Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 30 April 2024 – Friday, May 10 2024
Monday, 20 May 2024 – Thursday, 23 May 2024
Tuesday, 28 May 2024 – Friday, 14 June 2024

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Muriel Masih**
NMC PIN	84Y0009O
Part(s) of the register:	Registered Nurse – RN1, Adult Nurse (August 1984)
Relevant Location:	Middlesex
Type of case:	Misconduct
Panel members:	Philip Sayce (Chair, registrant member) Richard Luck (Registrant member) Margaret Jolley (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Muminah Hussain
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Mrs Masih:	Not present and unrepresented
Facts proved:	Charges 1, 3(a), 3(b), 4(a), 4(b), 5(a), 5(b), 5(c), 5(d), 5(e), 5(f), 5(g), 5(h), 6, 7, 8, 9, 10, 11(a), 11(b), 12, 13(a), 13 (b), 14, 15, 16, 17, 18, 19(a), 19(b), 20, 21(a), 21(b), 22 & 23
Facts not proved:	Charge 2 (fell away), 11(c) & 19(c)
Fitness to practise:	Impaired

Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Masih was not in attendance and that the Notice of Hearing letter had been sent to Mrs Masih's registered email address by secure email on 28 March 2024.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Masih's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Masih

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

Mr Radley referred the panel to the email from Mrs Masih dated 11 April 2024 which stated that she would not be attending her 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 Mrs Masih. In reaching this decision, the panel has considered the submissions of Mr Radley and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Masih;
- Mrs Masih has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Witnesses have attended to give live evidence throughout the hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2021;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Masih in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will

not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Masih's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

That you a registered nurse;

In relation to Resident A, being the Nurse in Charge on duty between the 23 and 24 May 2021;

1. Failed to conduct observations and/or ensure that observations were carried out on Resident A between 23.10 and 03.00.

2. In the alternative to charge 1, having conducted observations on Resident A between 23.10 and 03.00 failed to document such observations in Resident A's daily notes/logs.

3. Having discovered that Resident A was missing from their room, incorrectly declared;

    a. On the accident and incident reporting record that Resident A had *'absconded for half an hour'* or words to that effect.

b. Within Resident A's daily logs that *'Resident A was absconded from approximately 03.00 for half an hour'* or words to that effect.

4. Your declarations in charge 3 were misleading and/or dishonest in that you wanted others to believe that:
   a. Resident A had been missing for a short period of time when you knew that this was not true.
   b. Observations had been carried out hourly on Resident A prior to the discovery that Resident A had gone missing when you knew that this was not true.

5. Having completed the accident and incident reporting record dated 24 May 2021 failed to document on the record:
   a. Where Resident A was last seen.
   b. Who last saw Resident A.
   c. The time that Resident A was last seen.
   d. The names of the staff that assisted in searching for Resident A.
   e. How Resident A was feeling once found.
   f. How Resident A could have gained access to the garden where they were found.
   g. That Resident A's family are to be contacted about the incident.
   h. That the Manager was contacted or should be contacted regarding the incident.

In relation to Resident B:

6. On 8 July 2021 failed to administer Lansoprazole 30mg to Resident B.

7. On 8 July 2021 incorrectly documented in Resident B's MAR chart that Lansoprazole 30mg had been administered to them when it had not.

8. Your actions in charge 7 were dishonest in that you was attempting to create a misleading impression that the medication had been administered to Resident B when it had not.

9. On 8 July 2021 incorrectly declared to Colleague 2 that you had administered Lansoprazole 30mg to Resident B.

10. Your declaration in charge 9 were dishonest in that you were attempting to mislead Colleague 2 that you had administered the medication to Resident B when you knew that you had not.

11. On 8 July 2021 having not administered Lansoprazole 30mg to Resident B failed to:
    a. Document on the MAR chart the reason why the medication had not been administered to Resident B.
    b. To destroy the medication.
    c. Document in the medication waste book that the medication had been destroyed.

12. On 21 July 2021 during a telephone interview with Colleague 1 incorrectly declared to them that you had, *'administered Resident B's medication before signing their MAR chart'* or words to that effect.

13. Your declaration in charge 12 were dishonest in that you were attempting to mislead Colleague 1 that:
    a. You had administered the medication to Resident B when you knew that you had not, and/or
    b. You had followed the correct process when administering medication to Resident B when you had not.

In relation to Resident C:

14. On 8 July 2021 failed to administer Levothyroxine 100mg to Resident C.

15. On 8 July 2021 incorrectly documented in Resident C's MAR chart that Levothyroxine 100mg had been administered to them when it had not.

16. Your actions in charge 14 were dishonest in that you were attempting to create a misleading impression that the medication had been administered to Resident C when it had not.

17. On 8 July 2021 incorrectly declared to Colleague 2 that you had administered Levothyroxine 100mg to Resident C.

18. Your declaration in charge 17 were dishonest in that you were attempting to mislead Colleague 2 that you had administered the medication to Resident C when you knew that you had not.

19. On 8 July 2021 having not administered Levothyroxine 100mg to Resident C failed to:
    a. Document on the MAR chart the reason why the medication had not been administered to Resident C.
    b. To destroy the medication.
    c. Document in the medication waste book that the medication had been destroyed.

20. On 21 July 2021 during a telephone interview with Colleague 1 incorrectly declared to them that you had, *'administered Resident C's medication before signing their MAR chart'* or words to that effect.

21. Your declaration in charge 20 were dishonest in that you was attempting to mislead Colleague 1 that:

a. You had administered the medication to Resident C when you knew that you had not, and/or
b. You had followed the correct process when administering medication to Resident C.

22. On 8 July 2021 incorrectly declared in Resident C's daily notes/logs that you had administered Levothyroxine 100mg to Resident C when it had not.

23. Your declaration in charge 22 was dishonest in that you were attempting to mislead others who read Resident C's daily notes/logs that the medication had been administered to Resident C when you knew that it had not.

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

Decision and reasons on application to amend the charge

The panel proposed to amend charges 10, 13, 16, 18, 21 and 23.

The proposed amendment was to correct a grammatical error. It was submitted by Mr Radley that the proposed amendment would provide clarity and more accurately reflect the evidence.

> "That you a registered nurse;
>
> In relation to Resident A, being the Nurse in Charge on duty between the 23 and 24 May 2021;
>
> …

10. Your declaration in charge 9 were dishonest in that you ~~was~~ **were** attempting to mislead Colleague 2 that you had administered the medication to Resident B when you knew that you had not.

…

13. You**r** declaration in charge 12 were dishonest in that you ~~was~~ **were** attempting to mislead Colleague 1 that:…

…

16. Your actions in charge 14 were dishonest in that you ~~was~~ **were** attempting to create a misleading impression that the medication had been administered to Resident C when it had not.

…

18. Your declaration in charge 17 were dishonest in that you ~~was~~ **were** attempting to mislead Colleague 2 that you had administered the medication to Resident C when you knew that you had not.

…

21. You**r** declaration in charge 20 ~~was~~ **were** dishonest in that you was attempting to mislead Colleague 1 that…

…

23. Your declaration in charge 22 was dishonest in that you ~~was~~ **were** attempting to mislead others who read Resident C's daily notes/logs

that the medication had been administered to Resident C when you knew that it had not."

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Masih 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 ensure clarity and accuracy.

Background

The charges arose whilst Mrs Masih was employed as a registered nurse by Fern Gardens Care Home (the Home). There are three separate incidents which relate to three different residents.

Between 23 and 23 May 2021, Resident A went missing from their room and was discovered in the garden of the home around 03:55 on 24 May. The resident was unsupervised and it was raining. Mrs Masih allegedly checked on Resident A at 03:00 which is when she discovered Resident A missing.

It is alleged that Mrs Masih failed to ensure that checks on Resident A were conducted, and if such checks were carried out, that the checks were not documented.

Mrs Masih accepts that as she was the nurse in charge, the overall responsibility lay with her.

The second and third incidents both occurred on 8 July 2021, when Mrs Masih allegedly failed to administer Lansoprazole to Resident B, and Levothyroxine to Resident C. It is

alleged that Mrs Masih signed the MAR chart indicating that the medication had been given to both Resident B and Resident C.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Masih.

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: Regional Support Manager at Bond Care (at the time of the incidents)
- Witness 2: Deputy Home Manager for Fern Gardens (at the time of the incidents)
- Witness 3: Social Worker for the London Borough of Hounslow (at the time of the incidents)
- Witness 4 Social Worker for the London Borough of Hounslow (at the time of the incidents)

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC.

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

Charge 1

"That you a registered nurse;

In relation to Resident A, being the Nurse in Charge on duty between the 23 and 24 May 2021;

1. Failed to conduct observations and/or ensure that observations were carried out on Resident A between 23.10 and 03.00."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's written statement and oral evidence, Witness 3's written statement and oral evidence, and Resident A's care notes.

Witness 1's written statement reads:

> *"…it is evident, from Resident A's daily logs, that hourly checks had not been conducted on Resident A that night, as no one immediately noticed when the resident absconded from the Home. There is nothing documented on Resident A's daily logs past 23:00, by any member of staff, to state that hourly checks had been conducted on Resident A during the time the resident absconded."*

Witness 3's written statement reads:

> *"I also made further enquiries within the Home regarding where they looked for Resident A, how the Home's staff did not notice that Resident A was missing and what processes should have been followed … [Witness 1] was responding to all the queries."*

Witness 1 and Witness 3's oral evidence corroborated this.

The panel accepted that Mrs Masih had a duty to check on Resident A. It looked at Resident A's care notes and noted that on previous nights, Resident A was checked on hourly, however between 23:00 on 23 May and 03:00 on 24 May, the care notes had not been filled in.

The panel therefore finds charge 1 proved.

Charge 2

"That you a registered nurse;

In relation to Resident A, being the Nurse in Charge on duty between the 23 and 24 May 2021;

2. In the alternative to charge 1, having conducted observations on Resident A between 23.10 and 03.00 failed to document such observations in Resident A's daily notes/logs."

This charge falls away.

In reaching this decision, the panel took into account that charge 1 is proved. The panel determined that observations had not been carried out on Resident A, therefore there were no observations to document.

Charge 3(a) and 3(b)

"That you a registered nurse;

In relation to Resident A, being the Nurse in Charge on duty between the 23 and 24 May 2021;

3. Having discovered that Resident A was missing from their room, incorrectly declared;

    a. On the accident and incident reporting record that Resident A had *'absconded for half an hour'* or words to that effect.
    b. Within Resident A's daily logs that *'Resident A was absconded from approximately 03.00 for half an hour'* or words to that effect."

This charge is found proved in its entirety.

In reaching this decision, the panel took into account Witness 1's written statement and oral evidence, Witness 2's written statement and oral evidence, and Mrs Masih's email dated 11 October 2021.

Witness 1's written statement reads:

> *"Resident A was found in the garden in the rain at 04:00 on 24 May 2021. The Nurse had not noticed that Resident A had absconded from the Home, until 03:00, after which they, and other members of staff in the Home, began looking for the resident."*

Witness 2's written statement reads:

> *"…the Nurse called me around 01:00/02:00 on 24 May 2021 … The Nurse informed me over the call that she had been looking for Resident A, who had gone missing …"*

Both Witness 1 and Witness 2's oral evidence corroborated this.

Mrs Masih's email dated 11 October 2021 stated:

> *"Around 3am, when I went round the unit again, I noticed that Resident A wasn't in her room this time."*

The panel noted that the incident report recorded that Resident A had *'absconded for half an hour'*, and Resident A's daily logs stated that *'Resident A was absconded from approximately 03:00 for half an hour.'*

The panel determined that Witness 1 and Witness 2 gave cogent evidence. It noted that Mrs Masih called Witness 2 around 01:00 and 02:00 on the morning of 24 May 2021, and Resident A was found around 04:00. On this alone, the panel determined that Mrs Masih incorrectly declared that Resident A had absconded for only half an hour.

Witness 2 had informed the panel that as there were no care notes for Resident A after 23:10, Mrs Masih could not have been certain that Resident A had only *'absconded for half an hour'*.

The panel determined that Mrs Masih had incorrectly declared that Resident A had *'absconded for half an hour'* on the accident and incident report, and also that *'Resident A was absconded from approximately 03.00 for half an hour'* on Resident A's daily records.

The panel therefore finds charge 3 proved in its entirety.

Charge 4(a) and 4(b)

"That you a registered nurse;

In relation to Resident A, being the Nurse in Charge on duty between the 23 and 24 May 2021;

4. Your declarations in charge 3 were misleading and/or dishonest in that you wanted others to believe that:

    a. Resident A had been missing for a short period of time when you knew that this was not true.
    b. Observations had been carried out hourly on Resident A prior to the discovery that Resident A had gone missing when you knew that this was not true."

These charges are found proved.

In reaching this decision, the panel took into account Witness 2's written statement and oral evidence, the accident and incident report and Mrs Masih's email dated 11 October 2021.

Witness 2's written statement reads:

> *"…the Nurse called me around 01:00/02:00 on 24 May 2021 … The Nurse informed me over the call that she had been looking for Resident A, who had gone missing …"*

Mrs Masih's email dated 11 October 2021 stated:

“Around 3am, when I went round the unit again, I noticed that Resident A wasn’t in her room this time.”

The panel was of the view that Mrs Masih minimised the amount of time that Resident A was missing in an attempt to be misleading. The panel determined that Mrs Masih’s declarations in charge 3 were misleading and dishonest.

In relation to charge 4(b), the panel noted its findings in charge 1, which were that observations had been carried out on Resident A between 23:10 and 03:00, and determined that Mrs Masih was dishonest.

The panel took into account what an honest and decent person would do in this situation. It also referred to the case of *Ivey v Genting Casinos* [2018] A.C.391.

The panel firstly ascertained the subjective state of Mrs Masih’s knowledge or beliefs as to the facts and the reasonableness of his belief. The panel determined that Mrs Masih knew that by misrepresenting how long Resident A had been missing, the facts around the resident would not be accurate.

The panel then went on to determine whether Mrs Masih’s conduct was dishonest by applying the objective standards of ordinary decent people. The panel determined that an ordinary and decent person would know that by intentionally providing a misleading account about this incident, this would be dishonest.

The panel therefore finds charge 4 in its entirety proved.

Charge 5

“That you a registered nurse;

In relation to Resident A, being the Nurse in Charge on duty between the 23 and 24 May 2021;

5. Having completed the accident and incident reporting record dated 24 May 2021 failed to document on the record:

a. Where Resident A was last seen.
b. Who last saw Resident A.
c. The time that Resident A was last seen.
d. The names of the staff that assisted in searching for Resident A.
e. How Resident A was feeling once found.
f. How Resident A could have gained access to the garden where they were found.
g. That Resident A's family are to be contacted about the incident.
h. That the Manager was contacted or should be contacted regarding the incident."

This charge is found proved in its entirety.

In reaching this decision, the panel took into account Resident A's incident report and Witness 2's oral evidence.

The panel noted that Mrs Masih filled in the incident report, and it was missing:

- Where Resident A was last seen.
- Who last saw Resident A.
- The time that Resident A was last seen.
- The names of the staff that assisted in searching for Resident A.
- How Resident A was feeling once found.
- How Resident A could have gained access to the garden where they were found.
- That Resident A's family are to be contacted about the incident.

From the evidence before it, the panel noted that Resident A was last seen in her room at 23:10 on 23 May 2021, Mrs Masih was the last person to see Resident A before she was noted as missing, there are no names of staff who assisted in searching for Resident A, there is no evidence that Resident A was asked how they were feeling, there was no evidence to suggest how Resident A accessed the garden where they were found, and no evidence to suggest Resident A's family had been contacted about the incident.

The panel was of the view that it would have been reasonable to ask Resident A how they had been feeling after the incident, however there is no documentation to suggest that this had taken place. The incident form reports only on Resident A's physical health, and not their mental health.

Witness 2 was asked if she knew how Resident A accessed the garden and informed the panel that:

> *"The garden door has a lock with a code, when it is opened without the code a small alarm goes off. I'm not sure how Resident A got out."*

The panel determined that Mrs Masih had failed to document vital information on the incident report form in accordance with the Home's missing person policy.

The panel therefore finds charge 5 proved in its entirety.

Charges 6 and 7

"That you a registered nurse;

In relation to Resident B:

6. On 8 July 2021 failed to administer Lansoprazole 30mg to Resident B.

7. On 8 July 2021 incorrectly documented in Resident B's MAR chart that Lansoprazole 30mg had been administered to them when it had not."

These charges are found proved.

In reaching this decision, the panel took into account Witness 1's written statement, Witness 2's written statement and oral evidence, Resident B's MAR chart and Witness 1's interview notes dated 21 July 2021.

Witness 1's written statement reads:

> *"On 8 July 2021, [Witness 2], came on duty that morning and found that the Nurse had not administered Resident B and C their morning medication … the Nurse had potted Resident B and C's medication, ready to give, which the Nurse had left on the medication trolley in the treatment room. When [Witness 2] checked the residents' MAR chart, they noticed that the Nurse had signed to say that the medication had been administered."*

Witness 2' written statement reads:

> *"… I noticed that the Nurse had failed to administer Resident B their morning medication of 30mg Lansoprazole… During my check, I also found Resident B's medication in the clinic room which had been popped out, and signed for, but not administered to the Resident. On Resident B's MAR chart, the Nurse has signed to say she has administered the residents Lansoprazole on 8 July 2021."*

The panel had sight of Resident B's MAR chart and determined that on 8 July 2021, Mrs Masih had signed it indicating that Resident B had been given their medication of Lansoprazole.

Witness 1's interview notes dated 21 July 2021 stated:

> *"Resident B meds was signed but not given. Found medication in treatment room, Lansoprazole. CD (Controlled Drug) not given and not signed as well."*

Witness 2 also corroborated this in her oral evidence.

The panel therefore finds charges 6 and 7 proved.

Charge 8

"That you a registered nurse;

In relation to Resident B:

8. Your actions in charge 7 were dishonest in that you were attempting to create a misleading impression that the medication had been administered to Resident B when it had not."

This charge is found proved.

In reaching this decision, the panel took into account what an ordinary decent person would do, and referred itself to *Ivey v Genting Casinos*.

The panel was of the view that Mrs Masih did give the impression that Lansoprazole had been given to Resident B through signing the MAR chart, when she knew it hadn't been. The panel determined that an ordinary decent person would find this to be misleading and dishonest.

The panel firstly ascertained the subjective state of Mrs Masih's knowledge or beliefs as to the facts and the reasonableness of his belief. The panel determined that Mrs Masih knew

that by signing for the medication, Mrs Masih misrepresented the facts around the medication administration.

The panel then went on to determine whether Mrs Masih's conduct was dishonest by applying the objective standards of ordinary decent people. The panel determined that an ordinary and decent person would know that by intentionally providing a misleading account about this incident, this would be dishonest.

The panel therefore finds charge 8 proved.

Charge 9

"That you a registered nurse;

In relation to Resident B:

9. On 8 July 2021 incorrectly declared to Colleague 2 that you had administered Lansoprazole 30mg to Resident B."

This charge is found proved.

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

Witness 2's written statement reads:

> *"The Nurse informed me that all of the residents had been administered their morning medication."*

This was confirmed in Witness 2's oral evidence.

The panel therefore finds charge 9 proved.

Charge 10

“That you a registered nurse;

In relation to Resident B:

10. Your declaration in charge 9 were dishonest in that you were attempting to mislead Colleague 2 that you had administered the medication to Resident B when you knew that you had not.”

This charge is found proved.

In reaching this decision, the panel took into account what an ordinary decent person would do, and referred itself to *Ivey v Genting Casinos*.

The panel was of the view that Mrs Masih did attempt to mislead Witness 2 in her declaration, when she knew the medication had not been administered to Resident B. The panel determined that an ordinary decent person would find this to be misleading and dishonest.

The panel firstly ascertained the subjective state of Mrs Masih’s knowledge or beliefs as to the facts and the reasonableness of his belief. The panel determined that Mrs Masih knew that by making the statement to Witness 2 that medication had been administered to Resident B, Mrs Masih misrepresented the facts around the medication administration.

The panel then went on to determine whether Mrs Masih’s conduct was dishonest by applying the objective standards of ordinary decent people. The panel determined that an ordinary and decent person would know that by intentionally providing a misleading account about this incident, this would be dishonest.

The panel therefore finds charge 10 proved.

Charges 11(a) and 11(b)

"That you a registered nurse;

In relation to Resident B:

11. On 8 July 2021 having not administered Lansoprazole 30mg to Resident B failed to:

    a. Document on the MAR chart the reason why the medication had not been administered to Resident B.
    b. To destroy the medication."

These charges are found proved.

In reaching this decision, the panel took into account Witness 1's written statement, Witness 2's written statement and Resident B's MAR chart.

Witness 1's written statement reads:

> *"… the nurse should have made a record of the failed attempt, and destroyed the medication. The process of destroying the medication is to first of all to record it in the MAR chart that the medication was destroyed due to being refused."*

Witness 2's written statement reads:

"As a result, the next person on duty was not aware that Resident B and C had missed their morning medication, therefore it was serious that the Nurse had not made accurate records."

The panel had sight of Resident B's MAR chart, and determined that Mrs Masih did not document on the MAR chart the reason why medication had not been administered to Resident B. The panel further determined that the records on the MAR chart do not document medication being destroyed.

The panel therefore determined that it was reasonable to suggest that the medication had not been administered, and had not been destroyed after being administered. The panel reminded itself of Witness 2's oral evidence in which she informed the panel that she had seen Resident B's medication on 8 July 2021, in the clinic room.

The panel therefore finds charges 11(a) and 11(b) proved.

Charge 11(c)

"That you a registered nurse;

In relation to Resident B:

11. On 8 July 2021 having not administered Lansoprazole 30mg to Resident B failed to:

    c. Document in the medication waste book that the medication had been destroyed."

This charge is found NOT proved.

In reaching this decision, the panel took into account witness 1's written statement.

Witness 1's written statement reads:

> *"The process of destroying the medication is to first of all to record it in the MAR chart that the medication was destroyed due to being refused. Then take it to the medication waste, put it in the medication waste, and then record in a medication waste book (which you record what you have destroyed)."*

The panel noted that it had no medicine waste book before it. The panel determined that due to finding that Mrs Masih had not destroyed the medication in charge 11(b), there would be no reasonable reason as to why she should document in the medication waste book that the medication had been destroyed.

The panel therefore finds charge 11(c) not proved.

Charge 12

"That you a registered nurse;

In relation to Resident B:

12. On 21 July 2021 during a telephone interview with Colleague 1 incorrectly declared to them that you had, *'administered Resident B's medication before signing their MAR chart'* or words to that effect."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's written statement and oral evidence, and the telephone interview notes dated 21 July 2021.

Witness 1's written statement reads:

"The Nurse was defensive about their actions, and the Nurse would change their narrative of what happened on 8 July 2021, from that they said that they had given Resident B and C their medication and then signed their MAR charts, to that they had not given the medication but still had signed the MAR chart …"

The telephone interview notes dated 21 July 2021 stated:

"MM: I did not give Resident B medications and both medications were taken already.

[W1]: Please confirm if you have given Resident B meds.

MM: Yes, I did give Resident B medication and signed them."

Witness 1's oral evidence corroborated this.

The panel determined that on the balance of probabilities, Mrs Masih did incorrectly declare that she had *'administered Resident B's medication before signing their MAR chart'* or words to that effect.

The panel therefore finds charge 12 proved.

Charges 13(a) and (b)

"That you a registered nurse;

In relation to Resident B:

13. Your declaration in charge 12 were dishonest in that you were attempting to mislead Colleague 1 that:

a. You had administered the medication to Resident B when you knew that you had not, and/or
b. You had followed the correct process when administering medication to Resident B when you had not."

These charges are found proved.

In reaching this decision, the panel took into account what an ordinary decent person would do, and referred itself to *Ivey v Genting Casinos*.

The panel reminded itself of the evidence found proved in charges 11 and 12. It was of the view that Mrs Masih did attempt to mislead Witness 1 in her declaration, when she knew the medication had not been administered to Resident B. The panel determined that an ordinary decent person would find this to be misleading and dishonest.

In relation to charge 13(b), the panel determined that you did not follow the correct protocol when administering medication to Resident B, given that you did not document in the MAR chart why medication was not given, did not destroy the medication that was not given and subsequently did not fill in the medication waste book.

The panel firstly ascertained the subjective state of Mrs Masih's knowledge or beliefs as to the facts and the reasonableness of his belief. The panel determined that Mrs Masih knew that by signing that she had administered the medication, she misrepresented the facts around the medication administration.

The panel then went on to determine whether Mrs Masih's conduct was dishonest by applying the objective standards of ordinary decent people. The panel determined that an ordinary and decent person would know that by intentionally providing a misleading account about this incident, this would be dishonest.

The panel therefore finds charge 13 proved in its entirety.

Charges 14 and 15

"That you a registered nurse;

In relation to Resident C:

14. On 8 July 2021 failed to administer Levothyroxine 100mg to Resident C.

15. On 8 July 2021 incorrectly documented in Resident C's MAR chart that Levothyroxine 100mg had been administered to them when it had not."

These charges are found proved.

In reaching this decision, the panel took into account Witness 1's written statement, Witness 2's written statement and oral evidence, and Resident C's MAR chart.

Witness 1's written statement reads:

> *"On 8 July 2021, [Witness 2], came on duty that morning and found that the Nurse had not administered Resident B and C their morning medication … the Nurse had potted Resident B and C's medication, ready to give, which the Nurse had left on the medication trolley in the treatment room. When [Witness 2] checked the residents' MAR chart, they noticed that the Nurse had signed to say that the medication had been administered."*

Witness 2's written statement reads:

"During my walk around, when I went to check in on Resident C, the resident complained to me that the Nurse had not given the resident their morning medication, Levothyroxine.

… When I checked Resident C's Medication Administration Record ("MAR") chart, which is kept in the clinical room, I saw that the Nurse had signed to say that she had administered Resident C their medication."

The panel had sight of Resident C's MAR chart and determined that Mrs Masih had signed that Levothyroxine had been given on 8 July 2021 when it had not been.

The panel therefore finds charges 14 and 15 proved.

Charge 16

"That you a registered nurse;

In relation to Resident C:

16. Your actions in charge 14 were dishonest in that you were attempting to create a misleading impression that the medication had been administered to Resident C when it had not."

This charge is found proved.

In reaching this decision, the panel took into account what an ordinary decent person would do, and referred itself to *Ivey v Genting Casinos*.

The panel reminded itself of the evidence found proved in charges 14 and 15. It was of the view that Mrs Masih did attempt to mislead when she knew the medication had not been

administered to Resident C. The panel determined that an ordinary decent person would find this to be misleading and dishonest.

The panel firstly ascertained the subjective state of Mrs Masih's knowledge or beliefs as to the facts and the reasonableness of his belief. The panel determined that Mrs Masih knew that by signing for the administration of the medication, she misrepresented the facts around the medication administration.

The panel then went on to determine whether Mrs Masih's conduct was dishonest by applying the objective standards of ordinary decent people. The panel determined that an ordinary and decent person would know that by intentionally providing a misleading account about this incident, this would be dishonest.

The panel therefore finds charge 16 proved.

Charge 17

"That you a registered nurse;

In relation to Resident C:

17. On 8 July 2021 incorrectly declared to Colleague 2 that you had administered Levothyroxine 100mg to Resident C."

This charge is found proved.

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

Witness 2's oral evidence reads:

"The Nurse informed me that all of the residents had been administered their morning medication."

This was confirmed in Witness 2's oral evidence.

The panel therefore finds charge 17 proved.

Charge 18

"That you a registered nurse;

In relation to Resident C:

18. Your declaration in charge 17 were dishonest in that you were attempting to mislead Colleague 2 that you had administered the medication to Resident C when you knew that you had not."

This charge is found proved.

In reaching this decision, the panel took into account what an ordinary decent person would do, and referred itself to *Ivey v Genting Casinos*.

The panel was of the view that Mrs Masih did attempt to mislead Witness 2 in her declaration, when she knew the medication had not been administered to Resident C. The panel determined that an ordinary decent person would find this to be misleading and dishonest.

The panel firstly ascertained the subjective state of Mrs Masih's knowledge or beliefs as to the facts and the reasonableness of his belief. The panel determined that Mrs Masih knew that by signing for administration of the medication, she misrepresented the facts around the medication administration.

The panel then went on to determine whether Mrs Masih's conduct was dishonest by applying the objective standards of ordinary decent people. The panel determined that an ordinary and decent person would know that by intentionally providing a misleading account about this incident, this would be dishonest.

The panel therefore finds charge 18 proved.

Charges 19(a) and 19(b)

"That you a registered nurse;

In relation to Resident C:

19. On 8 July 2021 having not administered Levothyroxine 100mg to Resident C failed to:

a. Document on the MAR chart the reason why the medication had not been administered to Resident C.
b. To destroy the medication."

These charges are found proved.

In reaching this decision, the panel took into account Witness 1's written statement, Witness 2's written statement, Resident C's MAR chart and the photo of Levothyroxine.

Witness 1's written statement reads:

> *"… the nurse should have made a record of the failed attempt, and destroyed the medication. The process of destroying the medication is to first of all to record it in the MAR chart that the medication was destroyed due to being refused."*

Witness 2's written statement reads:

> *"As a result, the next person on duty was not aware that Resident B and C had missed their morning medication, therefore it was serious that the Nurse had not made accurate records."*

The panel had sight of Resident C's MAR chart, and determined that Mrs Masih did not document on the MAR chart the reason why medication had not been administered to Resident C. The panel further determined that the records on the MAR chart do not document medication being destroyed. The panel had a picture of Levothyroxine in a pot in its evidence bundle which was taken by Witness 2, clearly not destroyed.

The panel therefore determined that it was reasonable to suggest that the medication had not been administered, and had not been destroyed after being administered. The panel reminded itself of Witness 2's oral evidence in which she informed the panel that she had seen Resident C's medication on 8 July 2021, in the clinic room and had documented this through a photo.

The panel therefore finds charges 19(a) and 19(b) proved.

Charge 19(c)

"That you a registered nurse;

In relation to Resident C:

19. On 8 July 2021 having not administered Levothyroxine 100mg to Resident C failed to:

c. Document in the medication waste book that the medication had been destroyed."

This charge is found NOT proved.

In reaching this decision, the panel took into account witness 1's written statement.

Witness 1's written statement reads:

> *"The process of destroying the medication is to first of all to record it in the MAR chart that the medication was destroyed due to being refused. Then take it to the medication waste, put it in the medication waste, and then record in a medication waste book (which you record what you have destroyed)."*

The panel noted that it had no medicine waste book before it. The panel determined that due to finding that Mrs Masih had not destroyed the medication in charge 19(b), there would be no reasonable reason as to why she should document in the medication waste book that the medication had been destroyed.

The panel therefore finds charge 19(c) not proved.

Charge 20

"That you a registered nurse;

In relation to Resident C:

20. On 21 July 2021 during a telephone interview with Colleague 1 incorrectly declared to them that you had, *'administered Resident C's medication before signing their MAR chart'* or words to that effect."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's written statement and oral evidence, and the telephone interview notes dated 21 July 2021.

Witness 1's written statement reads:

> *"The Nurse was defensive about their actions, and the Nurse would change their narrative of what happened on 8 July 2021, from that they said that they had given Resident B and C their medication and then signed their MAR charts, to that they had not given the medication but still had signed the MAR chart …"*

The telephone interview notes dated 21 July 2021 stated:

> *"MM: No, I gave the medication before I sign the MAR chart."*

Witness 1's oral evidence corroborated this.

The panel determined that on the balance of probabilities, Mrs Masih did incorrectly declare that she had *'administered Resident C's medication before signing their MAR chart'* or words to that effect.

The panel therefore finds charge 20 proved.

Charge 21

"That you a registered nurse;

In relation to Resident C:

21. Your declaration in charge 20 were dishonest in that you were attempting to mislead Colleague 1 that:

a. You had administered the medication to Resident C when you knew that you had not, and/or
b. You had followed the correct process when administering medication to Resident C."

These charges are found proved.

In reaching this decision, the panel took into account what an ordinary decent person would do, and referred itself to *Ivey v Genting Casinos*.

The panel reminded itself of the evidence found proved in charges 19 and 20. It was of the view that Mrs Masih did attempt to mislead Witness 1 in her declaration, when she knew the medication had not been administered to Resident C. The panel determined that an ordinary decent person would find this to be misleading and dishonest.

In relation to charge 13(b), the panel determined that you did not follow the correct protocol when administering medication to Resident C, given that you did not document in the MAR chart why medication was not given, did not destroy the medication that was not given and subsequently did not fill in the medication waste book.

The panel firstly ascertained the subjective state of Mrs Masih's knowledge or beliefs as to the facts and the reasonableness of his belief. The panel determined that Mrs Masih knew that by signing for the administration of medication, Mrs Masih misrepresented the facts around the medication administration.

The panel then went on to determine whether Mrs Masih's conduct was dishonest by applying the objective standards of ordinary decent people. The panel determined that an

ordinary and decent person would know that by intentionally providing a misleading account about this incident, this would be dishonest.

The panel therefore finds charge 21 proved in its entirety.

Charge 22

“That you a registered nurse;

In relation to Resident C:

22. On 8 July 2021 incorrectly declared in Resident C’s daily notes/logs that you had administered Levothyroxine 100mg to Resident C when it had not.”

This charge is found proved.

In reaching this decision, the panel took into account Resident C’s daily notes.

The panel had sight of Resident C’s daily notes and noted that Mrs Masih had incorrectly declared that Levothyroxine 100mg had been administered. Given the panels findings in charges 14 and 15, the panel determined that Mrs Masih had incorrectly declared the medicine had been administered to Resident C when it had not been.

The panel therefore finds charge 22 proved.

Charge 23

“That you a registered nurse;

In relation to Resident C:

23. Your declaration in charge 22 was dishonest in that you were attempting to mislead others who read Resident C's daily notes/logs that the medication had been administered to Resident C when you knew that it had not."

This charge is found proved.

In reaching this decision, the panel took into account what an ordinary decent person would do, and referred itself to *Ivey v Genting Casinos*.

The panel was of the view that Mrs Masih did attempt to mislead others by recording that medication had been given in Resident C's daily notes when she knew the medication had not been administered. The panel determined that an ordinary decent person would find this to be misleading and dishonest.

The panel firstly ascertained the subjective state of Mrs Masih's knowledge or beliefs as to the facts and the reasonableness of his belief. The panel determined that Mrs Masih knew that by signing for the administration of medication, Mrs Masih misrepresented the facts around the medication administration.

The panel then went on to determine whether Mrs Masih's conduct was dishonest by applying the objective standards of ordinary decent people. The panel determined that an ordinary and decent person would know that by intentionally providing a misleading account about this incident, this would be dishonest.

The panel therefore finds charge 23 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Masih's fitness to practise is currently impaired. There is no statutory definition of fitness to

practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

Mr Radley 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 Radley identified the specific, relevant standards where Mrs Masih's actions amounted to misconduct:

"The Panel will in the case of 'MM', no doubt, pay particularly attention to;

- *The period of time that the misconduct took place over,*

- *The resulting serious outcome of the misconduct (E.g – drug errors)*
- *The lack of professionalism in the behaviour*
- *The lack of documentation, notes and rational for the decisions especially when a Resident went missing.*
- *The fact that the roles of this nurse was within a 'chain of causation' leading to delay in locating the missing Resident.*
- *The findings of blatant dishonesty*
- *The Role as a Senior Nurse in the care setting*

These factors can have a serious effect on patient safety if it is not dealt with effectively. This we say underpins the need to identify this behaviour as serious misconduct in the case of both Registrants."

Submissions on impairment

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

Mr Radley submitted:

"MM has not attended and provided very little evidence of challenge that could be put to the witnesses.

In addition MM has a previous finding against her and a separate bundle has been produced in the knowledge of the Registrant about this.

There is little evidence that they have addressed or taken steps to address any concerns or risks identified in the case. The Registrant MM has provided:

- *No evidence of further relevant training and supervision reference.*
- *No information relating to reflection and understanding of the issues raised in the proven allegations*
- *No Acceptance of the insight / acceptance of the proven allegations*
- *No details of steps taken to address the concerns raised by the proven allegations*
- *No current evidence from others as to current skills and fitness to practise*

Whether it is likely that the conduct will be repeated is also a concern for the NMC. This will impact on the professional's ability to practise kindly, safely, and professionally, resulting in the NMC, suggest a finding of impairment.

The consequences of the professional's conduct affected patient care and could have been very serious

For these reasons the NMC say that … Mrs Masih fitness to practice is currently impaired."

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin) and *Calhaem v General Medical Council* [2007] EWHC 2606 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 Mrs Masih's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Masih's actions amounted to a breach of the Code. Specifically:

"1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

6 Always practise in line with the best available evidence

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

8 Work cooperatively

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

10 Keep clear and accurate records relevant to your practice

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

11 Be accountable for your decisions to delegate tasks and duties to other people

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard.

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place *[in its entirety]*

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

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

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

18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

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

19.2 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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that there were clinical failings on behalf of Mrs Masih, and she was dishonest.

In relation to Patient A, who had absconded in the garden for three hours, the panel found that there was no evidence that a sufficient physical and mental assessment had been carried out by Mrs Masih at the appropriate time.

In regard to dishonesty, the panel considered that Mrs Masih had failed to give medication and had lied about it on several occasions and this was dishonest. Further, she was dishonest about the length of time that a patient was missing.

In regard to her clinical failings, the panel noted that Mrs Masih was an experienced registered nurse on the night shift. It was of the view that she lacked insight and when incidents occurred, sought to minimise them. In doing this, she failed to be open and honest. The panel referred to 'FTPC-3a Serious concerns which are more difficult to put right':

"Breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague or member of the public who wants to raise a concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care;"

The panel determined that Mrs Masih put her needs above the patients' needs and this amounted to deliberate dishonesty on multiple occasions. Mrs Masih repeatedly made clinical mistakes including the errors of administration of controlled drugs, other medications, and appropriately monitoring the care of patients.

The panel found that Mrs Masih's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel determined that all limbs of the Dame Janet Smith test were engaged.

The panel finds that patients were put at risk as a result of Mrs Masih's misconduct. Mrs Masih's 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 charges relating to dishonesty extremely serious.

Regarding insight, the panel found no evidence to suggest that Mrs Masih had strengthened her practice.

The panel was not satisfied that the misconduct in this case is capable of being addressed. The panel considered that Mrs Masih's previous regulatory findings were of a similar nature to the concerns in these proceedings. It was of the view that the incidents identified occurred over a significant period of time, despite her previous regulatory intervention.

The panel is of the view that there is a risk of repetition based on her previous regulatory findings as well as the findings of this case. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required as a well-informed member of the public would be concerned to find Mrs Masih practising unrestricted.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Masih's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Masih off the register. The effect of this order is that the NMC register will show that Mrs Masih 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 Radley provided written submissions:

> ***"Can the Regulatory concern be addressed?***
>
> *In emphatic terms the NMC say that in this case they cannot. The concerns are of an extremely serious nature. The conduct found proven by the panel calls into question the Registrants professionalism, honesty / integrity and raises concerns about their suitability to remain on the register.*
>
> *The representations on aggravating factors for Mrs Masih are;*

a. *Registered nurses occupy a position of privilege and trust and maintain professional boundaries (dishonesty)*
b. *lack of insight into failings – Denials of the charges and a lack of any demonstration of insight*
c. *Impact on the profession – The trust and confidence in the profession has been damaged.*
d. *The four limbs of the Grant test are engaged.*
e. *Resident placed in unwarranted risk of harm/ physical distress due to the lack of care of the missing patient*
f. *Breaching a fundamental tenets of the profession*
g. *Lack of understanding of the seriousness – Dishonestly (where various untrue accounts were given to colleagues)*
h. *Lack of relevant up to date training/ reflection – None presented*
i. *Public interest and public protection are both engaged in this case.*
j. *A previous regulatory or disciplinary finding has been relied upon in this case of a similar nature.*

The mitigating features for Mrs Masih are;

a. *No direct lasting patient harm*
b. *Age and experience*

Proposed sanction for both Registrants

1. *Striking off*

- *Public Protection and Public Interest are both engaged*
- *lack of insight by both Registrants*
- *…*
- *Lack of acceptance of the wrong*
- *An unwillingness to rehabilitate shown by failures of engagement*

- *Huge impact on the Public Trust and confidence if the Registrants are permitted to continue to practice*

Conclusion

The Registrants have failed to maintain and promote good professional standards. In this case if the Registrants are permitted to practice, the NMC say that this would have a devastating effect on the Public's Trust and confidence in the Profession. This case has raised questions about the ability of the Nurses to uphold the standards and values of the profession and the Code."

Decision and reasons on sanction

Having found Mrs Masih'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:

- Any previous regulatory or disciplinary findings
- Lack of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put patients at risk of suffering harm.

The panel has drawn no adverse inference from the non-attendance of Mrs Masih, but noted that his non-attendance meant she could not inform the panel of any mitigating features of this case. The panel noted that Mrs Masih is currently under a conditions of

practice order, but noted that there is no evidence that she has complied with these conditions.

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

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

The panel next considered whether placing conditions of practice on Mrs Masih's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mrs Masih'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.*

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

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

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

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

Mrs Masih's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs

Masih's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

In *Parkinson v NMC* [2010] EWHC 1898 (Admin) Mr Justice Mitting said:
"A nurse found to have acted dishonestly is always going to be at severe risk of having his or her name erased from the register. A nurse who has acted dishonestly, who does not appear before the Panel either personally or by solicitors or counsel to demonstrate remorse, a realisation that the conduct criticised was dishonest, and an undertaking that there will be no repetition, effectively forfeits the small chance of persuading the Panel to adopt a lenient or merciful outcome and to suspend for a period rather than direct erasure."

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

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

This will be confirmed to Mrs Masih in writing.

Interim order

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

until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Radley. He submitted that …

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.