Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 25 September – Friday, 6 October 2023
Tuesday, 2 January – Wednesday, 3 January 2024,
Monday, 8 January – Thursday, 11 January 2024,
Monday, 22 April 2024 – Thursday, 25 April 2024
Monday 29 April 2024
Monday, 3 June – Tuesday, 4 June 2024

Virtual Hearing

Name of Registrant:	**Mark Andrew Hamilton**
NMC PIN:	01I1931E
Part(s) of the register:	RNA: Registered Nurse - Adult Nurse - Sub Part 1 Level 1 (9 September 2004)
Relevant Location:	Gloucestershire
Type of case:	Misconduct
Panel members:	Mark Gower (Chair, lay member) Isobel Leaviss (Lay member) Rosalyn Mloyi (Registrant member)
Legal Assessor:	Simon Walsh (25 September - 6 October 2023, 8 – 11 January 2024 and 22 - 25 & 29 April, 2 - 3 June 2024) Micheal Levy (2 - 3 January 2024)
Hearings Coordinator:	Margia Patwary (25 September - 6 October 2023, 2 - 3 and 8 - 9 January, 3 June - 4 June 2024) Yewande Oluwalana (10 -11 January 2024) Shela Begum (22 - 25 & 29 April 2024)
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter (25 September - 6 October 2023 and 2 - 3, 8 - 11 January, 3 June - 4 June 2024) Simeon Wallis, Case presenter (22 - 25 April 2024)

Mr Hamilton:	Present and unrepresented at the hearing until 29 April 2024 and thereafter not present or represented
Facts proved by admission:	Charge 2a(i), 2a(ii), 2a(iii), 2a(iv), 2b, 3a, 3b, 3c, 3d, 4, 9, 11 and 17
Facts proved:	Charges 1, 5, 6, 10, 12, 13a, 13b, 14 and 19
Facts not proved:	Charges 7, 8, 15, 16, 18, 20a, 20b, 21 and 22
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charges (as amended)

That you a registered nurse, whilst employed as a Band 6 Charge Nurse at the Acute Care Unit ('the Ward') at Cheltenham General Hospital;

1) On one or more occasion during working hours would leave the ward unattended.

On 18 January 2021; **[FOUND PROVED]**

2) When completing the Clinical Institute Withdrawal Assessment for Alcohol ('CIWA') for Patient A; **[PROVED BY ADMISSION]**

a) Did not record a rational for administering Diazepam to Patient A at;

i) 09:00
ii) 12:00
iii) 16:00
iv) 19:00

b) Did not use the assessment tool to correctly calculate the dose of Diazepam required for Patient A, in relation to Patient A's CIWA score of 10-30.

3) Incorrectly administered a dose of Diazepam 5mg instead of 7mg to Patient A at: **[PROVED BY ADMISSION]**

a) 09:00
b) 12:00
c) 16:00
d) 19:00

4) Administered Diazepam to Patient A at 16:00 without recording a CIWA score. **[PROVED BY ADMISSION]**

5) Administered Diazepam to Patient A without any clinical justification at; **[PROVED IN ITS ENTIRETY]**

    a) 09:00
    b) 12:00
    c) 16:00
    d) 19:00

6) Whilst speaking to one or more colleagues on the Ward used words to the effect, '*I will just keep giving Patient A Diazepam as he is already prescribed it*' **[FOUND PROVED]**

7) On one or more occasion administered an Intramuscular Injection/Lorazepam to Patient B whilst they were still sedated/asleep. **[FOUND NOT PROVED]**

8) On one or more occasion did not record the administration of an Intramuscular Injection/Lorazepam to Patient B in Patient B's MAR Chart. **[FOUND NOT PROVED]**

9) Took a strip of unknown medication from the analgesia cupboard and placed it in your pocket. **[PROVED BY ADMISSION]**

10) On one or more occasion consumed unknown medication/tablets whilst on shift. **[FOUND PROVED]**

On 19 January 2021;

11) On one or more occasion took a strip of unknown medication from the analgesia cupboard. **[PROVED BY ADMISSION]**

12) On one or more occasion consumed the unknown medication/tablets taken from the analgesia cupboard. **[FOUND PROVED]**

13) Whilst speaking to one or more colleagues on the Ward used words to the effect; **[PROVED IN ITS ENTIRETY]**

a) '*If you sedated your patients like I did, you would have less problems with patients wandering.*'
b) '*Every time Patient A looks at me, he is earning himself more Diazepam'*

On 22 January 2021

14) Left the Ward unattended for a period of 1/1.5 hours. **[FOUND PROVED]**

15) Inaccurately informed Colleague Z that you had left the Ward to attend a meeting in the Emergency Department **[FOUND NOT PROVED]**

16) Your actions in charge 15 above were dishonest in that you sought to mislead Colleague Z as to the reason you left the Ward. **[FOUND NOT PROVED]**

17) On one or more occasion took a strip of unknown medication/codeine from the analgesia cupboard and placed it in your left pocket. **[PROVED BY ADMISSION]**

18) On one or more occasion consumed the unknown medication/codeine that you had placed in your left pocket. **[FOUND NOT PROVED]**

19) Your actions in one or more of charges 9), 10), 11), 12), 17) & 18) were dishonest, in that you took/consumed medication belonging to your employer with an intention not to return it. **[FOUND PROVED]**

On 25 January 2021;

20) Inaccurately recorded/backdated on the Stock Medications ‘Lent to Other Wards’ Sheet that; **[FOUND NOT PROVED]**

a) Codeine had been loaned to Hazelton Ward on 22 January 2021

b) Co-Codamol had been loaned to Hazelton Ward on 22 January 2021

21) Your actions in one or more of charges 20 a) & 20 b) were dishonest in that you falsified records as you sought to misrepresent that medication had been loaned out to other wards. **[FOUND NOT PROVED]**

22) On 11 January 2021, administered Lorazepam to one or more patients who were, either asleep or not agitated, without any clinical justification. **[FOUND NOT PROVED]**

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

Decision and reasons on why part of the hearing should be held in private

At the outset of the hearing, the panel, of its own volition, decided that any reference to [PRIVATE]. The decision was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You made no objection.

Mr Kabasinskas, on behalf of the Nursing and Midwifery Council (NMC) also made no objection.

The legal assessor reminded the panel that while Rule 19 (1) of the Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (as amended 2012) (The Rules) provides, as a starting point, that hearings shall be conducted in public, Rule 19 (3) provides that the panel has a discretion to hold the hearing partly or wholly in private if it is satisfied that it is justified and outweighs any prejudice to the interests of any party for an open hearing.

Background

At the time of the alleged concerns, you were working as a Band 6 Charge Nurse at the Trust.

In September 2019, you were seconded from the Acute Care Unit ('the Ward') to a Band 7 practice development role within Accident and Emergency. You returned to the Ward as a Band 6 nurse on 11 January 2021.

When back on the Ward, concerns were raised about your clinical practice and professional conduct.

A local investigation was carried out and a disciplinary hearing was scheduled. You failed to attend this, so it was adjourned. You resigned from the Trust on 27 October 2021, prior to the second disciplinary hearing.

Decision and reasons on proceeding in the absence of Mr Hamilton

On Day 3 of the hearing, Mr Kabasinskas made an application, pursuant to Rule 21, that the hearing proceed in your absence.

The legal assessor questioned the applicability of Rule 21. Rule 21(2) is clearly predicated on a Registrant 'failing to appear' yet you were present in the room for the application.

Mr Kabasinskas clarified that his application was either (a) an anticipatory application based his expectation that you would fail to appear at 14:00 or (b) an application for the panel to use general (but by him unspecified) case management powers.

[PRIVATE]

[PRIVATE]. Significant efforts had been made subsequently by the hearings co-ordinator to rearrange witnesses and these had been successful to the extent that a witness was available on Day 2, two witnesses were available on Day 3 and it was hoped that other witnesses could be accommodated on Days 4 and 5.

On Day 3 the NMC identified that Witness 1 was only available to give evidence on Day 3; she was then unavailable due to annual leave commitments, until Day 7. Witness 2 was available on Day 3 and Day 4.

On Day 3 Mr Kabasinskas called Witness 2 first and her evidence finished around 12:00.

<u>Basis of Application</u>

Mr Kabasinskas told the panel that he was concerned that Witness 3 would not complete her evidence by 13:00. This would mean either that she would go part-heard until Day 7 or, more likely, that she would not give her evidence until Day 7. He submitted that this was highly undesirable as there was a significant public interest in hearings such as yours

being dealt with expeditiously. He conceded that there were no public protection issues and this was more of a question of effective, efficient, fair and economical disposal of proceedings and the regulation of you as a registrant.

Mr Kabasinskas submitted that Witness 3 was an important witness whose evidence was, in part, crucial to the NMC's case. He identified that you would be prejudiced if you were unable to hear Witness 3's evidence and were therefore unable to question the witness but he submitted that any prejudice to you was outweighed by the inconvenience to the NMC of having to wait until Day 7 to continue with this hearing. He further submitted that no NMC witness would be directly inconvenienced by the delay.

Further matters which the NMC instructed Mr Kabasinskas to ask the panel to consider were:

- [PRIVATE];
- [PRIVATE];
- [PRIVATE]; and
- The transcript could be shared with you after the witness gave their evidence.

During submissions, you appeared frustrated and stated that *"you guys go ahead without me"* or words to that effect. However, when you were asked for your views, you made it clear you preferred to attend the hearing because you did not agree with evidence Witness 3 was to give and that you needed to question her. [PRIVATE].

The legal assessor advised the panel that it was far from clear that Rule 21 applied at all. Rule 21(2)(a) and Rule 21(2)(b) required the panel to be satisfied that the Notice of Hearing had been properly served and therefore tended to indicate that Rule 21 was designed to deal with cases where a Registrant simply failed to attend a hearing at all.

The legal assessor was unable to identify any specific rule of case management that allowed a panel to proceed in the absence of a Registrant simply because the Registrant

was otherwise reasonably engaged for a short period. The LA advised that such a generalised proposition seemed to conflict fundamentally with Rule 20 (1) which provided that *"The presenter and the registrant shall be entitled to be heard by the committee".*

The legal assessor reminded the panel that when High Court judges are faced with questions about the applicability of rules or regulations, they will often in their judgments indicate what their decision would have been if the relevant rule or regulation had applied.

[PRIVATE]. He advised that each case would be a balancing exercise based on the particular facts and circumstances of the case.

Panel decision

The panel was not satisfied that Rule 21 applied as submitted by Mr Kabasinskas because you were currently present in the hearing and had every intention of attending each morning. Further, this was a prospective application for only one witness during one afternoon of a 10-day hearing. The panel considered where a Registrant *'gave up'* on a hearing once it had started Rule 21 probably applied. However, you have not *'given up'*.

Although concerned about the applicability of Rule 21, the panel went on to consider the application on the basis that Rule 21 applied.

The panel noted that whilst the Notice of Hearing in this case specified that the hearing would start each day at 09:00 and that a professional obligation to attend at that time might arise as a consequence, there was nothing in the Notice of Hearing to specify in the same way when the hearing might finish nor for how long it might last.

[PRIVATE]

The panel took into account your wish to attend the hearing when Witness 3 gave evidence, the importance this would have to your case and the panel's proper

understanding of it and the fact that if Witness 3 attended on the morning of Day 7 you would be available also.

In a case where the NMC sanction bid was one of a striking-off order, the panel considered that the balance of convenience fell clearly and substantially in your favour. The NMC had accepted that there was a risk of prejudice to you but the mitigation it had suggested (you providing questions for the witness and/or reviewing the transcript immediately afterwards) was not workable.

The panel determined, when considering all of the facts, there was a very real risk that if the panel proceeded as requested by Mr Kabasinskas, it would be unfair to you and could lead to the panel reaching the wrong conclusions. This could very easily be avoided by waiting until Day 7 to hear from Witness 3: such delays are neither unprecedented nor, in the current climate, particularly unusual.

The application was refused.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kabasinskas, to amend the wording of charge 5. He reminded the panel that it has the powers to amend the wording of the charges before making any findings on fact but, in doing so, the panel must have regard to the merits of the case, the fairness and any potential injustice to the registrant.

Mr Kabasinskas submitted that the proposed amendment was to replace Patient A with Patient B. He submitted that the proposed amendment would correct an administrative error. Further, he submitted it does not create any material change to the charge but instead provides clarity as to what the charge alleges.

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

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

On day 10 of the hearing, the panel of its own volition decided to make an amendment to charge 4 and 5. The proposed amendment in charge 4 was to remove the words 'any clinical justification/recording' and add '16:00' hours for charge 5. The panel was of the view that this essentially separates the two charges and reflect the evidence and provide clarity. The charge would read:

> 4) Administered Diazepam to Patient A at 16:00 without ~~any clinical justification/recording~~ a CIWA score.
>
> 5) Administered Diazepam to Patient A without any clinical justification at;

a) 09:00

b) 12:00

c) 16:00

d) 19:00

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

Mr Kabasinskas did not oppose to the proposed amendments.

You made no objections to the proposed amendments.

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you admit to charges 2a(i), 2a(ii), 2a(iii), 2a(iv), 2b, 3a, 3b, 3c, 3d, 9, 11 and 17.

On the basis of the amendment to charge 4, you told the panel that you admitted this charge.

The panel therefore finds charges 2a(i), 2a(ii), 2a(iii), 2a(iv), 2b, 3a, 3b, 3c, 3d, 4, 9, 11 and 17 proved, by way of your admissions.

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

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

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

- Witness 1: Ward Manager at the Trust
- Colleague Z/Witness 2: Sister in the ACU Ward at the Trust
- Witness 3: Sister in the ACU Ward at the Trust
- Witness 4: Health Care Assistant on the ACU Ward at the Trust

- Witness 5: Ward Manager of the Cardiac Ward

- Witness 6: Health Care Assistant. Witness statement was agreed on record

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessors who referred to the following cases:

Ivey v Genting Casinos [2017] UKSC 67*, Hussain v GMC* [2014] EWCA (Civ) 2246, *Re B (Children)* [2008] UKHL 35, *Hosny v GMC* [2011] EWHC 1355 (Admin), *Braganza v BP Shipping* [2015] UKSC 17, *El Karout (No 1) v NMC* [2019] EWHC 28.

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

Charge 1 and 14

1) On one or more occasion during working hours would leave the ward unattended.

On 22 January 2021

14) Left the Ward unattended for a period of 1/1.5 hours.

These charges are found proved.

The panel considered charges 1 and 14 together. The panel determined that the meaning of “unattended” in this context was not that there was nobody left on the ward but rather that the care of the patients that you were looking after was not handed over to someone with suitable skills to take over that care. This was put to you by a panel member, and you responded to this charge on that basis.

In respect of charge 14 the panel heard evidence from Witness 2 that she was the nurse in charge on that day. She told the panel '*CN Hamilton then disappeared off the ward within an hour of returning from the hospital appointment. He did not explain where he was going. He returned approx. 1-1.5 hours later explaining that he himself had attended 'a meeting' in the emergency department.'*

In the record of the investigation interview on 29 March 2021, Witness 2 said in respect of 22 January 2021:

> *"I was looking after his bay, I cannot pin point a timeframe, and it was more than an hour, maybe 1.5 or 2, a substantial amount of time. He came into the corridor and he said I've been in ED. I asked where you been?' and he said I've been in ED, and I said what's wrong. He said I've been at the meeting, and I asked what meeting? You don't work in ED, and he said it's good to support them. There was no definite answer, he didn't say what it was, he just said it was good to support them.*
>
> *I said to him you have patients here, where have been, he just said been to ED. Then he said I've been to the performance thing. He knew about it as […] had rang and I said about it to him. I was coordinating and said to […] about the meeting. He said I've been to that meeting, I knew it was later in that day. He implied that he had gone to 'the' meeting".*

When questioned about handing over patients in your care, you told the panel that you "made an assessment and they were discharge patients therefore you did not need to handover". You said that you would have told somebody that you were leaving but you could not recall who. In further questioning you said you would have told the person nearest to you but could not recollect who you told.

The panel concluded from your responses that you had made your own clinical assessment that it was safe for you to leave the ward, the panel determined that this was

not a decision for you to make. The panel was not satisfied that ongoing patient care had been handed over to someone with suitable skills prior to your 1 – 1.5 hours absence and therefore you left the ward unattended. The panel therefore finds charge 14 proved.

As a consequence of its decision in charge 14 the panel finds charge 1 proved in respect of one occasion. It went on to consider the other evidence in relation to other occasions when it was alleged you may have left the ward unattended.

Witness 2 told the panel:

> *'... Mark would frequently leave the ward during working hours, without prior arrangement, and staff would frequently be asking where he had gone."*

Witness 3 told the panel that *"there were shifts when I was looking for Mark, when I checked other nurses they did not know where he was"*. She told the panel that *"a nurse can leave the ward, as long as you notify nurse in charge"*. She also said that on one occasion that your patients were waiting for discharges, and you were not there to complete these.

The panel gave careful consideration to your evidence and your submissions about it.

You referred to Witness 1 telling the panel that it was not always necessary for a nurse to ask for permission before leaving the ward. This charge is not about asking for permission it is about whether the ward was left unattended (as defined above) when you did leave the ward. Witness 1's evidence did not assist the panel on the question that needed to be answered.

You told us that you would only leave the ward when staff and patient ratio was safe to do so and that you would always alert somebody that you were leaving the ward. You said that you were moved to Hazelton on a late shift, later that day because the patient to staff ratio was safe. The panel concluded that you had indicated on 22 January 2021 that the

patient to staff ratio was safe and you left the ward without letting someone know. In this regard, because you had not handed over, no one was aware of your assessment and the panel had found that the ward was unattended in the context of dealing with this charge.

The panel was satisfied that the evidence demonstrated a pattern of leaving the ward unattended whilst you were on shift when your colleagues on the ward were unaware of your whereabouts.

In light of the above, the panel therefore finds charge 1 proved in respect of leaving the ward unattended on one or more occasions.

Charge 5

5) Administered Diazepam to Patient A without any clinical justification at;
    a) 09:00
    b) 12:00
    c) 16:00
    d) 19:00

This charge is found proved in its entirety.

This charge relates to a Patient who was prescribed Diazepam for alcohol withdrawal, the management of the administration of diazepam is dependant on the assessment at given times in accordance with the Trust guidelines using the Clinical Institute Withdrawal Assessment – Alcohol revised scale (CIWA-Ar).

Ward nursing staff are responsible for the following:

- ….
- Assessing the patient using the Clinical Institute Withdrawal Assessment – Alcohol revised scale (CIWA-Ar) to decide if more medication is needed, or to withhold treatment if withdrawal symptoms are absent.

The panel heard oral evidence from Witness 1 that the policy had been in place for over two years and the observance of it was necessary and had to be followed and completed.

The panel was not satisfied that you had followed the clinical assessment protocol – Alcohol Detoxification Regime and yet you recorded that you had administered Diazepam to Patient A.

You further said you felt that your assessment must have been correct as the next person who completed the CIWA assessment process and score also gave diazepam.

The CIWA is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. The panel determined that you had not adhered to the protocol which is the clinical justification required by the Trust. It noted that although you may have been experienced in completing these assessments, however clinical justification is required through the specified structured combination of observation and direct questioning of the patient. In your evidence, you accept that you did not ask all of the questions because you explained that repeatedly asking the same questions, as you knew was required by the protocol, could agitate patients and potentially put you at risk of harm. You also said that your assessment must have been correct because another nurse gave a similar score after yours. The panel determined that another nurse's justification completed after yours cannot be used as your own because, clinical presentation of patients is changeable.

The panel noted that in the investigation interview record, you stated that you had developed "*naughty habits*" as you were attending to patients all day. In your submissions you stated you had calculated the clinical score in your head and recorded it at 09.00, 12.00 and 19.00 you said it was a human error that you had not entered in the score and that it may have been due to the day as they may have been a verbally abusive patient. Witness 6 stated in her evidence,

‘On the same day we had a patient in another bay who had been inappropriate towards staff: he had been verbally abusive towards staff and commenting on the staff, but I cannot recall.’

The panel noted that you had not documented how you had reached the CIWA scores on the 3 out of 4 occasions that you recorded them. It was not satisfied that you had followed the clinical process in your approach to demonstrate that there was clinical justification.

The panel find that your account and method did not amount to clinical justification. Someone else looking at the CIWA document for Patient A would not be able to identify why the patient was administered the drug amount at the time.

The panel did not accept under the context and circumstances of this charge that your personal clinical experience amounts to ‘clinical justification’. In light of the clear Trust policy, the panel considers that only a recorded decision following the scoring mechanism in the policy will amount to ‘clinical justification’. Therefore, the panel was satisfied that on the balance of probabilities you had administered Diazepam to Patient A without any clinical justification at 09.00, 12.00, 16.00 or 19.00.

In light of the above, the panel therefore finds charge 5 proved.

Charge 6

6) Whilst speaking to one or more colleagues on the Ward used words to the effect, ‘*I will just keep giving Patient A Diazepam as he is already prescribed it*’

This charge is found proved.

In reaching this decision, the panel took into account Witness 6’s email to Witness 1 dated 26 January 2021, the 29 March 2021 Internal Investigation interview notes with Witness 6 and Witness 6’s Witness Statement prepared for this Hearing.

Witness 6 was unable to attend this hearing but it was agreed by the parties that the Witness Statement would be admitted as hearsay evidence and that the weight to be attached to it would be a matter for the panel.

The panel also took into account your evidence.

In her email, Witness 6 stated

> *'…we had a patient in A4 that had he was inappropriate towards staff / using inappropriate language and Mark mentioned as a joke that he would keep giving him Diazepam to calm him down. Throughout the day speech became very slurred. I witnessed 3 pots of meds being given to … with multiple small tablets in them. The CIWA questions were not asked by Mark. The medication was just given.*

In the Interview notes, Witness 6 was recorded as having said:

> *'He was an MS patient, couldn't move from his bed. He was inappropriate towards female staff, swearing and shouting. Diazepam was given due to alcohol withdrawal. Mark gave multiple tablets, tiny white ones. 6pm observations, he could hardly talk to me. Slurred speak. Diazepam, I presume he took them. Mark is a jokey person but he made an inappropriate comment he said he was going to get more diazepam for that. He became slurred when he we did his observations.'*

In her Witness Statement, Witness 6 stated:

> *"On the same day we had a patient in another bay who had been inappropriate towards staff: he had been verbally abusive towards staff and commenting on the staff, but I cannot recall. Mark had mentioned earlier as*

a joke that he would just keep giving Patient Diazepam as he was already prescribed it. I don't know whether he did but I remember Mark giving him a white pot full of white tablets, but I don't know what they were."

You told the panel that you would not say this and in oral evidence you said that "*no, that's completely incorrect*". You also told the panel that you administered Diazepam but that you only administered Diazepam that had been signed for.

Witness 6 did not attend the hearing and so was not subject to cross examination. Her evidence was hearsay evidence. The panel gave this evidence full weight because Witness 6 had informed Witness 1 of this incident via email shortly after the incident. Her contemporaneous accounts (email and interview) were consistent. She also contacted Witness 2 where there were exchange of messages, Witness 2 confirmed during her evidence that she had received these messages and that they related to the concerns that Witness 6 had about the comments that she had heard. There was no evidence to suggest that Witness 6 had a reason to fabricate this allegation. The panel noted that she had also stated that you are a good nurse, whom she respects and that she knows you socially outside of work. Additionally, Witness 2 has stated in evidence that she heard similar comments on a different day and whilst this does not directly support the hearsay evidence for this charge, the panel consider that you do use such terminology.

Although this was unchallenged hearsay evidence, the panel accepted Witness 6's account and was therefore satisfied that it was more likely than not that you had used words to the effect, '*I will just keep giving Patient A Diazepam as he is already prescribed it*'.

The panel therefore finds charge 6 proved.

Charge 7

7) On one or more occasion administered an Intramuscular Injection/Lorazepam to Patient B whilst they were still sedated/asleep.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 6's witness statement, the email dated 26 January 2021 to Witness 1, and your Investigation Interview Record dated 21 June 2021. It also took into account your evidence.

Witness 6 in her witness statement said:

> *"On the date mentioned above, I was making the bed opposite patient with another staff member, but I cannot recall who, I saw Mark next to patient with a syringe.*
>
> *Usually there would normally be a couple of nurses there and curtains drawn for privacy but this was not the case. I did not see Mark put the syringe physically into patient but he definitely had it in his hand. I don't know what drug was in the syringe either."*

The panel also had regard to Patient B's MAR which shows that there were no records of you administrating Lorazepam to Patient on 18 January 2021.

In your oral evidence to the panel, you stated that *"if it is not signed for, its not been given*". You also stated that if you were seen carrying a syringe near a patient, it could have been for a number of reasons such as flushing an IV, taking bloods or giving prescribed IV medication. You said you cannot speak for what Witness 6 thinks she saw.

The panel noted that Witness 6 specifically said that she did not see an injection being administered. The NMC have not offered any further evidence for this charge.

The panel therefore finds that the NMC has not discharged its burden of proof and finds charge 7 not proved.

Charge 8

8) On one or more occasion did not record the administration of an Intramuscular Injection/Lorazepam to Patient B in Patient B's MAR Chart.

This charge is found NOT proved.

As charge 7 was found not proved Charge 8 must fail.

Charges 10, 12 and 18

On 18 January 2021;

10) On one or more occasion consumed unknown medication/tablets whilst on shift.

On 19 January 2021;

12) On one or more occasion consumed the unknown medication/tablets taken from the analgesia cupboard.

On 22 January 2021;

18) On one or more occasion consumed the unknown medication/codeine that you had placed in your left pocket.

Charges 10 and 12 are found proved. Charge 18 found NOT proved.

In reaching this decision, the panel took into account Witness 1, Witness 2, Witness 4, Witness 5 and Witness 6's evidence and your Investigation Interview Notes dated 21 June 2021. It also took into account your evidence.

The panel looked at charges 10, 12 and 18 both individually and together as they were similar in nature over the course of a few days.

The panel carefully considered all the evidence before it. The panel heard from three witnesses who gave accounts of what they had each seen and the panel heard your evidence.

Witnesses 2, 4 and 6 provided evidence of consumption of unknown medication either at the time of removal from the cupboard or at some time afterwards. Witnesses 2 and 4 challenged you following the consumption.

The evidence in relation to the incident on 19 January 2021 was the strongest. Witness 2 told the panel:

> *"During the morning shift I witness Hamilton taking an unknown drug from the painkiller cupboard and swallow it. I asked CN Hamilton if he was feeling unwell. He shrugged his shoulders, laughed and said 'No, No' and walked past myself out of the treatment room."*

Witness 2 told the panel that she was 2 metres from you and that she was sure that there was no confusion as to what she witnessed at that time. You challenged the witness in cross examination. Witness 2 stated she believed the drug to be codeine, explained where it was removed from and knew what was stored in the cupboard. She described different drug types to include painkillers and Nicotine patches.

Witness 5, who conducted the internal interviews, told the panel:

> *"Mark admittedly said that he would often 'borrow' them from the ACUC ward if he was running low. There are Nicorette tablets in the analgesia cupboard however there were none on the stocklist at the time. I do not*

recall any stock count done on the Nicorette lozenges. I had requested for an inventory from the Pharmacist of what would be kept around that time. The Nicorette lozenges were mainly white tablets in a blue plastic container. However, what Mark was seen taking were pills from what was a thin white silver strip of medication. This is different to that of the lozenges packaging said to be in stock at the time. I investigated into the issues of packaging but never found lozenges in any white silver striped pack. I even spoke to the witnesses to ask if they had seen Mark administer the patients with the medication strips, he had put in his pocket but he was not seen taking the medication to any of the patients' bedside."

In respect of the incident on 22 January 2021, Witness 4 told the panel:

"On 22 January 2021 I was working the day shift with the registrant. I heard him ask for the key to the treatment room which I thought was odd as usually nurses have a folder with them when they get the key and he didn't have one. He then went to the treatment room, opened the cupboard on the right where painkillers such as paracetamol and codeine are kept and took a strip of tables which he then put in his pocket. Later on the same shift I saw him take something from his pocket and pop it into his mouth."

Witness 4 reported the incident in an email dated 26 January 2021.

Witness 2 told the panel:

'January 22nd 2021 During the morning, not long after the drug round, I witnessed Hamilton removing a strip of medication from the painkiller cupboard. It is my belief that the blue thin box from which the medication was removed and placed into his left front pocket, was codeine.'

In relation to the incident on 18 January 2021 the only evidence comes from the hearsay evidence of Witness 6 the panel recognise that you have not had the opportunity to challenge this evidence, but in assessing the weight it should be given the panel

recognised the similarity between what Witness 6 said and the witnesses above said in respect of very similar incidents all taking place only few days apart. This allowed the panel to give significant weight to Witness 6's evidence.

In Witness 6's statement and her Investigation Interview Record dated 21 June 2021 she said she saw you removing a strip of medication from the analgesia cupboard. Although she did not see what you were accessing, she confirmed that she saw the white strip and that you put your hands down. She further stated that she saw you removing a little blue tablet out of your pocket and putting it in your mouth and that she saw you '*taking/swallowing'* tablet from your pocket again during the shift. Witness 6 reported this in an email dated 26 January 2021.

Your responses to these three charges were effectively the same.

You told the panel that you carry your own Nicotine Lozenges at work and that Witness 1 was aware that you take the tablets during your shift.

You submitted that the evidence of the witnesses about what they saw through the window in the door of the clinic room was unreliable and vague. You said the window was small and based on the distance the witnesses were away from you it was unlikely that what they say was indeed what occurred. You also said that there is no evidence to confirm you consumed stock medication whilst on shift.

Three separate witnesses provide descriptions of seeing you within 2 metres in distance. The panel preferred the evidence of the three witnesses who were very measured. The witnesses were clear on what they saw and identified where they were uncertain about what was removed/consumed but they were certain that you had removed/consumed an unknown medication. In the panel's view this gave the evidence a "ring of truth". In the case of Witness 2 in relation to 19 January 2021 she was in the treatment room with you.

You submitted the evidence of Witness 2 to be unreliable, she cannot name the drug she allegedly saw you take from the cupboard and that there is no evidence to suggest it was not one of your own Nicotine lozenges you had in your hand and put into your mouth.

The panel heard from Witness 2 who believed it to be codeine.

You further submitted Witness 2's evidence is unreliable and largely based on assumption due to the inconsistencies in descriptions of what remains to be an 'unknown medication'.

Although the panel accept that something was taken, it did not need to be satisfied about what you had put in your mouth to find this charge proved.

You submitted you did not sign your local interview as it was inaccurate in relation to admitting that you replaced your Nicotine lozenges with ward stock when you were low. When challenged about this you asserted you had previously been part of the NHS staff to help quit smoking programme and that all lozenges were your own.

The panel found that according to the notes of your internal investigation interview, you had appeared to accept that you were taking hospital Nicorette, that you would replace it and/or that you stored your own Nicorette in the cupboard. However, you had not made such submissions to this hearing. You told the panel that you had not taken hospital medication, that the only medication that you consumed whilst on shift were your own Nicorette's and that you did not store any of your own medication in the hospital cupboard.

The panel carefully considered all the supporting evidence that included the reference to not being seen to attend to patients after witnesses saw you remove unknown medications from the medicine cupboard or in the case of Witness 4 without a patient chart.

Two of the direct witnesses challenged you about what you were consuming at the times of the incidents and you ignored their questions. You told the panel that you did not recall this.

While not specific as to the items placed in your mouth on the occasions described, the panel determined it was more likely than not to have been Trust medication removed from the hospital.

In regard to charges 10 and 12, the panel found these charges proved.

In regard to charge 18 the evidence is lacking the specificity regarding the consumption of unknown medication from your ‘left pocket’ and taking into account your explanation about keeping patient medication and your Nicorette’s in your pockets, the panel on the balance of probabilities did not find this charge proved. Whilst there is evidence that unknown medication was placed into your left pocket however there is no evidence offered by the NMC that unknown medication was consumed from the left pocket.

Charge 19

> 19) Your actions in one or more of charges 9), 10), 11), 12) and 17) were dishonest, in that you took/consumed medication belonging to your employer with an intention not to return it.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1, Witness 2, Witness 4, Witness 5 and Witness 6’s witness statement. It also took into account your oral and documentary evidence and your Investigation Interview Record dated 21 June 2021.

The panel accepted the advice of the legal assessor: the proper approach to deciding if someone was dishonest in a context such as this is no longer that set out in the case of *R v Ghosh*. In *Ivey v Genting Casinos* [2017] UKSC 67 Supreme Court held that second part of the Ghosh test was no longer good law. The correct approach now is for you to determine the actual state of a nurse’s knowledge or belief as to the facts. Against that background, you then simply ask one question - whether the conduct was dishonest by applying the objective standards of ordinary decent (reasonable and honest) people. People in this context (as explained by the Court of Appeal in the case of *Hussain v GMC* [2014] EWCA (Civ) 2246) means nurses and healthcare professionals like yourself.

You admitted to charges 9), 11) and 17). The panel went on to consider whether your conduct in charges 9), 10), 11), 12) and 17) would be considered dishonest by any

reasonable nurse.

The panel was of the view that that there were three different witnesses who had seen you remove unknown medication from the analgesia cupboard. It concluded that the unknown medication, whatever it was, was more likely than not to be the Trust's property and consuming the unknown medication was a dishonest act.

The panel therefore concluded that an ordinary reasonable and decent nurse would consider that you took/consumed unknown medication belonging to your employer with an intention not to return it, to be dishonest.

The panel had regard to the local interview minutes dated 21 June 2021 in which it is recorded that when asked '*Can you recall an occasion where you attended the ward at 6.30am and asked for the drug keys, but at the time you were working within ED?*' you responded:

> *"I cannot re-collect, cannot recollect, and wasn't related to this. I was in the secondment role.*
> *Only time I can think about is that sometimes when my lozenges are low, I would pop to the ward and nick some from Nicorette mini, certainly not anything else.*
> *I have taken Nicorette when desperate, Depending on what's there, if same brands, I would get them replaced. These sit in my mouth the minis are medicine pots […]"*

The panel noted that you dispute that the minutes of this interview are accurately recorded. You did not sign the minutes of the interview confirming that they were accurate. In your oral evidence you stated that your comments were misinterpreted. The panel considered this evidence and your responses and decided that it would be unlikely for these comments to have been manufactured by the interviewer, they were sufficiently detailed for the panel to consider it unlikely there had been a misunderstanding. The panel therefore concluded that it was more likely than not that you had said words the effect of what was recorded.

The panel found that your actions in all of charges 9), 10), 11), 12) and 17) were dishonest. It was satisfied that you took/consumed unknown medication belonging to your employer with an intention not to return it.

The panel therefore finds charge 19 proved.

Charge 13

On 19 January 2021

1) Whilst speaking to one or more colleagues on the Ward used words to the effect;

a) '*If you sedated your patients like I did, you would have less problems with patients wandering.*'

b) '*Every time Patient A looks at me, he is earning himself more Diazepam'*

This charge was found proved in its entirety.

In reaching this decision, the panel took into account Witness 2's evidence and your evidence.

Witness 2 told the panel:

> *"January 19th 2021, I was allocated to work administratively i.e. not clinically on this day however, due to staff shortages I was working on the ward in the numbers. During handover I overheard CN Hamilton advising other staff that 'if they sedated their patients like he did, they would have less problems with patient wandering'. He explained that; 'every time Bed A4 Patient A look at me, the patient was earning himself more diazepam".*

Witness 2 told the panel that she was sure that the comment was made by you. Additionally, Witness 2 said the same thing in her contemporaneous local statement dated 19 January 2021. She provided details of where she was standing and accepted she may be mistaken as to whom the comments were directed.

In your oral evidence, you denied that you had ever worked together on the same shift with Mr 1 and Witness 2. You submitted a work rota that you had downloaded that showed you had not worked together on that day. The panel accepted that this may have been the case however it is irrelevant whom the comment was said to.

You told the panel *"I wouldn't have said that to one of my colleagues"*. The panel heard evidence from Witness 2 and accepted the specificity of her account and preferred her evidence.

Therefore, in light of the above, the panel finds charge 13a and 13b proved in its entirety.

Charge 15

15) Inaccurately informed Colleague Z that you had left the Ward to attend a meeting in the Emergency Department

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence and your evidence.

Witness 2 told the panel:

> *"CN Hamilton then disappeared off the ward within an hour of returning from the hospital appointment. He did not explain where he was going. He*

returned approx. 1-1.5 hours later explaining that he himself had attended 'a meeting' in the emergency department.

I asked CN Hamilton why he was attending Emergency Department meetings when he did not work for the Emergency Department. CN Hamilton reasoned 'I went to support the emergency team; it is good to support them'. I was not aware an ED meeting was taking place and unsure as to why CN Hamilton would not have stated where he was going. CN Hamilton then went to commence his late shift on Hazelton ward where he worked alongside […], on January 22/01/2021.

[…] attended cardiac 2 ward approx. 17.00pm on 22/01/2021 and asked how the performance meeting went. I explained that she had not called to check it was safe for me to leave and attend and consequently I had not attended the meeting.

[…] then called staff involved in the meeting to give apologies for both herself and Cardiac 2/ACUC for not attending the meeting.

I later learnt that CN Hamilton explained to management that he himself had attended the performance meeting. During my morning phone call with […], I was told that the meeting was to take place much later in the day than the time CN Hamilton had left the unit. I was also told the meeting was in Alex House, not the emergency department where CN Hamilton has stated he had been."

Witness 2 told the panel that she thought you had not attended the performance meeting because when the call was made to ED to convey apologies for there having been no representation from the ward, they would have mentioned if you had been there.

[PRIVATE], you took the opportunity to prepare an office you had vacated some days earlier and conduct a handover meeting for the person taking over your role in ED.

On your return to the ward Witness 2 asked you where you had been. You told her you had been to ED for 'the meeting'. You submitted that Witness 2 had merely implied that you had been to the performance meeting that the Matron had called about but you denied to the panel that this was the meeting you went to.

In reaching its decision, the panel applied the cogency test to this charge and determined that the evidence provided by the NMC was not sufficient. A distinct lack of clarity existed about which meeting was being spoken about. The panel determined that it was likely that there was probably confusion as to which meeting was being referred to in conversation between you and Witness 2.

The panel therefore finds that the NMC has not discharged its burden of proof and finds charge 15 not proved.

Charge 16

16) Your actions in charge 15 above were dishonest in that you sought to mislead Colleague Z as to the reason you left the Ward.

This charge is found NOT proved.

As charge 15 was found not proved, charge 16 must fail.

Charge 20

On 25 January 2021;

20) Inaccurately recorded/backdated on the Stock Medications ‘Lent to Other Wards’ Sheet that;

a) Codeine had been loaned to Hazelton Ward on 22 January 2021
b) Co-Codamol had been loaned to Hazelton Ward on 22 January 2021

This charge is found NOT proved.

The only original document that related to this charge was the 'Stock Medications Lent to Other Wards' sheet ('the sheet') found at page 20 of the Exhibits Bundle. The panel found this to be a profoundly unsatisfactory document. The first column ('DATE') was illegible. The second column ('Medicine Borrowed') showed no consistency in the way in which it was completed. There was, for example, no way of ascertaining the strength of medications lent (the panel from its own knowledge noted that co-codamol tablets come in various concentrations of codeine phosphate). Equally, it was impossible to identify whether some of the quantities recorded referred to tablets, strips of tablets or boxes of tablets. The third column ('Ward') was legibly completed but unhelpful in terms of the charge the panel was considering.

The panel asked questions of several witnesses to ascertain how the lending system operated. The picture that emerged was of a very 'ad hoc' system with no proper checks and balances. This system seemed to work for the purposes for which it was used, namely to ensure that no ward suddenly ran out of medication it needed, and especially so during the Covid-19 difficulties. However, the system was wholly unsuitable for auditing or even checking stock levels and still less for proving a case of misconduct against a nurse.

There was never a record made of how, when or why a request to 'borrow' medications was made nor, perhaps importantly, by whom the request was made. There was no protocol or rule as to how the lending of medications was to be recorded: the sheet the panel saw was simply 'stuck up on the wall'. There seemed to be no method at all by which the arrival of the borrowed medications would be recorded in the 'destination' ward. Finally, there was no system by which either borrowed medications would be returned to the ward of origin or by which they would otherwise be accounted for in the hospital's pharmacy (or even internal accounting) records.

In these circumstances, it was impossible to show that the medications you said you took to Hazelton ward were “inaccurately recorded”.

You told the panel that you ‘borrowed’ the medication on a Friday but did not fill in the sheet until the following Monday. There was no (and given the way the system operated, could not have been any) allegation that it was wrong to fill in the sheet after the medications had been lent.

The charge that the backdating was inaccurate was not made out on the evidence presented. Therefore, on the balance of probabilities, the panel find charge 20 not proved.

Charge 21

21) Your actions in one or more of charges 20 a) & 20 b) were dishonest in that you falsified records as you sought to misrepresent that medication had been loaned out to other wards.

This charge is found NOT proved.

As the factual basis on which this charge relied was found not proved, this charge was incapable of proof.

Charge 22

22) On 11 January 2021, administered Lorazepam to one or more patients who were, either asleep or not agitated, without any clinical justification.

This charge is found NOT proved.

The only evidence for this charge came from Witness 3. She was able to describe only two patients to who the charge could refer. She was unable to identify who these patients were. The panel will refer to them as Patient U1 and Patient U2.

Before looking at the evidence, the panel noted the real difficulties you had in defending your actions towards patients who could not be identified and in respect of whom there were, necessarily, no medical records available for you to refer to.

Patient U1 was referred to in para 5 of Witness 3's statement. Witness 3 said she knew that you had given this patient Lorazepam as she had seen and recognised your signature next to a relevant entry in the patient's records. The panel had no reason to doubt this and accepted this evidence.

The crucial question for the panel was whether the NMC could prove a lack of clinical justification for the administration of the Lorazepam - it was not for you to prove that you had clinical justification.

Patient U1 was not Witness 3's patient. The responsible nurse was you and it was you who would have been observing Patient U1 throughout the day in question. At the point of administration of the medications, Witness 3 was not there: she could not say whether the medication was needed at the time it was given. All Witness 3 could tell the panel was that she did not think Patient U1 was agitated *"that day"*. In the panel's view, this evidence amounted at its highest to no more than a difference of professional opinion as to the propriety of giving a particular medication at a particular time. It was not evidence that the Lorazepam given to Patient U1 was given *"without any clinical justification"*.

In respect of Patient U2, Witness 3 was unable to say whether or not that any medication was given to Patient U2 at all, still less that it was given by you. In her written statement Witness 3 told the panel that she told you that she didn't think Lorazepam was necessary for this patient … *"but [you] may still have administered it when I'd gone."* In the panel's view, this evidence falls way short of showing, on the balance of probabilities or indeed at

all, that any medication was given by anybody to Patient U2 at the time in question, let alone that such medication might have been given *“without any clinical justification”*.

In considering all of the charges, the panel also noted your suggestion that many of the allegations made against you could have been either invented or exaggerated because of personal and professional differences between you and Witness 2. However, the panel did not find there to be any credible evidence that this was the case.

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.

NMC submissions on misconduct

Mr Wallis referred the panel 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.'*

Mr Wallis submitted that the standard of propriety may often be found by reference to the rules and standards ordinarily to be followed by a medical practitioner in the particular circumstances, and that in these circumstances, this means the NMC's code. He acknowledged that it has been repeatedly affirmed that not simply any breach of the code will amount to misconduct but that in order to be properly so described it must be serious.

Mr Wallis dealt with the charges by breaking them down into three sets of charges. The first, he said, dealt with the unjustified administration of medication and related to comments made to colleagues about that practice. The second, he said dealt with the taking/consuming of medication by you and the third dealt with leaving the ward unattended.

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

Mr Wallis identified the specific, relevant standards where the NMC say your actions amounted to misconduct.

Mr Wallis submitted that the unjustified administration of medication, lack of record keeping and comments made to colleagues relates to charges 2, 3, 4, 5, 6 and 13. He submitted that, in terms of the seriousness of these charges, there is a clinical element here, a failure of record keeping and perhaps what might in other circumstances be fairly characterized as something like *'sloppy practice'* and, as recorded as having been said by you in your local interview, as '*naughty habits'*. He submitted that your conduct demonstrated that you were cutting corners as far as the diagnostic tools that you were required to use and perhaps were taking a cavalier approach. In respect of charges 6 and 13, Mr Wallis submitted that these effectively suggest that, as well as not being clinically justified in the strict sense, medications were used for the non-clinical purpose of ensuring compliance by vulnerable patients which may have put you under a degree of considerable pressure, which the panel will also take into account.

Mr Wallis submitted that providing medication in such circumstances and making comments announcing the type of reasons given by you to others around you is first and foremost an abuse of the power and responsibility that a nurse holds when caring for vulnerable patients. He submitted that your actions modelled a particularly serious kind of

poor practice to your colleagues. He invited the panel to find that these charges amounted to misconduct.

Mr Wallis addressed charges 9, 10, 11, 12, 17 and 19. He referred the panel to the NMC's guidance for the assessment of seriousness in relation to dishonesty cases which comes under the Sanctions Guidance. He acknowledged that this case has not reached the sanction stage but submitted that this guidance presents a useful set of questions to assess the seriousness of dishonesty charges.

Mr Wallis submitted that there is a spectrum of dishonesty, and it is important that the panel consider where dishonesty of this kind falls. He submitted that in this case, the dishonesty did result in personal gain in that medication was taken by you for your own personal use and was consumed by you on hospital grounds. He submitted that the panel may make an inference that this was driven by a deep-seated problem, but not by the sort of cynical motive that is suggested by the simple phrase at personal financial gain, so it sits perhaps on the 'halfway' mark.

Mr Wallis submitted that another consideration for the panel is whether the conduct is spontaneous or whether it is systematic. He submitted that there was a pattern of this behaviour but may not be considered to go as far as systematic, organised or premeditated. He submitted that the panel may consider that your conduct was opportunistic but that it was an opportunity that was taken repeatedly. He further submitted that this was an opportunity that you had as a result of being in a position of trust and responsibility. He submitted that the panel may think that this is like most cases where a nurse takes advantage of access to medication that belongs to their employer to use personally in a way that is unsupervised, and that is inherently serious. However, he acknowledged that there is no suggestion in this case as there is in others, that the medication was being taken to be sold on nor evidence as to precisely what medication was being used, whether controlled drugs were involved.

Mr Wallis submitted that nurses are required by the Code to be accountable for decisions to delegate tasks and duties to other people, and where patients were being left without someone who was assigned to care for them, there were obvious risks. He acknowledged the reasons provided by you for having left the ward unattended. He submitted that whether those were the result of dishonest statements or simply an honest but misunderstood conversation about a meeting or a responsibility elsewhere is a matter for the panel. Further he stated that if this was one occasion in isolation that a Ward was left unattended by you the NMC's position on misconduct and impairment would probably be a different one. However, he submitted there were two occasions where this occurred and therefore does amount to misconduct.

NMC submissions on impairment

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

Mr Wallis submitted that a finding of misconduct does not automatically mean that the practitioner's fitness to practice is impaired. He acknowledged that assessing misconduct is an assessment of the previous behaviour whereas impairment considers your fitness to practise as of today's date.

Mr Wallis referred the panel to the question set out in the NMC's guidance and encouraged the panel to consider first and foremost is: 'can the nurse midwife or nursing associate practise kindly, safely and professionally?'

Mr Wallis referred the panel to the case of *Grant* and invited it to give careful consideration to the tests as set out in this case. He submitted that in line with the considerations as set

out in the case of *Grant*, the NMC's position is that in respect of your breaches of the code that are numerous and sufficiently serious to constitute misconduct, your fitness to practise is impaired.

Mr Wallis submitted that your behaviours, whilst some have elements of issues relating to clinical competency and judgements, all stem from attitudinal issues. He submitted that, there is an attitude of disregard for the rules that exist to make practitioners and patients safe.

Mr Wallis submitted that such issues, are in the category of problems that are more difficult to put right. [PRIVATE], the NMC's position is that there is an inherent risk of repetition.

Mr Wallis submitted that in performing the exercise of looking at the past behaviour and making a judgment about the likelihood of recurrence in the future there would need to be compelling evidence of insight and remediation in order to reach a conclusion. He submitted that the panel must assess whether you have demonstrated insight into the reasons that you acted in the way that you did and the potential consequences on patient safety, colleagues and yourself. He submitted that this is a difficult task in relation to those charges which have been denied throughout the proceedings.

Mr Wallis submitted that given the extent of the findings compared to what was admitted at that earlier stage, there is not sufficient evidence of insight or remediation, such as to balance out the serious concerns of the misconduct in this case. He submitted that regrettably, in light of the findings that have been made at the facts stage, and for all of the reasons outlined, a finding of impairment is required on public protection and public interest grounds. He submitted that this is a case, as well as being one of dishonesty, where the fundamental tenets of the nursing profession have been breached.

Your submissions on misconduct and impairment

You provided written submissions on misconduct and impairment in which you stated:

"Charge 1 and 14
[…]
Context
Personal: I was in a transition period of leaving my Emergency Department Band 7 Practice Development Nurse role and starting my Band 6 Nurse role on Cardiac 2/ The Ward. I had a responsibility to handover to my replacement, this was conducted via multiple face to face meetings, phone calls, emails, a shared drive and hardback resources such as files in the office. The PDN role is responsible for the education of 250 members of staff across both sites, the extensive nature of this role requires an in-depth handover period, this was the first time I had experienced handing over in this nature. [PRIVATE].

Professional working environment and culture: I was not given a supernumerary period when starting on Cardiac 2/ the Ward. A full ward handover is given at 07:15 and all members of staff hold a written copy of this. I let a member of staff know I was leaving the Ward and staff-patient ratio was safe.

Learning, insight and steps to strengthen practice: On reflection I have learnt a supernumerary period would have supported my transition and reporting to the nurse in charge would prevent this incident from occurring again. I would ensure both of these steps in future practice.

Misconduct
I believe this to be a clinical mistake. It was assumed the full handover at the beginning of the shift was sufficient.

Fitness to Practice Today

I believe this does not impair my fitness to practice today, in future it can be prevented by supernumerary period and reporting to nurse in charge if leaving a clinical area.

Charge 2a (i), 2a(ii), 2a(iii), 2a (iv)
[…]

Personal: Had not used CIWA chart for 18 months during PDN role.
Professional/ environment: Patient A was high violence and aggression risk.

Learning: Reflection on the situation has made me aware that my documentation of a total CIWA score seemed sufficient rationale and resulted in me not recording individual scores on the calculations page.
Allow more reading time when using CIWA prescription chart.

Misconduct: I consider this unintentional human error and a minor clinical mistake.

Fitness to Practice Today: I am aware of the error I made and have identified a method to prevent it from happening again, I believe this does not impair my fitness to practice today.

Charge 2b
[…]
Personal: Calculated score in head and failed to record calculations on chart.

Professional/ environment: Returned to clinical practice after being non clinical for 18 months.

Learning: I recognise I failed to record calculations and am aware more time reading was required to familiarise self with CIWA.

Misconduct: I consider this to be a minor clinical mistake that caused no harm.

Fitness to Practice Today: I do not consider this to impair my fitness to practice today, I have recognised the mistake I made and ways to prevent it from occurring again.

Charge 3a, 3b, 3c 3d
[…]
Personal: Mis-read the treatment dose as 5mg instead of 7mg for a CIWA score of 10 or above.

Professional/ environment: On reflection I should have familiarised myself with the CIWA chart again on return to the area.

Learning: Familiarise self with protocols when returning to practice, have supervised practice or supernumerary period to facilitate transition back to practice, allow more time to read charts fully to minimise mis-reading/ mistakes being made.

Misconduct: I consider this to be human error that was unintentional and a minor clinical mistake that caused no harm.

Fitness to Practice Today: I believe I have shown insight into the mistake and identified methods to ensure it would not happen again, I consider this not to impair my fitness to practice today. In future I could update alcohol detoxification training.

Charge 4
[…]
Context: Human error, calculated score in head and failed to record at the time. Patient A had persistently presented with symptoms of alcohol withdrawal throughout the day and into the night shift.

Learning: I recognise there were gaps in my record keeping, I feel the nature of the situation with Patient A being a high violence and aggression risk contributed to parts of the chart not being filled in completely. On reflection I feel I managed Patient A's symptoms appropriately but this could have been improved with complete documentation.
Misconduct: I consider this to be a minor clinical error that caused no harm.
Fitness to Practice Today: I believe this does not impair my fitness to practice today and I have recognised errors made in relation to CIWA with methods to prevent them from reoccurring.

Charge 5
[…]
Personal factors that relate to the professional: Experienced at managing alcohol detoxification using CIWA but had not used a CIWA chart for 18 months during PDN role.
Professional working environment and culture: Patient was displaying signs of alcohol detoxification and high violence and aggression risk.
Learning, insight and steps to strengthen practice: Previously completed advanced violence and aggression training and am always cautious of situations that may escalate quickly. I have gained insight into the reasons why I failed to record individual scores for each question; I used a combination of skills such as visual assessment and kept questioning as natural as possible to prevent feelings of judgement/ paranoia/ interrogation. By integrating questions into natural conversation/ interaction with the patient I failed to record the scores individually and only documented the total score.
Misconduct
I consider this a clinical mistake due to human error of calculating the total CIWA scores in my head and not documenting them fully.
Fitness to Practice Today

I have learnt from this mistake and believe it does not impair my fitness to practice today, in future it can be prevented by familiarising myself with protocols and allowing myself more time to read and complete prescription charts fully.

Charge 6
[…]
Personal factors that relate to the professional: Nurses commonly talk about management plans for patients and it is accurate that Patient A was on a CIWA chart and the management of Patient A's alcohol withdrawal was Diazepam. I explained in evidence I would not say this, I was unable to ascertain the content of the conversation which this was allegedly said. This was submitted as hearsay evidence, not capable of being tested and I was unable to challenge Witness 6.

Professional working environment and culture: In her local email to Witness 1, Witness 6 states "Mark mentioned as a joke he would keep giving him Diazepam to calm him down". The use of the word "joke" implies that Witness 6 was not concerned. During local investigation I was informed staff had been told to 'observe' me and feel Witness 6 was guided to report to the Ward Manager.

Learning, insight and steps to strengthen practice: I can understand how a discussion regarding Diazepam could be misinterpreted or concerning to a Health Care Assistant who is untrained in the use of CIWA. I believe this can be prevented in future by ensuring patient management and medication is discussed confidentially with appropriately trained nurses.

Misconduct
I consider this a misinterpretation of a conversation regarding a patients management plan.

Fitness to Practice Today

I believe this does not impair my fitness to practice today, I have gained insight how the incident may have occurred and feel it can be prevented by ensuring medication related conversations are only discussed with trained nurses in confidential areas.

Charge 9, 11 and 17
[…]
Personal: Had not been clinical for 18 months, had not completed training to use electronic system to access patient observations. Due to Covid restrictions carrying medication in pocket reduced number of times treatment room had to be accessed.

Professional/environmental: Had no supernumerary period to complete new e-learning for electronic system and Covid restrictions meant only 2 people allowed in treatment room at one time. Ward was a temporary area created during Covid.

Learning: On reflection it has been recognised by myself and others that individual drug trolleys in each bay would be beneficial to staff rather than one set of keys and very small clinical drug room being the only access to medication. I recognise carrying medication in my pocket or taking it out of treatment room and to the patient was careless and put myself at risk by not following protocol. However there was no adjustments made to the protocol during the Covid pandemic and I was trying to do the best for my patients.

Misconduct: I consider the Covid pandemic to add a disparity perspective and be a contributory factor, my actions were made in the best interests of my patients and rules/ restrictions were ever-changing.

Fitness to Practice today: I believe this would not impair my fitness to practice today, that I have recognised contributory factors of the Covid pandemic caused altered medication administration and this could be rectified by medicines management course and supervised practice.

Charge 10

[…]

Personal: Own Nicotine Lozenge kept in uniform pocket and consumed during shift.

Professional: Not all colleagues were aware I carried own Nicotine Lozenge and consumed during shift time.

Learning, insight, steps to strengthen practice: I understand how the action of consuming a Nicotine Lozenge can be mistaken for a tablet/ unknown medication in an environment where multiple medications/tablets are stored and administered. To prevent this from reoccurring I would be more careful and only consume Nicotine Lozenge at break times or when off the Ward.

Misconduct

I believe this was a careless mistake not misconduct.

Fitness to Practice Today

I believe this does not impair my fitness to practice today, I have learnt from this carelessness and would not consume own Lozenge in clinical environment in future.

Charge 12

[…]

Personal: Not trained to use Sun Rise electronic system took longer to check patient observations and carried commonly used stock medication including analgesia in pocket to be more efficient.

Professional: Restrictions in treatment room 2 people at a time due to Covid, intention was to practice more effectively and ensure patient received medication on time. One set of keys.

Learning: Put myself at risk by carrying both analgesia from cupboard and own Nicotine Lozenges in uniform pocket. Would not carry stock medication in pockets in future. Temporary area during Covid meant there were no individual drug trolleys for each bay, changing the storage of medication to individual drug trolleys could prevent this from happening again.

Misconduct: Explained I only consumed own Nicotine Lozenges, can understand how Witness 2 mistook these for ward stock when stored in pocket.

Fitness to Practice Today: I believe this does not impact my fitness to practice today and can be rectified through medications management training and supervised medication administration.

Charge 13
[…]
Personal: Explained in evidence I would not have said this. It is common practice for nurses to discuss patient management plan and Patient A's was Diazepam.

Professional: I feel evidence provided by Witness 2 carries no weight and is unfair to use. Diazepam administered to Patient A is clearly documented on CIWA chart. Witness 2 provided inaccurate account of being sure this was said to Mr 1 when it was proven we were not on shift together. Management of Patient A was Diazepam using CIWA chart this is likely to have been discussed by nurses in handover.

Learning: Keep handover of patients precise, factual and to a minimum. I've gained awareness of how conversations with staff may be mis-heard or mis-interpreted and would be careful when discussing patient management in future.

Misconduct: I did not say this and believe there was no misconduct.

Fitness to Practice Today: I do not believe this impairs my fitness to practice today, I have identified errors I made when using the CIWA chart. I feel this evidence is admissible on the basis of an inaccurate account and no direct witness.

Charge 19
[…]
Personal: New to the Ward, had not completed relevant training to use electronic system and carried stock medication in pockets.

Professional: No supernumerary period to complete relevant training for new electronic system. Incident of carrying medication in pockets occurred due to Covid pandemic and lack of training.

Learning: In pandemic polices were amended on a daily basis I have gained insight into why I carried stock medication in my pockets, this was due to a lack of training using new electronic systems and Covid restrictions.

Misconduct: Always returned medication but put self at risk by not adhering to POPAM policy, risk was taken due to pandemic and lack of training.

Fitness to Practice Today: Can assure this would not happen through completing appropriate training for electronic systems, medications management course and supervision."

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Nandi v GMC [2004] EWHC 2317 (Admin), Mallon v GMC [2007] CSIH 17, Holton v GMC [2006] EWHC 2960 (Admin), Meadow v GMC [2007] QB 462, Cohen v GMC [2008] EWHC 581 (Admin), CHRE v (1) NMC (2) Grant [2011] EWHC 927 (Admin), SRA v Sharma [2010] EWHC 2022 (Admin) and Parkinson v NMC [2010] EWHC 1898 (Admin).*

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 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:

1 Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

[In respect of charges 1, 2, 3, 4, 5, 6, 13 and 14]

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

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

[In respect of charges 1, 2, 3, 4, 5, and 14]

8 Work co-operatively

8.2 maintain effective communication with colleagues [In respect of charges 1, 6, 13 and 14]

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff [In respect of charges 1 and 14]

8.6 share information to identify and reduce risk [In respect of charges 1 and 14]

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.

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.
[In respect of charges 2, 4, and 5]

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

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs [In respect of charges 2, 3, 4 and 5]
18.4 take all steps to keep medicines stored securely [In respect of charges 9 and 17]

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

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 [In respect of charges 2 and 5]
19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures [In respect of charges 2 and 5]

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 [In respect of charges 1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 17 and 19]
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment [In respect of charge 19]
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people [In respect of charges 6 and 13]

20.4 keep to the laws of the country in which you are practising [In respect of charge 19]

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel went on to consider whether your actions as set out in the charges amounted to misconduct.

In respect of charges 2, 3, 4 and 5, the panel noted that these related to four instances across one shift which related to the administration of Diazepam without clinical justification. It noted that these charges occurred as a result of you having failed to follow the proper protocol and utilise the CIWA tool as required which in the panels view may have led to you making medication errors in respect of administering the incorrect dosage of Diazepam. The panel noted that you were familiar with the CIWA scoring method to the extent of having previously delivered training on it. The panel determined that, having been familiar with the proper protocol and structured procedure, you did not follow this which was demonstrative of a disregard for a nursing duty which is ordinarily required to be carried out with a high level of accuracy.

The panel determined that your actions as set out in these charges demonstrated a series of conscious decisions made by you that were indicative of poor practice and dangerous attitudes to the safety of people receiving care. The panel has taken account of the context and that you were working within a challenging environment, had not had a supernumerary period following return to work on the ward and aware that you stated you had not used the CIWA process for 18 months. However, you made entries on a form which clearly required a structured process to be followed. You did not request training or ask for guidance. There was a domino effect from failure to follow the required approach which heightened the concerns as to the potential risk to patients from your conduct. The panel determined that you put a patient in your care at a risk of harm and concluded that your actions as set out in charges 2, 3, 4 and 5 amounted to misconduct.

In considering whether charges 6 and 13 amounted to misconduct, it noted that these related to the comments made by you about your medication administration practice. The panel considered that your comments as set out in charge 6 must be seen in the context of other actions taken by you. The panel considered that charge 6, on its own, without any findings of you having failed to follow the proper medication administration protocols and procedures, may not have been considered sufficiently serious to amount to misconduct. However, the panel determined that given the context in which this occurred, having been linked to your not following a protocol on a drug for a detoxing patient, makes your actions in charge 6 much more concerning and found that your behaviours are indicative of attitudinal issues.

In respect of charge 13, the panel noted that these comments have not directly been linked to a medication administration failure by you. However, the panel determined that these were wholly inappropriate comments to have been making and concluded that any suggestions of medications being administered without due process is alarming. Further, the panel determined that making comments about administering medications to patients to make them more compliant rather than for an informed clinical purpose would not be considered appropriate in any circumstances or environment, let alone in a clinical environment around other colleagues.

The panel noted that on two consecutive days, two different colleagues heard you make comments which were inappropriate in nature and set a bad example to colleagues, whether they were said in a joking manner or otherwise. The panel noted that in respect of both charges 6 and 13, there is no evidence that your comments led to actual patient harm. However, the panel has noted its finding in charge 5 that you have administered medications without any clinical justification and found there to be a concerning link between the nature of your comments and the attitudes demonstrated in your nursing practice in respect of medications administration. One of the comments being said the same day that Diazepam had been administered to Patient A without any clinical justification and another comment being made the following day about Patient A. The panel concluded that your comments as set out in charges 6 and 13 demonstrate a

serious falling short of what would be proper in the circumstances and are sufficiently serious to constitute misconduct.

In relation to charges 9, 10, 11, 12, 17 and 19, the panel noted that these related to the taking and consuming of unknown hospital medication. The panel noted that you accepted having stored hospital medications in your pockets during your shift which does not conform with proper nursing practice procedures and the Trust's medication management policy. The panel determined that, on its own, the storage of medications in your pocket whilst on shift would be considered poor practice and a departure from the proper procedures but did not consider that this alone would constitute misconduct. However, the panel considered that your conduct in these charges involved you storing the medications in your pocket and subsequently taking and consuming hospital medications, which are intended for the patients, which can be regarded as theft. The panel determined that your actions demonstrated a serious departure from what would be proper in the circumstances, and that the taking and consuming of medication which is intended for patients is wholly unacceptable. It determined that your actions as set out in these charges demonstrates a serious falling short of the proper standards expected of a nurse.

The panel considered whether charges 1 and 14 amounted to misconduct. It noted that this involved you leaving an acute medical ward unattended for an extended period of 1.5 hours. The panel had already determined that the meaning of "unattended" in this context was not that there was nobody left on the ward but rather that the care of the patients that you were looking after was not handed over to someone with suitable skills to take over that care.

The panel took into account that you explained your reasons for leaving the ward and the professional pressures you were under. You said that on one of the occasions you had left the ward to deliver a handover elsewhere which you had not anticipated taking a lengthy amount of time. Additionally, you stated you had assessed the staff to patient ratio and found it sufficient. You said the fact that you were released in the afternoon to go to work on another ward was evidence that there was enough staff on the ward. Finally, you said

that the patients were pre-discharge and were therefore stable. You stated that you had told a colleague, who you now could not remember, that you were leaving the ward. However, the nurse in charge told the panel that she was not aware that you had left the ward, where you had gone, when you were expected back and that you had not handed the care of your patients over. The panel determined that leaving a ward unattended for this length of time placed patients at a real risk of harm. Although the patients were pre-discharge, the panel determined that in a hospital situation it is possible for conditions to change. Additionally, the panel heard evidence from colleagues including the nurse in charge that you frequently left the ward unattended. The panel determined that this was a serious departure from what would have been proper in the circumstances, and should you have been required to leave the ward, it should have been done safely.

In all these circumstances, 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 and to maintain professional boundaries. 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 a risk of harm as a result of your misconduct. It determined that in not following the proper protocols and procedures for the administration of medication and leaving patients you were looking after unattended, you placed patients in your care at a risk of harm. The panel concluded that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find the charges relating to dishonesty serious.

Regarding insight and the risk of repetition, the panel took into account that you have accepted some of the charges. It noted that you stated that you have learnt from your mistakes and stated that you could assure that your actions would not be repeated.

However, the panel found that you focused on the fact that no actual harm was caused to patients and said that you had put yourself at risk by not following protocols, but you did not address the risk to patients or the impact on colleagues. The panel therefore was not satisfied that you have sufficiently demonstrated an understanding of your actions had the potential to put the patients at an unwarranted risk of harm. In particular, the panel considered that you had not taken full responsibility for your failure to follow medication administration procedures or for leaving the ward unattended. Further, the panel was not satisfied that you have demonstrated an understanding of the negative implications of your actions on the reputation of the nursing profession.

You stated that your fitness to practise is not impaired and that these incidents would not reoccur because you would familiarise yourself with protocols, undertake retraining on the relevant areas, and that you have ‘ways’ or ‘methods’ to prevent your failings from reoccurring. For example, you say that in future if you are leaving a clinical area you would inform the nurse in charge. However, the panel decided you have not sufficiently demonstrated how you would handle these situations differently in the future.

The panel found that you have not shown remorse, even for the charges that you had made early admissions to. Instead, you sought to minimise the severity of your actions, relying on the fact that no harm came to any patients. You also sited system and environmental factors such as the Covid pandemic, alleged regular changes to procedures during this time and the ward having a small medication room with one key.

The panel noted that some of the concerns in this case could be addressed by retraining, for example, the medication administration failures. However, the panel took into account that the concerns in this case are indicative of an underlying attitudinal issue which is more difficult to put right and makes it difficult to demonstrate that you have sufficiently addressed the concerns to minimise the risk of repetition.

The panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account that you say

you have had three years to reflect on the incidents and that with 22 years of experience you are mentally ready to return to clinical challenges but that you have been ‘in limbo’ pending the outcome of your case. You have not been able to practise as a nurse and the panel did not have any evidence of relevant training undertaken by you to address the concerns.

The panel determined that, given the level of your insight at this stage, and the lack of sufficient steps taken to address the concerns, there remains a risk of repetition. The panel therefore determined that you are liable in the future to act so as to put a patient or patients at unwarranted risk of harm. 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.

However, the panel determined that a finding of impairment on public interest grounds was not necessary. The panel concluded that a fully informed member of the public would not expect a finding of impairment to be made on public interest grounds. The panel was satisfied that the finding of impairment on public protection grounds alone was sufficient in this case.

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

Decisions and reasons on application to adjourn

You made an application to adjourn this hearing. You told the panel that it is going to be simply unrealistic for you to be able to properly prepare and present your case in terms of your responses to the NMC's position on sanction. You stated that you are new to this formal process and have never been in a situation like this and therefore feel you are completely out of your depth.

You told the panel that in order to make this '*a fair playing field'* you would need to be able to properly present your case which involved putting before the panel references from former colleagues and a reflective piece which you have not yet prepared for this stage.

You informed the panel that you also intend on possibly seeking legal advice due to the pace the hearing is currently going at and you feel completely out of your depth in trying to manage and prepare for this hearing. You stated that at this moment, you do not have the resources to be ready before the last day of the hearing.

In response to questions from the panel, you clarified that this is an instance where you understand your career is in jeopardy as the NMC has indicated that they are seeking a striking-off order. You confirmed that you were not expecting this outcome and you now intend seeking some further advice.

In response to further questions, you confirmed that you want to properly address the relevant considerations for the sanction stage and to do this you will need time to obtain the necessary information which will support your case.

You informed the panel that you were not previously aware that supporting documents such as references, testimonials or reflective pieces would have been a relevant consideration for the panel at this stage, but you are aware now. You informed the panel that as you now understand your career is in jeopardy on the basis of the current findings

on misconduct and impairment, you would '*be a fool not to'* request the time to obtain the relevant documentation.

In response to a question from the panel in relation to how long a period of adjournment you are asking for, you indicated that a period of two-weeks and if possible, longer.

Mr Wallis opposed the application on behalf of the NMC. He prefaced the reasons for this as follows: these are adversarial proceedings, that you, because of your lengthy and otherwise unblemished record, do not have familiarity. He submitted that although every effort is made to provide those participating in these proceedings with the information they need, that is not a substitute for proper representation.

Mr Wallis submitted that there is a strong public interest in these proceedings, which have already been adjourned once, being concluded as swiftly as possible. He submitted that the public interest is the key interest which the panel will balance against your interest.

Mr Wallis submitted that this is a case where the NMC says a striking-off order is an appropriate sanction but that this will always be a matter for the panel. He submitted that it is not a surprise to any of the parties that this is a serious case given the nature of the allegations and noted that you were made aware of the NMC's sanction bid from the outset.

Mr Wallis submitted that the panel will no doubt have some sympathy with you and your understanding of what would be required. He submitted that you are able to give evidence at the sanction stage if you so wish and there is no requirement on you to serve a witness statement or a reflective piece.

Mr Wallis submitted that panel would be capable of making reasonable adjustments for an unrepresented registrant.

Mr Wallis submitted that there is no suggestion that you have anything other than an unblemished record. He submitted that, given many of the serious charges in this case have been denied by you, and given the contents of your submissions at the last stage in respect of some of those charges, which seem effectively to still be not accepted by you, the evidence in relation to insight and remediation is perhaps unlikely to shift very much.

Mr Wallis submitted that the panel will no doubt consider the difficulties you face in presenting your own case, which you have done carefully and courteously throughout what have been lengthy proceedings, whilst juggling other important responsibilities. He submitted that these are not improper things to take into account.

Mr Wallis submitted that if this case adjourns at this stage, the NMC cannot suggest, other than the cost of proceedings, that there is any particular prejudice to public safety or the public interest.

Mr Wallis submitted that the panel could conclude that you will be able to put forward your case on the key points as, by virtue of the previous adjournment, you have had sufficient time to prepare for a decision on the facts which, by its very nature, was always potentially adverse.

Mr Wallis submitted that there is a weekend between now and the last day of the hearing and you could potentially use that time to try and gather references. However, he informed the panel that he does not place very much weight on this as he acknowledged the potential difficulties this may create on this hearing concluding on time in any case.

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

In deciding whether or not to adjourn this hearing, the panel considered the relevant factors as set out in Rule 32(4) of the Rules which states:

"32(4) In considering whether or not to grant a request for postponement or adjournment, the Chair or Practice Committee shall, amongst other matters, have regard to -
(a) the public interest in the expeditious disposal of the case;
(b) the potential inconvenience caused to a party or any witnesses to be called by that party; and
(c) fairness to the registrant"

The panel considered the public interest in the expeditious disposal of this case. It noted that this application relates to a relatively short-term adjournment for the purposes of you obtaining further information to put before the panel for its consideration on sanction. The panel determined that the documents you are intending on putting before it will be helpful in terms of allowing the panel to make a more fully informed decision as to what sanction to impose.

The public interest element in the expeditious disposal is outweighed by your interests, given the stage the hearing is at, the length of time elapsed to date since the commencement of this hearing and the three years since the date of the incidents.

The panel next considered the potential inconvenience to people who have made themselves available for this hearing. The panel noted that the witness evidence in this hearing has already been dealt with and therefore determined that an adjournment of this hearing, at this stage, will not cause inconvenience to any of the parties.

The panel considered fairness to you.

The panel noted that the sanction sought by the NMC is that of a striking-off order, which is the most severe sanction available to it. It took into account that the notice of hearing had informed you that this was the sanction the NMC was seeking. The panel considered that you may have anticipated different outcomes at the previous stages of the hearing because of the charges which were found not proved. As a consequence, you are

unprepared for the hearing as it is now. The panel is of the view that all registrants have a responsibility to be prepared for their fitness to practise hearings and, particularly given the period of time that these matters have been live for, the onus is on you as the registrant to have been more prepared.

The panel took into account that you are an unrepresented registrant and have described feeling '*out of your depth'*. These proceedings are unfamiliar territory for you and that you have explained you are '*learning as you go'*. You have had a long-standing career as a nurse and the NMC are seeking the most severe of sanctions. It determined that, in fairness to you, if you are able to gain access to legal advice to support your current position, obtain and present references, testimonials and a reflective piece and any other supporting information which you feel may assist your case, then you should be afforded the opportunity to do so.

The panel therefore determined to accede to the application to adjourn this hearing. This hearing will resume at 09:30 on Monday 3 June 2024 (for two days).

In order to ensure the expeditious conclusion of this hearing, the panel directs that any documents you wish to put before the panel (such as a reflective piece, references, testimonials or other evidence of your personal circumstances) must be provided to the NMC in advance so that they can be given to the panel in good time. <u>These must be provided to your case officer by 4pm on Wednesday 29 May 2024.</u>

In accordance with Rule 32(5), the panel considered whether or not it was required to impose an interim order. However, the panel was already aware due to the previous period of adjournment that an interim order is in place upon your registration and therefore did not give this matter further consideration.

The hearing resumed on Monday, 3 June 2024

Decision and reasons on proceeding in the absence of Mr Hamilton

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

Mr Kabasinskas referred the panel to the email from Mr Hamilton dated 3 June 2024 at 1:15am. Mr Hamilton had provided the panel with his written closing statement in relation to his case.

Mr Kabasinskas submitted that this hearing was listed in Mr Hamilton's presence and for his convenience following his request for an adjournment at the end of the impairment stage. Therefore, Mr Hamilton was aware of this hearing.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mr Hamilton. In reaching this decision, the panel has considered the submissions of Mr Kabasinskas and the advice of the legal assessor. The panel were made aware of the email communication between the case officer and Mr Hamilton that resulted in his final written closing statement. The panel took from this closing statement that Mr Hamilton would not wish to participate further in these proceedings. It has had particular regard to the factors set out in the decision of *R v*

Jones and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Hamilton;
- Mr Hamilton has engaged with the NMC but has not responded to any of the emails sent to him about this hearing day;
- There is no reason to suppose that adjourning would secure his attendance at some future date.

There is some disadvantage to Mr Hamilton in proceeding in his absence. Furthermore, the limited disadvantage is the consequence of Mr Hamilton's decisions to absent himself from the hearing, waive his rights to attend and to not provide evidence or make submissions on his own behalf. The panel considered that it could minimise any disadvantage to Mr Hamilton by ensuring that it took account of his earlier submissions when considering sanction.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Hamilton.

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 Hamilton off the register. The effect of this order is that the NMC register will show that Mr Hamilton 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.

Submissions on sanction

Mr Kabasinskas addressed the panel providing detailed submissions that included reference to earlier written submissions provided by the previous case presenter. These had been sent to Mr Hamilton.

Mr Kabasinskas informed the panel that the NMC was seeking a strike-off order.

Mr Kabasinskas invited the panel to consider the NMC's guidance on *'Factors to consider before deciding on sanctions'* reference: SAN-1.

Mr Kabasinskas outlined the aggravating features and submitted that there are no mitigating features in his case.

Mr Kabasinskas submitted that no order or a caution order would be insufficient in Hamilton's case given the seriousness of his case.

Mr Kabasinskas submitted that there are no workable or practicable conditions that can be formulated to address elements of dishonesty through a conditions of practice order. He further submitted that there are also elements of deep-seated attitudinal concerns in Mr Hamilton's case.

Mr Kabasinskas invited the panel to consider the NMC's guidance on *'Considering sanctions for serious cases'* reference: SAN-2. He referred the panel to the section of *'Cases involving dishonesty'*. He further submitted that allegations relating to dishonesty will always be serious, and a nurse who has acted in a dishonest manner will always be at some risk of being removed from the register.

Mr Kabasinskas drew the panel's attention in great detail to the cases of *Sawati v GMC* [2022] EWHC 283 and *PSA v NMC and Jalloh* [2023] EWHC 3331.

Mr Kabasinskas submitted that if the panel is of the view that a striking-off order is either unnecessary or disproportionate, he invited the panel to consider the NMC's guidance on *'Suspension order'* reference: SAN-3d where a checklist was provided.

Mr Kabasinskas submitted that a striking-off order is the only sanction sufficient to protect patients, members of the public and to maintain professional standards.

The panel had regard to Mr Hamilton's written closing statement which he provided on 3 June 2024 at 1:15am. In order to be as fair as possible to Mr Hamilton in his absence, the panel also looked back at his previous submissions when considering sanction.

Decision and reasons on sanction

Having found Mr Hamilton'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:

- Limited insight into failings
- Multiple failings covering a range of different concerns
- A pattern of misconduct over a 7 day period
- Conduct which put patients at risk of harm.

The panel also took into account the following mitigating features:

- Early admission to some allegations
- Personal mitigation
    - Returning to a previous role without supernumerary period
    - [PRIVATE]
    - Working environment during Covid-19

The panel also looked for and took into account evidence of good practice.

It considered Witness 1's witness statement in which he made comments on Mr Hamilton's practice.

"On 4th November 2019 Mark was seconded as a Band 7 Practice Development Nurse to the Emergency Department ("ED") for 18 months where he was an educational practitioner whilst working in a clinical role."

…

"There were no concerns in relation to Mark's clinical performance before the alleged concerns below were raised."

…

Witness 6 stated in her written statement:

"Like I said at the start, Mark was a fantastic nurse before he went on secondment to the Emergency Department but when he came back, he was different, he was still good according to me but I don't know if others would say so. I think what has happened in relation to this NMC referral was a shock to most people. That he did something like he did, and all this has come off it. I am not in touch with him since it all happened".

Turning to insight, the panel revisited its findings on impairment and its conclusion that Mr Hamilton had shown limited insight. The panel found no new evidence of further insight from Mr Hamilton's written closing statement.

As required by Article 29(3) of the Nursing & Midwifery Order 2001, the panel first considered (pursuant to Article 29(4)) whether to undertake mediation or to take no further action. The panel considered that both of these would be inappropriate as neither would restrict Mr Hamilton's practice. The public would therefore not be appropriately protected.

The panel then moved on to consider the available sanctions, as set out in Article 29(5). The panel determined that a caution order would be inappropriate as it would also not restrict Mr Hamilton's practice and would not provide appropriate protection to the public.

The panel next considered whether placing conditions of practice on Mr Hamilton'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 range and serious nature of the findings. The misconduct in this case includes dishonesty and deep-seated attitudinal concerns which are not something that could be easily addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Hamilton's registration 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 suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

Mr Hamilton stated in his evidence that some of the failings were bad practice. However, in considering the failings collectively, the panel recognised a theme which it would describe as dangerous practice. Diazepam was administered without clinical justification, and improperly and inaccurately calculated and recorded. Furthermore, Mr Hamilton made wholly inappropriate comments regarding the administration of medication without justification. Patients under Mr Hamilton's care were left unattended, on one occasion perhaps for as long as an hour and a half. Mr Hamilton removed and consumed medication belonging to the Trust which was dishonest.

The catalogue of serious misconduct over seven days represented multiple significant departures from the standards expected of a registered nurse and put patients at risk. Honesty is a fundamental element in nursing practise so allegations of dishonesty will always be serious. However, not all dishonesty is equally serious.

The panel considered that whilst Mr Hamilton's dishonesty was repeated, for personal advantage and during his professional practice, it was opportunistic and small scale so was at the lower end of the spectrum. However, when considering the findings together, the panel concluded that there was a pattern of deep-seated attitudinal concerns which raised fundamental questions about Mr Hamilton's professionalism. Administering Diazepam without clinical justification despite having the CIWA tool available, showed a deliberate disregard for patient safety, as did leaving the ward unattended. A further area considered by the panel to be a very concerning attitudinal issue was the making of wholly inappropriate comments. The panel decided that public confidence in the profession would not be maintained if Mr Hamilton remained 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 Hamilton'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 particular case demonstrate that Mr Hamilton's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Hamilton'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.

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

This will be confirmed to Mr Hamilton in writing.

Submissions on interim order

The panel took account of the submissions made by Mr Kabasinskas. He submitted that, due to the panel making a strike-off order, an interim order was required to protect the public and the public interest. Mr Kabasinskas invited the panel to make an interim suspension order for a period of 18 months.

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. In reaching the decision to impose an interim order, the panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order namely that Mr Hamilton's misconduct was fundamentally incompatible with him remaining on the register.

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 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that 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 Hamilton is sent the decision of this hearing in writing.

That concludes this determination.