until the action plan was signed off.

26. [PRIVATE] also confirmed the support that was given to the Registrant: The Registrant had been asked to ensure her training was up to date, that she completed reflections on her practice and that she read all policies and was expected to sign to confirm this. In addition, the Registrant worked closely with [PRIVATE] and the two junior Sisters on the Ward so that the Registrant's practice could be observed.

27. On 12 January 2021 an investigatory meeting was held where the Registrant confirmed that she wanted the investigation re medication errors and the

investigation re secondary employment with the Agency [PRIVATE] to be dealt with in one investigation. The Registrant made admissions re the medication errors and explained that [PRIVATE] at the time which started after the Stroke unit closed and she went to Ward 3. She stated she understood the implications and the severity of her errors and how she could have put patients at risk of harm. The Registrant also explained that she had picked up the additional shifts at the Agency despite being supervised in her full time role as she was familiar with the shifts as she had been doing shifts long before the investigation had even started. The Registrant stated that she fully understood the Trust's concerns about her working unsupervised for the Agency but said she was confident that she could do it, but she realised that she should have checked with someone before she undertook any additional shifts with the Agency to see whether she could or could not work for the Agency whilst on restricted practices. The Registrant admitted that she did not ask this question because she knew what the answer would be and [PRIVATE].

28. On 25 March 2021, the Registrant [PRIVATE]. The Registrant explained that she did not feel well supported at work and being supervised meant she did not feel that she was fully part of the team and this could [PRIVATE]. It was advised that the Registrant was [PRIVATE]. It was also advised that the Registrant [PRIVATE] would benefit from regular constructive feedback and regular contact with management.

29. The Registrant was suspended from duty on 28 September 2021 whilst an investigation was undertaken in relation to the Registrant working for the Agency [PRIVATE].

30. On 10 December 2021 an investigatory meeting was held specifically in relation to the Registrant working for the Agency [PRIVATE]. The Registrant explained that she undertook secondary employment [PRIVATE] and because the disciplinary process was taking too long. The Registrant also explained that [PRIVATE] and in

terms of putting patients at risk by not informing the Agency of the restrictions on her practice. The Registrant displayed regret and remorse for her behaviour.

31. In August 2022, the third internal investigation completed and the Registrant was dismissed.

32. In February 2023, the Registrant then went on to be employed as a Band 5 nurse by Spire Healthcare. Her day-to-day responsibilities were to perform general nursing duties appropriate to her band and this was whilst completing out Spire's 12 week probation plan. In addition to this plan, because of the Registrant's interim conditions on her practice imposed by the NMC, Spire decided to add some additional mandated training/requirements to the 12 week plan, with time frames. The Registrant was also assigned a 'buddy' and Spire stipulated that the Registrant was not to administer medications without being observed by a senior nurse (it could not be a nurse of the same grade i.e. a Band 5).

33. The Registrant made 3 near miss errors within her probation period. The near miss errors were:

a) The Registrant was about to give a patient medication via an oral route, when it should have been via an IV route. The Sister in charge prompted the Registrant to read the drug chart and review the administration method. The Registrant did this after being prompted, and the patient was given the medication by the correct safe method.

b) The Registrant failed to get medication signed off by a senior nurse and got authorisation from a Band 5 nurse. This was against the restrictions that Spire had put in place. Witnesses [Mr 1] and [Ms 6] also referred to this as a breach of the Registrant's ICOPO, but having looked at the ICOPO imposed in November 2022, the Registrant was in fact not in breach of her ICOPO as the conditions allow for administration under supervision from any registered nurse (Band 5 onwards).

34. At an 8 week review the 2 above incidents were discussed with the Registrant and it was explained to the Registrant that she needed to remain on the close supervision stage of her probation. The Registrant was again reminded that she needed to double check medicines and the administration of them and that it was a requirement to have a Band 6 nurse oversee her.

35. The Registrant carried on working without any errors but under close supervision. On 12 May 2023, at the 12 weekly final probation review, it was decided to extend the Registrant's probation period. Later that same day, the third medication error occurred:

c) The Registrant admitted a patient to a ward with an incorrect name on their wrist band. The patient had said that he had told the Registrant that this was not his correct name on the band but the Registrant did not do anything about it. The patient was so concerned that he highlighted this to one of the HCAs on shift at the time'.

Decision and reasons on facts

At the outset of the hearing, you made full admissions to all of the charges.

The panel therefore finds charges 1, 2, 3, 4, 5a, 5b, 5c, 5d, 5e, 5f, 5g, 6, 7a, 7b, and 7c proved in their entirety, by way of your admissions.

Fitness to practise

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

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr White referred to the cases of *Yeong v the General Medical Council* [2009] EWHC 1923 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

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

Mr White referred to the sections titled 'Practise effectively', 'Preserve safety', and 'Promote professionalism and trust' within the Code.

Mr White submitted that your actions demonstrate failures under the three sections of the Code referenced.

In these circumstances, Mr White invited the panel to find that the charges found proved amount to misconduct.

You gave evidence under affirmation, in regard to both misconduct and impairment.

You told the panel that you are deeply ashamed and understand that you have breached the NMC Code.

In response to the panel's questions regarding the seriousness and risk associated with the conduct, you said that you agree that the charges are so serious that they amount to misconduct and that you understand the severity of them.

Submissions on impairment

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

Mr White referred the panel to the NMC's guidance on impairment and took it through the facts that should be considered when deciding whether a registrant's fitness to practise is impaired.

In relation to the nature of the concerns, Mr White submitted that there was a catalogue of medication errors that occurred over a prolonged period of time. He submitted that there were multiple incidents of dishonest conduct, which you have admitted.

Mr White submitted that charge 1 relates to your having continued to work for other employers [PRIVATE] from your principal employment with the Trust. He referred to Schedule 1 and said that this reflects the number of dates and period during which this conduct occurred. He told the panel that there are 15 dates listed in total, which include various dates in July 2019 and August 2019, and others in April 2020.

Mr White submitted that, by your admission of charge 2, you accept that this conduct was dishonest. As such, he submitted that this charge amounts to dishonest conduct on your part, and on 15 separate dates within the space of a year. He submitted that this was no ‘one-off’ mistake.

Mr White submitted that charge 3 relates to your having failed to inform your other employers of local restrictions on your practice. He submitted that this charge refers to a period between January 2019 and December 2020, although it is apparent from paragraph 13 of the Agreed Statement of Facts that the local restrictions only took effect from the end of April 2019. Nonetheless, he submitted that it remains a significant period of time during which to withhold information regarding local restrictions on practice, which ought to have been disclosed.

Mr White submitted that, by your admission of charge 4, you accept that this information was withheld dishonestly. He submitted that, again, this points away from any suggestion that you made a ‘one-off’ mistake. He also submitted that it appears that this information was withheld, dishonestly, for over a year and a half.

In light of the above, Mr White submitted that the conduct identified in charges 1 and 3 is admitted to have been dishonest which is an important consideration for the panel.

Mr White submitted that charges 5 to 7 list a catalogue of medication errors that you made with different employers, spanning a period of almost six years between 29 July 2017 to 12 May 2023. He submitted that the potential harm or risk of harm to patients arising from these individual errors varies, but that the charges include the following:

- Administering medication to the wrong patients (for example, charges 5a and e);
- Providing patients with incorrect doses of medications or using incorrect methods (for example, charges 5c, f and g and charge 7a); and
- Administering medication without a prescription (for example, charge 5d).

Having regard to the number of allegations, the period of time in which they continued (notwithstanding support and supervision having been put in place for you), and the nature of the conduct, Mr White submitted that, taken together, these raise serious concerns over patient safety.

When looking at the NMC guide on impairment and the nature of the concern, Mr White submitted that ‘harm’ in the traditional sense is perhaps less relevant to charge 1 and 2, albeit the Trust will have suffered financially.

As for charges 3 and 4, Mr White submitted that there was an increased risk of harm to patients by your failing to disclose restrictions that had been put in place as a safeguard.

As for charges 5 to 7, Mr White submitted that patients were clearly put in harm’s way by the conduct described in those charges.

Mr White submitted that there does remain a real risk of unwarranted harm to patients. He referred to the nature and number of reported incidents, and the period of time during which medication errors continued. He submitted that this, alongside your decision to dishonestly continue to practise administering medication for other employers without advising them of local restrictions imposed by your main employer, gives rise to concerns of a significant nature and continuing risk of repetition.

Mr White submitted that the panel may form a view on the seriousness of your misconduct and whether you have displayed behaviour suggestive of ‘attitudinal issues’. He submitted that the persistent significant errors, despite best efforts to assist with improvement of your practice, and multiple instances of dishonesty demonstrated by your conduct, may assist the panel in forming that view.

Mr White acknowledged that there has been a degree of reflection by way of your references and reflective piece which he accepted that you spent time on and supported with literature. He submitted that you have clearly engaged your mind into your failings,

but there is still [PRIVATE]. He submitted that [PRIVATE]. Further, he submitted that your reflective pieces heavily focus on the medication errors that you made, and less on your dishonesty.

Therefore, Mr White invited the panel to find that your fitness to practise is impaired by reason of your misconduct, both on grounds of public protection and public interest.

You gave evidence under affirmation. You told the panel that you are not a bad person but that you have made some wrong choices and understand how this looks bad. You said that you have made some changes. [PRIVATE].

You informed the panel that you have undertaken a lot of reflection regarding the process which started in 2018. You said that you have a lot to give and love your job. You expressed that you cannot stress enough how important nursing is to you. You told the panel that you do three shifts a week. You said that you need a chance to redeem yourself. You told the panel that you had attended all of your interim order hearings and had been working successfully within your restrictions.

You told the panel that you receive lots of support from colleagues and management at your workplace. You said that you do not want to be in this situation again and that you would do anything to redeem yourself, whether that be training or whatever else is required.

You informed the panel that you have a supportive partner. You expressed how sorry you are, and you acknowledged that you have let yourself down as well as the nursing profession.

In response to a question from Mr White, in relation to whether your fitness to practise is currently impaired and why the panel should be confident that the errors will not reoccur, you stated that you qualified in 2008 and that [PRIVATE]. You said that [PRIVATE] you would never be dishonest in the future.

In response to questions from the panel, you stated that [PRIVATE].

You told the panel that you are a fantastic nurse that made some mistakes with the drug errors and not being truthful. You said that you have extensive experience and lots to give to the profession, and so you want to be afforded another chance.

[PRIVATE].

[PRIVATE].

[PRIVATE].

Therefore, you invited the panel to find that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor which included reference to *CHRE v NMC and Grant* [2011] EWHC 927 (Admin).

Decision and reasons on misconduct

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

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code, specifically the following:

*‘**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

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

8 Work co-operatively

To achieve this, you must:

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk...

13 Recognise and work within the limits of your competence

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

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

To achieve this, you must:

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

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

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times…

23 Cooperate with all investigations and audits This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body'.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the above paragraphs of the Code were fully engaged in this context.

The panel determined that charges 1 to 4 are related to dishonesty. As such, they are particularly serious and your actions in these charges amount to misconduct.

The panel determined that your actions in charges 5 to 7 constitute a large number and wide range of clinical failings and collectively amount to misconduct.

The panel found that you breached the Code in areas of safety and practising effectively, and not being professional within your role.

Therefore, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide, if as a result of the misconduct, your fitness to practise is currently impaired.

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel finds that patients were put at risk as a result of your misconduct. Your 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.

In these circumstances, the panel determined that all four limbs of *Grant* are engaged, in relation to your actions in the past.

The panel had regard to your reflective piece and a reflective essay, dated 8 July 2024, titled *‘Reflection on Medication Errors and Mental Health Impact Using Gibbs Reflective*

Model'. It also had regard to several testimonials dated between 2020 and 2023, as well as your training certificates dated 2022 and 2023.

The panel considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account the successful training that you undertook in 2022 and 2023.

Regarding insight, the panel took into account that you made full admissions to all of the charges and that you verbally apologised for your misconduct which you accepted is serious. You have also provided some information as to how you would handle the situation differently in the future and [PRIVATE].

However, the panel was of the view that your reflective pieces mainly focus on one aspect, namely the drug administration errors, and that they do not fully address the risk that you posed to patients, or the impact that your actions had on patients and colleagues. You have not fully recognised the seriousness of making these errors and the seriousness of being under local conditions by the Trust yet choosing to go and work somewhere else, without restriction.

In these circumstances, the panel determined that you have not fully demonstrated an understanding of how your actions put patients at a risk of harm, nor demonstrated a complete understanding of why what you did was wrong and how this impacted negatively on the reputation of the nursing profession.

Further, the panel was of the view that you have not yet remedied the risk to the public as your reflective pieces and oral evidence did not fully address the dishonesty charges. The panel acknowledged [PRIVATE] but was unable to satisfy itself that there was a direct linkage between these and your dishonest actions.

The panel found your testimonials to be brief and they did not reference the extent or nature of the charges against you.

The panel was of the view that medication errors are in principle remediable. It considered, however, that dishonesty charges are more difficult to remediate as they are attitudinal in nature, and the bar to remediation in this case is therefore high.

The panel acknowledged that you were signed off as competent in medication administration by [PRIVATE] on 16 January 2024. However, given the number and nature of your previous failings it was not yet satisfied that you have demonstrated a long enough period of safe practice. In regard to the dishonesty charges, it determined that the high bar to remediate these has not yet been met.

In light of the above, the panel determined that there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel concluded that public confidence in the profession would be undermined if a finding of impairment was not made in this case. The panel therefore decided that a finding of impairment is also necessary on the grounds of public interest.

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

Sanction

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

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr White informed the panel that in the Notice of Hearing, dated 12 June 2024, the NMC had advised you that it would seek the imposition of a 6 month suspension order with review before expiry if it found your fitness to practise currently impaired.

Mr White directed the panel to the NMC guide on sanctions which states that any sanction that the panel imposes must be proportionate and justifiable.

In relation to aggravating features, Mr White submitted that the following are relevant in your case:

- Pattern of misconduct over a period of time.
- Conduct which put patients at risk of suffering harm.
- Lack of insight into failings.

In relation to mitigating features, Mr White submitted that you have shown some insight into the concerns raised and that you have made admissions. He submitted that there is

evidence of you keeping up to date with recent training programmes and evidence that you are making attempts to strengthen your practice.

Further, Mr White submitted that [PRIVATE], in particular that there had been changes to your work as you were moved to a different ward in 2018. He submitted that [PRIVATE]. However, he reminded the panel that at the impairment stage it was unable to satisfy itself that there was a direct linkage between [PRIVATE] and your dishonest actions.

In relation to previous interim orders and their effect on sanctions, Mr White submitted that the panel will be aware that you have been subject to an interim of conditions practice order that was first imposed on 18 November 2022. He informed the panel that the interim conditions of practice order was varied and continued on two occasions between 2023 and 2024, and that the order expires in February 2025.

Mr White submitted that it appears that you have made positive progress under your current interim conditions of practice order as you have engaged in various training modules at your workplace. He informed the panel that you have worked at your current workplace since July 2023. He also informed the panel that, at the time of the last interim order review hearing, there may have been an issue about whether you had fully complied with all of the existing conditions. In any event, the interim conditions of practice order was continued.

Mr White submitted that you have accepted the dishonesty in your case and he made reference to the NMC guidance on *'Considering sanctions for serious cases'* (Reference SAN-2).

Mr White then referred the panel to *'Available sanction orders'* (Reference SAN-3) within the NMC's guide.

Mr White submitted that taking no further action would be inappropriate as you present a continuing risk to patients, you were responsible for the conduct that undermined the

public's trust in nurses, and you breached fundamental tenets of the profession. For the same reasons, he submitted that a caution order would not be an appropriate sanction to impose in this case.

Mr White submitted that there are a range of medication errors and that the dishonest conduct may be hard to address under a conditions of practice order. He acknowledged that you have shown willingness to respond positively to training, and that there is evidence of some insight.

However, Mr White submitted that you have not been entirely successful in preventing errors occurring in the past, and that you have worked with an employer without disclosing previous conditions in place. He submitted that the panel should consider whether the conditions that it may choose to impose could be monitored and assessed. He submitted that the panel should give thought to whether the conditions achieve their aim of public protection, in a way that is fair to you, and that they should be relevant, proportionate, workable and measurable.

Mr White submitted that a suspension order may be appropriate in cases where the misconduct is not fundamentally incompatible with the nurse continuing to be a registered professional, and where the NMC's overarching objective may be satisfied by a less severe outcome than permanent removal from the register.

Mr White submitted that the charges are serious and that it is your demonstration of remorse and your willingness to improve your practice that stand in your favour. Whilst the allegations involve dishonesty, he submitted that you have expressed regret and that you have stated that you will not repeat the misconduct.

Mr White further submitted that you have worked for your employer, subject to an interim conditions of practice order, without any issues since July 2023.

In light of these circumstances, Mr White submitted that a suspension order for a period of 6 months might be the most appropriate sanction. He submitted that this would allow you a further opportunity to engage with your reflection, to strengthen your practice, and [PRIVATE].

Mr White submitted that a striking-off order would be disproportionate in this case.

You accepted that your actions towards patient safety and the dishonesty elements were unacceptable. You acknowledged that you put pressure on the Trust, colleagues, and patients. You submitted that you understand the gravity of your previous unprofessional behaviour and that you will always adhere to the NMC Code in the future. You submitted that you will never be untruthful again, and that you will always be open and honest. You further submitted that you would maintain your professional skills and behaviour and will never fall below the NMC's standard again.

You submitted that have met the NMC's standard within your current employer, and that you follow the guidance set out by the NMC. You told the panel that you currently have support and that you wish to continue completing any relevant courses to prove that you are more than capable of nursing. You also submitted that, with your new-found confidence, you have demonstrated that you have learned from your mistakes. You expressed how upset you would be if you lost your NMC PIN.

You submitted that you wish to continue with the conditions of practice order, if possible, to show your continued progression of development. You submitted that you do not want to be struck off the register. [PRIVATE]. You submitted that you are deeply remorseful and that this process has been horrific for everybody.

In these circumstances, you invited the panel to impose a conditions of practice order.

Decision and reasons on sanction

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

The panel first considered the element of dishonesty. It was of the view that your dishonesty was at the higher end of the spectrum as you obtained a personal and financial gain by deliberately choosing not to tell the Agency that you had restrictions on your practice and worked shifts for them on multiple occasions including [PRIVATE]. You also misrepresented to the Agency that you were able to practise without restriction when you knew that you were not able to and this action put patients at risk of harm. The panel also found that you breached the professional duty of candour.

The panel took into account the following aggravating features:

- Dishonest conduct is always serious and this was at the higher end of the spectrum.
- Pattern of medication errors and multiple instances of dishonesty that occurred over a period of time.
- Conduct which put patients at risk of suffering harm.
- Lack of full insight into the dishonesty aspects of the case.

The panel also took into account the following mitigating features:

- Full admissions to the charges.
- Demonstrated remorse and verbally apologised for the misconduct.

- Your considerable efforts to develop insight, albeit this is not yet complete in respect of the dishonesty aspects.
- Undertaken training to strengthen practice in relation to the medication errors.
- Large number of positive testimonials albeit they do not mention the charges.

The panel also noted your [PRIVATE], albeit [PRIVATE] carries less weight in a regulatory case than it does in a criminal case. The panel could not identify an obvious direct linkage between [PRIVATE] and the dishonesty.

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

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

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*

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

The panel is of the view that there are no practicable or workable conditions that could be formulated, given the nature of the charges in this case. Whilst the medication errors could potentially be addressed by conditions of practice, the dishonest misconduct identified in this case was not something that can be addressed through retraining as dishonesty is attitudinal in nature.

Further, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not sufficiently mark the public interest.

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

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

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

The panel was mindful of the NMC's submission advocating a suspension order. It considered that, whilst your misconduct was serious and was not a single incident, you have made considerable efforts to develop your insight, you have shown remorse and made admissions. As such, whilst dishonesty is attitudinal in nature, it did not consider that you demonstrated harmful, deep seated personality or attitudinal problems that could not be remediated. The panel also considered that there have been no complaints or repetition of the misconduct while you have been working under interim conditions of practice with your current employer. The panel recognised that your remediation in respect of your dishonesty was as yet incomplete, but it was satisfied that you were making genuine efforts in this respect.

The panel did not consider that there was a significant risk of your repeating your dishonest conduct. The panel also took account of the agreed fact that [PRIVATE], albeit it could not establish a direct linkage between [PRIVATE] and the misconduct. The panel considered your evidence that [PRIVATE]. Weighing all of these factors, the panel was satisfied that in this case the misconduct was not fundamentally incompatible with your remaining on the register.

In considering the serious nature of the misconduct of your case, the panel gave careful consideration as to whether it should impose a striking-off order. However, given the background and context of your case, and taking account of the mitigation provided, the panel concluded that it would not be necessary to impose a striking-off order at this stage.

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

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by:

- A further reflective piece focusing on your understanding of how your dishonesty put patients at risk and how it negatively affected your colleagues and the reputation of the nursing profession.
- Your continued attendance and engagement with the NMC.
- Evidence of your continuing to keep up to date with the nursing practice.
- Further testimonials from current employers.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the

protection of the public, is otherwise in the public interest or in your own interests until the suspension sanction takes effect.

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

Submissions on interim order

The panel took account of the submissions made by Mr White. He submitted that an interim suspension order for a period of 18 months is necessary given the panel's findings in order to protect the public and meet the wider public interest.

Mr White submitted that this was required to cover the 28-day appeal period and, if you do appeal the decision, the period for which it may take for that appeal to be heard.

You did not oppose the application.

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 cover the 28-day appeal period and any period during which an appeal may be heard.

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

That concludes this determination.