Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
3-7 and 10-14 and 17 June 2024

Virtual Hearing

Name of Registrant:	**Abraham Morgen**
NMC PIN	08B0675E
Part(s) of the register:	Registered Nurse – Adult Nursing
Relevant Location:	Dudley
Type of case:	Misconduct
Panel members:	Rachel Childs (Chair – Lay member) David Raff (Lay member) Richard Weydert-Jacquard (Registrant member)
Legal Assessor:	Suzanne Palmer [3-14 June 2024] Paul Housego [17 June 2024]
Hearings Coordinator:	Vicky Green
Nursing and Midwifery Council:	Represented by Arran Dowling-Hussey, Case Presenter
Mr Morgen:	Present and represented by Neair Maqboul, Counsel, instructed by the Royal College of Nursing
No case to answer:	Charges 8 and 9
Facts proved by admission:	Charges 1 (in its entirety), 2 (in its entirety), 3 (in its entirety), 4, 6 (in its entirety)
Facts proved:	Charges 5 and 7
Facts not proved:	None
Fitness to practise:	Impaired

Sanction:	**Conditions of practice order – 18 months**
Interim order:	**Interim conditions of practice order – 18 months**

Charges

That you, a registered nurse:

1. On 11 June 2021 in relation to Resident A:

   i) Failed to dispose of the resident’s Alfacalcidol medication by destroying the tablet and returning it to the pharmacy. **[Proved by admission]**

   ii) Failed to record the disposal of Alfacalcidol in the resident’s clinical notes. **[Proved by admission]**

   iii) Did not hand over and/or escalate to a member of staff the medication error. **[Proved by admission]**

2. On 27 July 2021 in relation to Resident B:

   i) Failed to dispose of the resident’s medication by destroying the tablets and returning them to the pharmacy **[Proved by admission]**

   ii) Failed to record the disposal of medication in the resident’s clinical notes. **[Proved by admission]**

   iii) Did not hand over and/or escalate to a member of staff the medication error. **[Proved by admission]**

3. On an occasion between October 2021 and April 2022:

   i) Used the incorrect dressing for Resident C’s wound. **[Proved by admission]**

   ii) Failed to record the wound in Resident C’s clinical notes. **[Proved by admission]**

   iii) Incorrectly recorded wound care in Resident D’s clinical notes. **[Proved by admission]**

iv) Made inaccurate records in one or more resident’s clinical notes that tasks had been completed. **[Proved by admission]**

v) Failed to complete clinical tasks required of you. **[Proved by admission]**

4. Your actions in charge 3 iv) were dishonest because you knew you had not completed those tasks. **[Proved by admission]**

5. On 26 September 2022 did not check the electronic medication administration record (eMAR) against medication blister packs for one or more residents. **[Proved]**

6. On 10 October 2022:

   i) Failed to administer pain relief to Resident E. **[Proved by admission]**

   ii) Incorrectly recorded pain relief had been administered to Resident E. **[Proved by admission]**

   iii) Failed to administer a Butrans Patch to Resident F in the morning. **[Proved by admission]**

7. On a date between 26 September 2022 and 11 October 2022 failed to have the administration of Gabapentin to Resident G checked and/or failed to ensure it was signed by a second member of staff. **[Proved *in respect of failure to ensure signature by a second member of staff. Not proved in relation to failure to have the administration checked*]**

8. On 6 September 2022 during a telephone call with Willing Care Recruitment Agency said that you were not currently subject to an NMC investigation. **[No case to answer]**

9. Your actions in charge 8 were dishonest in that you intended the agency to believe you were not under investigation when you knew you were subject to an NMC investigation. **[No case to answer]**

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Dowling-Hussey on behalf of the Nursing and Midwifery Council (NMC). This application was made pursuant to Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (the Rules) to allow the witness statement of Mr 6 into evidence. He referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council [2014]* EWHC 1565 (Admin) and set out the principles established in this case.

Mr Dowling-Hussey referred the panel to a bundle of documents containing a number of communications between Mr 6 and the NMC. He submitted that Mr 6 does not appear to have a good reason for non-attendance, and appears to be *'broadly'* reluctant to attend this hearing to give oral evidence. Mr Dowling-Hussey referred the panel to Mr 6's responses to the NMC in the email communications and submitted that he has no documentation from the time in question and therefore said that he would be unable to assist at this hearing.

Mr Dowling-Hussey submitted that the witness statement of Mr 6 is relevant and goes directly to charge 8 and the consequential charge 9. He also submitted that it is not the sole or decisive evidence as it is supported by the evidence of Ms 5. Mr Dowling-Hussey submitted that Mr 6 had no reason to fabricate his evidence. He submitted that the NMC had taken reasonable steps to secure Mr 6's attendance at this hearing.

Mr Dowling-Hussey submitted that the witness statement of Mr 6 was made not too long after the incident and is not the only evidence in respect of charges 8 and 9. He submitted the witness statement of Mr 6 should be admitted as hearsay evidence and then the panel could determine what weight should be attached to it. Mr Dowling-Hussey submitted that in all of the circumstances, balancing your rights and the duty of

the NMC in allowing the evidence that goes to charges 8 and 9 to be properly assessed the evidence of Mr 6 should be admitted.

Ms Maqboul, on your behalf, opposed this application. She submitted that the witness statement of Mr 6 is the sole and decisive evidence in respect of charges 8 and 9 and Mr 6 is the only person who can give direct evidence about what Willing Care Recruitment Agency (the Agency) was told by you. Ms Maqboul referred the panel to the email from Mr 6 to the NMC dated 9 May 2024 in which he stated the following:

> *'Sorry I do not recall any evidence that I have provided for this case and due to this I will be unable to attend.'*

She referred the panel to an email from Mr 6 to the NMC dated 14 May 2024 in which he stated the following:

> *'I have emailed [NMC case officer] to raise my concerns about attending the hearing. I do not remember providing the evidence that you require me to discuss at this meeting. I do remember briefly having a conversation with someone and they asked me a few questions regarding the placement of the named individual, but I do not remember being made aware that I would need to provide evidence in this manor.*
>
> *I have no documentation from that long ago and do not feel comfortable providing accurate information.'*

Ms Maqboul also referred the panel to an email from Mr 6 to the NMC dated 15 May 2024 in which he stated the following:

> *'As previously mentioned, when I was originally contacted, I was never made aware that I would need to provide evidence. I just thought I was helping support your case. I do not feel comfortable providing evidence and I am not going to be available on the dates provided.'*

Ms Maqboul submitted that Mr 6 is explicitly reluctant to give evidence. She submitted that in his emails to the NMC he appears to have clearly detracted from what has been said in his witness statement and it would therefore be unfair to admit this witness statement into evidence. Ms Maqboul further submitted that Mr 6 has stated he has no documentation from the time in question, and does not feel comfortable in providing accurate information. She submitted that caution must be exercised as it would be highly irregular and unsafe to admit Mr 6's witness statement when there is a clear reluctance from him and *"a huge question mark hanging over him"* in feeling comfortable in providing this information.

Ms Maqboul submitted that if Mr 6's statement is admitted into evidence, you will not have the opportunity to cross examine him and neither would the panel. She submitted that in fairness to you and given the grave concerns about the witness statement and Mr 6's responses to the NMC, it should not be admitted into evidence.

The panel accepted the advice of the legal assessor who referred it to the cases of *Thorneycroft* and *R (Bonhoeffer) v General Medical Council [2011] EWHC 1585 (Admin)*.

The panel had regard to the principles set out in the cases of Bonhoeffer and *Thorneycroft*. It also had regard to the NMC Guidance on *'Evidence',* in particular *'Hearsay'* (Reference: DMA-6 Last Updated 01/07/2022).

The panel determined that the witness statement of Mr 6 is clearly relevant and goes directly to charge 8 and charge 9 which arises from charge 8. The panel noted that although you accept that there was a telephone conversation and that you inadvertently misled the Agency, you said that you misunderstood what you were being asked. The critical issue to explore at this hearing would therefore be the precise question which Mr 6 asked you during that conversation and your response to that question. Mr 6's evidence went to that issue.

The panel was of the view that the evidence of Mr 6 is the sole and decisive evidence in respect of charges 8 and 9 as he was the only person, other than you, that was party to

the conversation from which these charges arose. The panel acknowledged that Ms 5 has provided some evidence about what she was told by the Agency, however she had no knowledge and gave no evidence about any conversation between you and the Agency. The extent of her evidence was that she was told by the Agency that you had not declared that you were under NMC investigation. Ms 5 did not say that the Agency had told her that they had asked you whether you were under investigation by the NMC. Furthermore, Ms 5 did not say that she was told by the Agency that you had positively said you were not currently subject to an NMC investigation as per the terms of charge 8.

The panel noted that although efforts were made to secure the attendance of the witness, the NMC has been aware of his reluctance to give evidence for a number of months and has not applied for a witness summons or made you aware of the witness' position until after this hearing had started. The panel was concerned about Mr 6's responses, namely that he did not recall giving the statement and that he did not feel comfortable about the accuracy of the information that he would be able to provide if he did attend the hearing. It considered that Mr 6 was clearly reluctant to attend, and in his absence there would be no way to test his evidence or assess its reliability, particularly as he now has no recollection of making his statement or of the events themselves.

The panel determined that it would be unfair to you to allow the witness statement of Mr 6 into evidence as hearsay given that he is the sole and decisive witness in respect of this charge, you would not have the opportunity to cross examine his evidence and charges 8 and 9 relate to dishonesty, which could have potentially serious consequences for you if found proved.

Having regard to all of the above, the panel decided to reject this application.

Decision and reasons on application for no case to answer in respect of charges 7, 8 and 9

The panel considered an application from Ms Maqboul, after the NMC had closed its case, that there is no case to answer in respect of charges 7, 8 and 9. This application was made pursuant to Rule 24(7) of the Rules.

Ms Maqboul referred the panel to the case of *R v Galbraith* [1981] 1 WLR 1039 and set out the following basic principles established in this case:

(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.

(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.

a. Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.

b. Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.'

In respect of Charge 7, Ms Maqboul submitted that there is no evidence upon which the panel can safely rely to find this charge proved. She submitted that the only evidence before the panel is that of a conversation between Ms 5 and Ms 7 about what Ms 7 said that she had seen. Ms Maqboul submitted that Ms 7 has not provided any evidence to the panel and that Ms 5 did not directly witness your alleged failure to have the administration of Gabapentin checked and counter signed by a second member of staff. Ms Maqboul submitted that Ms 5 accepted that there was no evidence of her checking

the MAR chart at the time and that this MAR chat has not been produced in evidence. She also submitted that Ms 5 was unable to assist with which resident this incident related to or the date it is alleged to have happened.

In respect of charges 8 and 9, Ms Maqboul submitted that as the panel has refused to admit the witness statement of Mr 6, there is no evidence to support this charge.

Mr Dowling-Hussey submitted that you have provided some responses to charge 7 in your witness statement and the panel has not yet had the benefit of hearing evidence from you. He submitted that a number of the witnesses have given evidence about your alleged difficulties in the administration and recording of medication. He submitted that Ms 5 was consistent in her evidence and in her position as a Home Manager, she would not have directly witnessed incidents, but concerns were raised with her. Mr Dowling-Hussey submitted that Ms 5 was clear that Ms 7 had raised the issues set out in charge 7 with her and Ms 5 believed that the incident had happened. He submitted that this charge should not fall away at this stage as there is clear and coherent evidence.

In respect of charges 8 and 9, Mr Dowling-Hussey agreed with Ms Maqboul's submission that in this context they stood and fell together. He referred the panel to your reflective statement. He submitted that there is no dispute that a conversation between you and the Agency took place, however, the dispute is about the wording of the conversation. Mr Dowling-Hussey submitted that Ms 5 gave clear evidence that after she received a phone call from the NMC, she called the Agency who told her that you had not made them aware that you were subject to an NMC investigation. Mr Dowling-Hussey submitted that in her evidence, Ms 5 told the panel that she was satisfied that the Agency had acted appropriately and performed their own investigations. He submitted that we have not yet heard evidence from you. Mr Dowling-Hussey invited the panel to refuse this application.

The panel accepted the advice of the legal assessor in which she referred to the panel a number of cases including *R v Galbraith* [1981] 1 WLR 1039.

The panel had regard to the NMC guidance on *'Evidence'* (Reference: DMA-6 Last Updated:01/07/2022), in particular, the section entitled *'No case to answer'*. The panel had regard to the following:

> *'There will be no case for a nurse, midwife or nursing associate to answer where, at the close of our case, there is:*
>
> 1. *no evidence*
> 2. *some evidence, but evidence which, when taken at its highest, could not properly result in a fact being found proved against the nurse, midwife or nursing associate, or the nurse, midwife or nursing associate's fitness to practise being found to be impaired.*
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> *The question of whether there is a case to answer turns entirely on our evidence. Evidence which might form part of the nurse, midwife or nursing associate's case will not be taken in to account.'*

The panel first considered whether there was a case to answer in respect of charge 7:

7. On a date between 26 September 2022 and 11 October 2022 failed to have the administration of Gabapentin to Resident G checked and/or failed to ensure it was signed by a second member of staff.

The panel noted that Ms 5 had provided evidence that a number of residents required Gabapentin during the period of time covered in this charge. Ms 5 told the panel that although at the time, Gabapentin was not a controlled drug, the home's policy required a second checker when it was administered. Ms 5's evidence was that you would therefore have been made aware from the first time you observed a medication round on the unit of the requirement for a second checker. The panel considered that Ms 5 was clear in her evidence that she had been informed by Ms 7 that you had failed to have the administration on Gabapentin checked and signed by a second member of staff. The panel also took into account that Ms 5 in her oral evidence stated that she had been shown the controlled drugs record book which did not contain a second signature next to the record of Gabapentin that you had administered to Resident G.

The panel also had sight of a contemporaneous note of the concerns reported by Ms 7 in relation to this charge. Having regard to all of the above, the panel decided that there was some evidence in support of this charge, which was not of a tenuous nature, and that this charge should continue to be considered and tested in the normal course of proceedings. The panel therefore refused the application of no case to answer in respect of charge 7.

The panel went on to consider whether there was a case to answer in respect of charges 8 and 9:

10. On 6 September 2022 during a telephone call with Willing Care Recruitment Agency said that you were not currently subject to an NMC investigation.

11. Your actions in charge 8 were dishonest in that you intended the agency to believe you were not under investigation when you knew you were subject to an NMC investigation.

Having decided not to accept the witness statement of Mr 6 into evidence as hearsay evidence, the panel noted that there was no direct evidence to support this charge. Whilst the panel noted that Ms 5 had provided some hearsay evidence about her conversation with someone at the Agency, she was not party to the telephone call that took place on 6 September 2022, and her evidence was limited in the way described above in relation to the hearsay application in respect of Mr 6. Further, there was no contemporaneous note or other documentary evidence of this conversation.

The panel noted that you appear to accept that a telephone call did take place between you and the Agency on 6 September 2022. Your reflective statement therefore provided the only evidence in relation to the telephone call. However, taken at its highest the evidence in reflective statement is unclear and equivocal about precisely what was said by Mr 6, what your misunderstanding was, and what your response was. This evidence was too vague and tenuous to be capable of supporting a clear finding in due course about what you were asked and how you responded. Moreover, the panel was mindful in any event, that the burden of proof rests with the NMC. The panel had regard to the

NMC guidance and noted that evidence which might form part of the nurse, midwife or nursing associate's case will not be taken into account in determining whether there is case to answer. The panel considered that in the absence of any clear, direct or contemporaneous evidence about the telephone call, and any direct evidence from the NMC about that call, there was insufficient evidence to support charges 8 or 9.

Having regard to all of the above, the panel decided to accede to the application of no case to answer in respect of charges 8 and 9.

Decision and reasons on application pursuant to Rule 19

Before you gave evidence, Ms Maqboul made an application pursuant to Rule 19 of the Rules, for parts of your evidence to be heard in private. She informed the panel that in your evidence you will make reference to the personal circumstances you faced at the time the charges arose. Ms Maqboul submitted that these matters should be heard in private to protect your right to privacy.

Mr Dowling-Hussey did not oppose this application.

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

Having heard that there will be some reference to personal matters, the panel determined to hold these parts of the hearing in private. It was of the view that any public interest in holding the entire hearing in public was outweighed by your right to keep matters relating to your personal life in private.

Background

On 30 July 2021 the NMC received a referral from Black Country Housing and Community Services Group (the Agency 1). The Agency 1 is an agency through which, you had been undertaking shifts as a Registered Adult Nurse. The original referral

related to alleged incidents at two different Care Homes. Those alleged incidents form the basis of Charges 1 to 4. During the course of the NMC's investigation into that original referral, additional concerns came to light in relation to alleged incidents at a third Care Home at which you had been placed by a different recruitment agency, Willing Care Agency (Agency 2). Those additional alleged incidents, and an alleged failure by you to disclose information to Agency 2 about your ongoing NMC investigation, form the basis of Charges 5 to 9.

The Agency 1 placed you at Gower Gardens Care Home (the Home 1) where the first charges arose. You worked a total of three shifts at Home 1, placed by two different agencies. It is alleged that on 11 June 2021, whilst working at the Home 1, you failed to appropriately dispose of Resident A's Alfacalcidol medication by destroying the tablet and returning it to the pharmacy. Instead, you told Home 1 and Agency 1, you disposed of the medication in a yellow sharps bin when you realised it should not be administered to Resident A. It is further alleged that you failed to record the disposal of the Alfacalcidol in Resident A's clinical notes and it is also alleged that you did not hand over and/or escalate this medication error to a member of staff.

Whilst working at the Home 1, it is alleged that on 27 July 2021, you failed to appropriately dispose of Resident B's medication by destroying the tablets and returning them to the pharmacy. Again, when the incident was investigated locally, you said that you had realised that the medication should not be administered to Resident B and disposed of it in a yellow sharps bin. It is alleged that you failed to record the disposal of the tablets in Resident B's clinical notes and it is also alleged that you did not hand over and/or escalate this medication error to a member of staff.

In September 2021, you started working for Rylands View Nursing Home (the Home 2) under a six month probationary period. It is alleged by Home 2 that during your probationary period you were not meeting the expected standards. It is alleged that concerns were raised about your timely completion of tasks and workloads, wound care management, accuracy of documentation, lack of candour and slow pace of medication administration. It is alleged that these concerns were raised with you by the nurse who

was your mentor, and by the Home Manager, and you resigned at the end of your six month probation period in March 2022.

On 26 September 2022, you commenced employment as a Registered Nurse at Wyncroft House Nursing Home (the Home 3) where you had been placed by Willing Care Agency (the Agency 2). It is alleged that on 26 September 2022, you did not check the Electronic Medication Administration Record (eMAR) against blister packs for one or more residents. It is also alleged that on 10 October 2022, in respect of Patient E, you failed to administer pain relief and you incorrectly recorded that pain relief had been administered when it had not. It is further alleged that on 10 October 2022, you failed to administer a Butrans Patch to Resident F in the morning. At the Home 3, whilst Gabapentin was not a controlled drug, it was the Home's policy that when it was administered that:

> *'Two staff members are required to check the correct item has been chosen to be dispensed as per the EMAR. The current stock is counted to ensure that it is correct. The item is then taken to the correct resident straight away and the person who assists (e.g. patch renewal) signs as the second checker / witness.'*

It is alleged that on an unknown date between 26 September 2022 and 11 October 2022 you failed to have the administration of Gabapentin to Resident G checked and/or failed to ensure that it was signed by a second member of staff.

It is alleged that the Home Manager of Home 3 discovered from Agency 2 that Agency 2 was not aware, at the time it recruited you and placed you with Home 3, that you were subject to an ongoing NMC investigation into the earlier referral. That allegation formed the basis of Charges 8 and 9, in respect of which the panel has found no case to answer.

Decision and reasons on facts

At the outset of the hearing, Ms Maqboul on your behalf told the panel that you admitted charge 1 in its entirety, charge 2 in its entirety, charge 3 in its entirety, charge 4 and charge 6 in its entirety.

The panel therefore finds charges 1, 2, 3, 4 and 6 proved by way of your admissions. Having found no case to answer in respect of charges 8 and 9, the remaining disputed charges for the panel to determine at the facts stage were therefore charges 5 and 7.

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 Dowling-Hussey on behalf of the NMC and the submissions made by Ms Maqboul on your behalf.

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 under oath and affirmation from the following witnesses called on behalf of the NMC:

- Ms 1: Deputy Manager of the Home 1.
- Ms 2: Home Manager at the Home 2.
- Ms 3: Unit Manager of the Haines Unit at Home 2. A registered nurse and your mentor/supervisor at Home 2.
- Ms 4: Registered Nurse at Home 3. Your mentor/supervisor at Home 3.
- Ms 5: Home Manager at the Home 3.

The panel also heard evidence from you under affirmation.

The panel accepted the advice of the legal assessor.

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

Charge 5

5. On 26 September 2022 did not check the electronic medication administration record (eMAR) against medication blister packs for one or more residents.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 4 and Ms 5.

The panel had sight of Ms 4's witness statement to the NMC dated 13 February 2023 in which she stated the following:

'On 26 September 2022, I noted some concerns with Mr Morgen's medication administration. Medication for residents will arrive in a blister pack of 28 tablets, with one to be given each day. It is the job of the nurse to check that what is documented on the electronic medication system (the "E-Mar system") corresponds with what has been sent to us in the blister pack to ensure that nothing is missing. I noticed that Mr Morgen was not doing this; he was just taking the medication out of the blister pack without checking the E-Mar system.

I raised this issue with Mr Morgen at the time. I told him he must always complete these checks and ensure that everything is correct.'

In her oral evidence, Ms 4 told the panel that she saw you taking the tablets out of the blister packs without checking the eMAR. She stated that as she was with you she was aware of the errors that you made.

The panel also had sight of a document created by Ms 5 soon after 26 September 2022. In this document, Ms 5 recorded the following comments made by Ms 4:

> *'Mon 26th Sept: "I supervised Abraham on his first shift doing Lodge meds, he wasn't sure how to use the I pad and needed a lot of assistance. He didn't check the E mar against the blisters/boxes as going along so kept missing things and putting the wrong amounts in."'*

In her witness statement to the NMC dated 5 January 2023, Ms 5 stated the following:

> *'On 26 September 2022, [Ms 4], a registered nurse at Care Home 3, approached me to raise some concerns about Mr Morgen's medication administration [Exhibit MC/01]. A resident of Care Home 3 had returned from hospital with medication that they would need to receive. When this happens, the nurse should always check that the dosage on the medication box is the same as what has been logged on the E-Mar system to ensure that the correct dose will be given. Ms [4] told me that Mr Morgen had failed to check this.'*

In her oral evidence, Ms 5 confirmed to the panel that Ms 4 had informed her that you had not checked the eMAR before administering medication to patients on 26 September 2022.

In your evidence, you told the panel that you had checked the eMAR using the iPad before administering medication to patients.

The panel found Ms 4's evidence to be consistent, credible and reliable in respect of this charge. Her evidence was consistent with the concerns she had raised at the time as set out in the evidence of Ms 5 and the documentary record of her reporting her concerns to Ms 5. Ms 4 was balanced and fair in her evidence and made positive

comments about your qualities as a nurse. The panel was of the view that this went to her reliability, and it therefore determined that there was no reason for her to fabricate her evidence and that, as acknowledged by Ms Maqboul on your behalf, there was no reason to suggest that she had an *"axe to grind"*. The panel considered that Ms 4 was an experienced nurse who was acting as your mentor or supervisor during your initial period of employment. She was working closely with you and observing what you were doing. She also spoke to you after the incident to explain what you should have done differently. The panel was satisfied that she would have seen if you were checking the iPad before administering the medications.

The panel noted that you had a different recollection of events. However this had to be seen in the context of you being a relatively inexperienced nurse who had already had errors and concerns raised in respect of your medications practice at Home 1. On the balance of probabilities, the panel considered that your recollection was incorrect, and preferred the evidence of Ms 4.

The panel therefore determined that it was more likely than not that on 26 September 2022 you did not check the eMAR against medication blister packs for one or more residents. Accordingly, the panel found this charge proved.

Charge 7

7. On a date between 26 September 2022 and 11 October 2022 failed to have the administration of Gabapentin to Resident G checked and/or failed to ensure it was signed by a second member of staff.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 5.

The panel first considered whether you had a duty to have the administration of Gabapentin checked and signed by a second member of staff.

In her witness statement to the NMC dated 5 January 2023, Ms 5 stated the following:

> *'[The Home 3's] controlled drugs procedure is standard and as follows: 'Two staff members are required to check the correct item has been chosen to be dispensed as per the EMAR. The current stock is counted to ensure that it is correct. The item is then taken to the correct resident straight away and the person who assists (e.g. patch renewal) signs as the second checker / witness.'*
>
> *[The Home 3] has access to a drug called Gabapentin, which is used to treat conditions such as epilepsy and nerve damage. Gabapentin was initially a controlled drug, which as explained above means that it needs to be checked by two different people before it can be administered, and signed off in the controlled drugs book kept in [the Home 3]. At the time of the incident, Gabapentin was, legally, no longer a controlled drug, so these measures did not have to be taken. However, it was [the Home 3's] policy to still use these measures. As such, two people should still sign the controlled drugs book and check the administration. Mr Morgen was informed of this during his training period when he joined [the Home 3].'*

Following questions from the panel, Ms 5 in her oral evidence, said that you would have been accompanied by another nurse during your first medication round. She said that the nurse would have explained the process for the administration of Gabapentin and in particular, the requirement for checking/sign off by a second member of staff. Upon further questions from the panel, Ms 5 stated that at the time in question, a number of the residents were receiving Gabapentin and it would have therefore been discussed during your first medication round.

Although there was no direct evidence from the NMC that you were informed of Home 3's policy in relation to Gabapentin, the panel accepted Ms 5's evidence and was satisfied on the balance of probability that you were made aware of the policy, and therefore of the requirement for a second checker and signatory. The panel noted that at times, you appeared to accept in your own oral evidence that you were aware of that

requirement, although the panel did not place significant reliance on your evidence because your evidence in relation to this charge was confused and confusing.

The panel therefore determined that you were under a duty to have the administration of Gabapentin checked and signed by a second member of staff.

Having established that you were under a duty to have the administration of Gabapentin checked and signed by a second member of staff, the panel went on to decide whether on the balance of probabilities, between 26 September 2022 and 11 October 2022 you failed to have the administration of Gabapentin to Resident G checked and/or failed to ensure it was signed by a second member of staff.

The panel had sight of Ms 5's witness statement to the NMC dated 5 January 2023 in which she stated the following:

> *'However, I was informed by [Ms 7] that Mr Morgen did not follow this procedure [Exhibit MC/01]. He signed the controlled drugs book to state that he had administered Gabapentin to a resident, but did not ensure that this was checked by a second nurse. The other nurses in [the Home 3] had no knowledge of the drug being given.'*

The panel also had sight of a document that was created by Ms 5 to record (amongst other concerns) what had been reported by Ms 7 in which the following was stated:

> *'[Ms 7] had to discuss with him:*
>
> *• Signing our controlled drugs and giving without asking anyone to be witness to both processes'*

In her oral evidence, following questions from the panel, Ms 5 said that Ms 7 showed her the controlled drugs book and she saw that you had signed to say that you had administered Gabapentin to Resident G but that there was no second signature.

In the reflective statement you provided to the panel you said that at the time of the alleged incident, Gabapentin was not a controlled drug and therefore that a second checker and signatory was not required. The inference from that assertion was that you did not have the administration of the medication checked or signed. However, in your oral evidence in response to questions from the panel, you said that you were aware of Home 3's policy to treat Gabapentin as if it were a controlled drug, and that you never gave it without a second checker.

The panel accepted that it had no direct evidence from Ms 7 in relation to this charge, and that it had not been provided with a copy of the Controlled Drug book referred to by Ms 5. The panel noted that there was an element of inconsistency and a lack of clarity in your evidence. It did not consider that it could place reliance on your recollection in relation to this charge. It preferred the evidence given by Ms 5, which it found to be consistent credible and reliable in respect of this charge.

The panel noted that there were two elements of this charge, namely, whether you had a second checker and/or whether you had a second member of staff sign when you administered Gabapentin. Having heard direct evidence from Ms 5 that she saw the Controlled Drugs book and found only your signature against an entry stating that Gabapentin had been administered to Resident G, the panel was satisfied that it was more likely than not that you failed to ensure that the administration of Gabapentin was signed by a second member of staff.

The panel noted that the NMC had placed no direct evidence before it in relation to your alleged failure to ask a second of member of staff to check your administration of Gabapentin to Resident G between the dates in question. For reasons set out above, the panel was unable to place reliance on your own evidence, but it was mindful in any event that the burden of proof rests with the NMC. It did not consider that the hearsay evidence contained in Ms 5's witness statement was sufficient to establish this. Accordingly, the panel found that there was insufficient evidence to demonstrate on the balance of probabilities that you failed to have a second checker, and found that aspect of the charge not proved.

Having regard to all of the above, the panel found this charge proved on the basis that it was more likely than not that on an occasion between 26 September 2022 and 11 October 2022 you failed to ensure that the administration of Gabapentin to Resident G was signed by a second member of staff. It did not find that you failed to have this checked by a second member of staff.

Fitness to practise

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

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

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

Submissions on misconduct

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 Dowling-Hussey invited the panel to take the view that the facts found proved amount to misconduct. He submitted that you commenced practice as a registered nurse in 2011 and only passed your probationary period in four out of 15 roles. Mr Dowling-Hussey submitted that the charges found proved relate to basic and core nursing skills and breached parts of the *'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)'* (the Code) and fundamental tenets of the profession.

Ms Maqboul, on your behalf, submitted that you accepted that the charges found proved amount to misconduct.

Submissions on impairment

Mr Dowling-Hussey 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. He submitted that you lack insight into your shortcomings and were not open and candid about what went wrong. Mr Dowling-Hussey submitted that there is a risk of repetition of the misconduct and that there is no evidence that you would be able to practise safely. He submitted that the charges arose on a number of occasions at several different places of work and had the potential to place patients at risk of harm and have a negative impact on your colleagues.

Ms Maqboul submitted that you accepted that your fitness to practise is currently impaired on both public protection and public interest grounds. She referred the panel to your remediation bundle, specifically, your reflective statement. Ms Maqboul submitted that reflection is an ongoing process and there are some *"green shoots"* in your reflection since the charges arose, it has developed and will continue to develop.

Ms Maqboul summarised your evidence. She submitted that you accepted that your actions, omissions and dishonesty had the potential to have *"grave"* consequences for patients. Ms Maqboul submitted that in your evidence, you acknowledged that you

would need some additional assistance in returning to safe practice. She submitted that you accepted that your fitness to practise is currently impaired.

The panel accepted the advice of the legal assessor in relation to both misconduct and impairment, 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), *R (Remedy UK Ltd) v GMC* [2010] EWHC 1245 (Admin), *R (Calhaem) v GMC* [2007] EWHC 2606 (Admin), *Johnson & Maggs v NMC (No. 2)* [2013] EWHC 2140 (Admin), *Cohen v GMC* [2008] EWHC 581 (Admin), *CHRE v NMC & Grant* [2011] EWHC 927 (Admin), *Schodlok v GMC* [2015] EWCA Civ 769, *Kimmance v GDC* [2016] EWHC 1808 (Admin), and *Lusinga v NMC* [2017] EWHC 1458 (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: Professional standards of practice and behaviour for nurses and midwives (2015)'* (the Code) in making its decision.

The panel was of the view that your proven actions and omissions in this case breached the following provisions of the Code:

> ***'1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> > ***1.2*** *make sure you deliver the fundamentals of care effectively*
> > ***1.4*** *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***8 Work co-operatively***
>
> *To achieve this, you must:*

__8.2__ maintain effective communication with colleagues
__8.5__ work with colleagues to preserve the safety of those receiving care
__8.6__ share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:

__10.1__ complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
__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 records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

To achieve this, you must:

__14.1__ act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm
__14.2__ explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

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'*

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 all of the charges, with the exception of charges 1, 3.v) and 7, represented sufficiently serious departures from required standards that they amounted to misconduct.

Charges 1 and 2

The panel noted that charges 1 and 2 were similar in nature, relating to the failure to dispose of medication appropriately, record the disposal and handover and/or escalate the medication error. The panel noted that you had, in both instances, realised your error prior to administering the medication and that you had disposed of the medication, albeit using the incorrect method. It accepted that you had no intention to mislead.

The panel considered that the first incident, on 11 June 2021, when viewed in isolation, did not represent good practice, but was not so serious as to amount to misconduct. It noted that you were relatively new to Home 1 at the time and may have been unaware of local policy and procedure. However, the panel noted that following this incident, concerns were raised with you through your agency. Despite this, you proceeded to make a very similar error on 27 July 2021. The panel considered that on this second

occasion you should have been aware of the need to track and record the disposal of medication and medication errors. Failure to do so had the potential to cause harm to patients as it would not be clear whether or not medication had been administered.

In all the circumstances, the panel concluded that your actions and omissions in relation to charge 1 did not amount to misconduct, but that your actions and omissions in relation to charge 2 were a sufficiently serious departure from standards to amount to misconduct. It therefore found that charge 2 amounted to misconduct.

Charge 3

In respect of charge 3, the panel determined that i)-iv) amounted to misconduct. The panel heard evidence that you had failed to apply a secondary dressing which is used to protect the wound from infection and to prevent the initial dressing from moving and damaging the wound. The panel also noted that failing to record the wound and/or wound care given, accurately or at all, in respect of two patients placed those patients at risk of harm because any reviewing nurse would not be able to establish whether the wound had deteriorated and provide the appropriate care. The panel therefore decided that charges 3.i)-iii) were a sufficiently serious departure from standards to amount to misconduct.

In respect of charge 3.iv), the panel considered that making inaccurate records suggesting that tasks had been completed had the potential to build up a false picture of care given and therefore to impact on future care. It considered that charge 3.iv) was a sufficiently serious departure from standards to amount to misconduct. This was compounded by the dishonesty which you have admitted in charge 4 in relation to these records.

The panel considered that charge 3.v) lacked specificity about which clinical tasks were not completed and was therefore unable to assess the seriousness of your failures. On the basis of the evidence available to it, the panel was unable to identify any act or omission in relation to this charge that was sufficiently serious to be characterised as misconduct. The panel therefore found that charge 3.v) did not amount to misconduct.

Charge 4

The panel considered that charges relating to dishonesty in a clinical setting are always serious and have the potential to place patients at risk of harm. Nurses need to be open and honest and act with integrity and candour. Dishonest record-keeping about what tasks have been completed could impact on future patient care and cause harm. Accordingly, the panel determined that charge 4 was sufficiently serious to amount to misconduct.

Charge 5

In respect of charge 5, the panel was mindful that the eMAR system is used to ensure that patients receive the correct medication and dose. By failing to check medication against that system before administering it, you placed patients at risk of receiving incorrect medication or not receiving medication prescribed to them. These possible consequences had the potential to place patients at risk of harm. The panel therefore determined that your actions and omissions in charge 5 represented a sufficiently serious departure from standards to amount to misconduct.

Charge 6

In relation to charge 6, the panel considered that this involved two instances of failure to administer pain relief due to patients: in the first instance the medication was not provided at all, and in the second instance it was delayed. This had the potential to cause patients harm, in that they could experience a higher level of pain than would otherwise be the case. In one of the two instances, you inaccurately recorded that the pain relief had been administered, which had the impact on future care as staff treating the patient would be under the impression that pain relief had already been provided, potentially resulting in further delay before further pain relief could be administered. The panel noted that in care homes, some patients can lack capacity, and in these cases they would not be able to communicate that they had not received any pain relief. The

panel considered that your actions and omissions in relation to charge 6 represented a sufficiently serious departure from standards to amount to misconduct.

Charge 7

The panel noted that at the time the charge arose, Gabapentin was not legally classified as a controlled drug. There was no evidence to suggest that you had not checked the drug yourself and administered it appropriately, notwithstanding your failure to adhere to the Home 3's local policy. The panel considered that charge 7 related to a single instance of breaching local policy in respect of obtaining the signature of a second checker. Whilst this was not good practice, the panel considered in all the circumstances that it did not amount to a sufficiently serious departure from required standards to be characterised as misconduct.

Conclusion

In respect of charges 2, 3.i)-iv), 4, 5 and 6, the panel found that your actions and omissions fell sufficiently far short of the conduct and standards expected of a nurse that they amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide whether, as a result of the misconduct it had found in relation to charges 2, 3.i)-iv), 4, 5 and 6, your fitness to practise is currently impaired.

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
>
> > *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

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

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

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

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's guidance 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 considered that all four limbs were engaged in this case. The panel was of the view that your actions and omissions in this case were wide ranging and encompassed a number of core nursing duties. They included multiple failures in respect of medication administration, record-keeping and wound care, which persisted over a significant period of time and in a number of different workplace settings. Your failures had the potential to put patients at unwarranted risk of harm and to bring the nursing profession into disrepute. They involved breaches of tenets of the profession, which the panel identified as the safe administration of medication, transparency and candour with colleagues, and the effective delivery of the fundamentals of care. There was also a finding of dishonesty.

Having determined that all four limbs of the *Grant* guidance were engaged, the panel went on to consider whether you were liable, or likely, to repeat your acts and omissions in future. In considering the risk of repetition, it had regard to the evidence and submissions placed before it in relation to the issues of remorse, reflection, insight and remediation.

The panel determined that concerns that are clinical in nature are generally remediable. It noted that charges relating to dishonesty are inherently more difficult to remediate, although they are capable of being remedied.

The panel had regard to your remediation bundle, reflective statement and the evidence you provided in relation to this stage of the proceedings. The panel acknowledged that

you admitted many of the charges which have been found proved and that you have demonstrated remorse for your actions. You have reflected on your actions and omissions and demonstrated developing insight. The panel considered that you were able to articulate the potential impact of your actions on patients, colleagues, employers and the profession, and the importance of candour and honesty in clinical practice.

However, the panel had some concerns about your level of understanding and whether, if faced with a similar set of circumstances in the future, you would act differently. It noted that the many of the failures including your dishonesty, occurred when you felt under pressure because you were in a new setting and working at a slow pace, You have not yet been able to demonstrate that you have sufficient levels of insight and adequate coping strategies in place to avoid repeating those acts or omissions if you return to nursing practice and once more find yourself in a stressful environment. The panel agreed with Ms Maqboul's submission that there were some *"green shoots"* in your reflection but that it is an ongoing process.

The panel had sight of a number of training certificates and two testimonials. The panel noted that you had only provided one testimonial from a colleague who had previously worked with you. The panel noted that you are not currently working as a registered nurse and it therefore had no evidence of strengthened practice. It did not have evidence that the lessons you have learned from these events and the subsequent training and reflection you have undertaken have been tested in a clinical setting to ensure that they are embedded into safe clinical practice.

The panel considered the following question as set out in the NMC Guidance on determining fitness to practise:

> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

The panel determined that at this time, as your insight is still developing and there is insufficient evidence of strengthened practice, there remains a risk of repetition of the failures identified in this case and a consequent risk of harm to patients. 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 considered that a fully informed member of the public would be concerned if a finding of impairment was not made in a case where there have been multiple and wide ranging errors that placed a number of patients at a risk of harm in several care homes. The panel also considered that a member of the public would also be concerned if a finding of impairment was not made in a case involving dishonesty that has not yet been remediated in a clinical setting. The panel therefore concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel determined that your fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Mr Dowling Hussey submitted that the panel should impose a striking-off order. He submitted that this case involved multiple and wide-ranging errors in several locations over a period of time, involving a risk of harm to patients. He submitted that your conduct involved a lack of professionalism in core areas of nursing and that you have demonstrated a lack of insight and understanding in relation to what happened and the potentially significant consequences of your actions. He submitted that there was a risk of repetition and that public confidence in the profession would be undermined if you were permitted to practise as a nurse in future. He submitted that the panel was required to carry out a balancing exercise but that this case raised such fundamental questions about your professionalism that, in his submission a striking-off order was necessary and was the only appropriate sanction. Mr Dowling-Hussey made no submissions in relation to other sanctions available to the panel.

Ms Maqboul reminded the panel of the need to consider the available sanctions in ascending order. She submitted that there are two categories of charges found proved: the majority are clinical in nature and one charge relates to dishonesty. In respect of the clinical errors, Ms Maqboul acknowledged that there were numerous failings and that there had been some repetition of errors. She submitted that your clinical failings were not attitudinal in nature and that you had recognised your failings and demonstrated some insight into them, although this still required development. She reminded the panel of the evidence from NMC witnesses who described you as polite, willing to get your hands dirty, and happy to assist.

Ms Maqboul said that you recognise that you need to go “back to basics” to remedy your past failings, which were largely in the areas of the administration of medication and wound dressing. She submitted that these were capable of being remedied and that the public would be protected by the imposition of conditions of practice. She submitted that you are willing to address your failings and informed the panel that you have identified classroom based courses which you intend to undertake in relation to medication management and wound care. Ms Maqboul said that these are four hour, interactive courses that are held in person in Birmingham and the next that you can attend commences on 13 July 2024 and then every month thereafter. Ms Maqboul submitted that this demonstrates a shift in your thinking, as all previous training that you have undertaken has been remote or online. She submitted that in a classroom based setting, you will be able to ask questions.

Ms Maqboul submitted that a stringent conditions of practice order in conjunction with the training courses would assist you in developing coping strategies to address workplace pressure, in order to safeguard against the issues identified by the panel at the impairment stage. Ms Maqboul identified a number of conditions that in her submission would address the concerns including further reflection, training, supervision, a Performance Development Plan (PDP), weekly supervision meetings, and restrictions on your ability to work as a sole nurse on duty or to undertake medication administration without being signed off as competent to do so.

In respect of the dishonesty in this case, Ms Maqboul submitted that you have made full admissions to this at the outset of the hearing and have accepted your dishonesty with candour in your reflective statement. She submitted that your dishonesty did not raise deep-seated attitudinal concerns about your character. Ms Maqboul submitted that your dishonesty was not pre-meditated and it is not at the higher end of the spectrum of dishonesty. She submitted that a conditions of practice order, together with further training would address your inability to cope within pressurised situations, which was the context in which the dishonesty occurred.

Ms Maqboul referred the panel to your remediation bundle. She said that you accept the limitations which the panel has identified in relation to the evidence in that bundle.

However she pointed out that it contained a testimonial from a band 7 nurse with whom you have previously worked and who speaks very highly of you. She submitted that you have been described as a caring nurse who is liked by patients and colleagues.

In response to panel questions, Ms Maqboul submitted that her primary position is that a conditions of practice order would be the most appropriate order in this case, and she invited the panel to impose such an order. In relation to a suspension order, she acknowledged that the panel might wish to consider such an order but submitted that this would not focus on your development and progression. Ms Maqboul submitted that a suspension order would also limit a reviewing panel who would have only limited information about your development if you were prevented from practising during a period of suspension. She submitted that a suspension order would prevent you from being able to demonstrate tangible change.

The panel accepted the advice of the legal assessor in relation to matters it should take into account when reaching its decision on sanction, including reference to the NMC's Sanctions Guidance ("SG").

Decision and reasons on sanction

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

The panel first considered the aggravating and mitigating features which it identified in this case. It took into account the following aggravating features:

- Your misconduct placed multiple vulnerable patients in several care homes at a risk of harm.

- The proven charges demonstrated multiple concerns involving fundamental aspects of nursing practice, over a period of time and in a range of care home settings, on the part of a registrant now of 16 years standing.

The panel also took into account the following mitigating features:

- You made early admissions to the majority of the charges at the outset of the proceedings, including charge 4 relating to dishonesty.
- You have expressed strong and genuine remorse for your actions and offered repeated apologies.
- You have demonstrated developing insight, although you acknowledge that it requires further development.
- You have provided some evidence of strengthened practice, although to date this is limited and ongoing, and you have demonstrated that you are committed to continuing to strengthen your practice through in person retraining.
- At the time the charges arose, you were experiencing some difficult personal circumstances, although as the panel has no clear evidence of how this directly impacted on your practice or led to the failings identified in this case, it did not give it much weight.

The panel considered that the clinical failings identified in this case, although wide-ranging and in some instances repeated, were not attitudinal in nature and were capable of being remedied.

The panel went on to assess the level of seriousness of your dishonesty. It had regard to the NMC Guidance on *'Considering sanctions for serious cases'* (Reference: SAN-2 Last Updated 27/02/2024) and the case of *Lusinga v NMC* [2017] EWHC (Admin). The panel had particular regard to the section of the above guidance entitled *'Cases involving dishonesty'* in which the following is stated:

> *'Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*
- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception*

Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *incidents outside professional practice'*

The panel considered that the dishonesty in this case occurred at a time when you felt under pressure to be seen to have got things done because of the time it was taking for you to undertake clinical tasks. To a significant extent it was therefore linked to your clinical failings. The panel considered that, whilst the dishonesty occurred in a clinical setting, it was opportunistic rather than pre-meditated or systematic. The evidence was unclear as to the number of occasions on which it occurred but there was no evidence to suggest that it persisted over a prolonged period of time. The panel noted that you promptly accepted that you had been dishonest when concerns were raised with you by your supervisor and you also admitted the dishonesty charge at the outset of this hearing. The panel considered that although your insight is developing and at this stage you do not have full insight into how to prevent a recurrence, you have apologised for your conduct and expressed strong and genuine remorse.

The panel had regard to the case of *Lusinga v NMC* [2017] EWHC 1458 (Admin), in particular paragraph 103 in which Kerr J observed the following:

> *'…without alluding to the possibility that dishonest conduct can take various forms; some criminal, some not; some destroying trust instantly, others merely undermining it to a greater or lesser extent.'*

The panel was mindful that dishonesty is always a serious matter, particularly where it occurs in a clinical context and has the potential to impact on patient care. However, for the reasons set out above, the panel was of the view that the dishonesty in this case should not be viewed as destroying trust instantly, but rather as undermining trust to a lesser extent. The panel bore in mind that this was a single charge and that there was no evidence that you were habitually dishonest in your clinical practice. Having regard to all of the evidence before it, the panel was satisfied that the dishonesty in this case is not indicative of any deep-seated attitudinal issues. It found that the dishonesty in this case fell at the middle to lower end of the spectrum of dishonesty, although not at the bottom.

The panel next considered what sanction would be appropriate and proportionate in all the circumstances. In accordance with the guidance contained in the SG, it started by considering the least restrictive sanction and continued up the scale. It bore in mind its earlier finding that, at this stage, your insight is still developing and your past failings have not been fully remedied, and that there therefore remains a risk of repetition. It had regard to the need to protect the public from any risk of harm associated with repetition, and also to the need to address the wider public considerations of declaring and upholding professional standards by marking the misconduct identified in this case, and thereby maintaining public confidence in the profession.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues identified. The panel was of the view that an order that does not restrict your practice would neither protect the public nor be sufficient to address the wider public interest considerations in this case.

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

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *…*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and workable conditions which would address the clinical failings highlighted in this case. The panel acknowledged that it is harder to formulate conditions which can address dishonesty. It noted, however, that the dishonesty in this case related to your practice in only one of

the care homes and was closely linked to the deficiencies in your clinical practice. It arose because of the pressure which you felt due to the time it was taking you to complete some of your nursing duties, particularly the administration of medication. The panel considered that the remediation of your dishonesty would therefore involve: development of fuller insight into how and why it happened, taking steps to avoid the circumstances in which the dishonesty occurred and insight into coping strategies you can put in place to avoid feeling under pressure and avoid acting dishonestly in future. In the particular circumstances of this case, your dishonesty was, in the panel's view, therefore capable of being remedied within the context of working under stringent conditions of practice.

The panel noted that you have already taken some steps to strengthen your clinical practice by completing online courses. It also noted that you have expressed a willingness to take further steps and have already identified classroom based courses on medication management and wound care that you intend to attend. The panel was reassured that you are committed to strengthening your practice and that you would fully engage and comply with a conditions of practice order. The panel was satisfied that a stringent conditions of practice order would protect the public and give you the opportunity to demonstrate strengthened practice and fully develop your insight.

The panel had careful regard to the wider public interest considerations in this case given the seriousness of any finding of dishonesty, particularly when associated with clinical practice. It therefore considered carefully whether a suspension order was required in order to mark the seriousness of your actions. However, having concluded that the dishonesty was at the middle to lower end of the spectrum of dishonesty, that there are no harmful or deep-seated attitudinal concerns, and that the dishonesty is capable of being remedied through conditions of practice in this case, the panel was satisfied that the imposition of conditions would be sufficient to mark the seriousness of the misconduct and satisfy the wider public interest considerations. The panel considered that a reasonable, fully informed member of the public, having regard to all the circumstances of this case, would consider a conditions of practice order to be an appropriate and proportionate sanction. The panel further considered that it was in the

public interest that, with appropriate safeguards, you should be able to return to safe practice as a nurse.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order. The panel considered that a suspension would not address the deficiencies in your practice as a conditions of practice order can do. The panel carefully considered whether the finding of dishonesty should be marked by a period of suspension. The panel concluded that in all the circumstances this would be disproportionate. The panel was of the view that to impose a striking-off order would be wholly disproportionate and unduly punitive in this case in light of the mitigating features identified above.

The panel concluded that the conditions of practice order should be for a period of 18 months. This would allow sufficient time for you to undertake further training, secure employment and undertake a period of supervised practice without further incident and provide evidence of safe practice to demonstrate to a reviewing panel. Furthermore, you will have the opportunity to demonstrate full insight and remediation of your past misconduct.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order for 18 months will serve to protect the public while you take the steps you need to take to develop your insight, strengthen your practice and remedy the failings identified in this case. A conditions of practice order will also be sufficient to mark your misconduct and to send to the public and the profession a clear message about the standards of practice and conduct required of a registered nurse, in order to maintain public confidence in the profession.

The panel determined that the following conditions are appropriate and proportionate in this case:

> *'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of*

educational study connected to nursing, midwifery or nursing associates.'

1. You must limit your nursing practice to one substantive employer, which must not be an agency.

2. You must successfully complete face to face classroom-based training on medication management and administration and wound care.

3. You must not administer or manage medication or dress wounds unless under direct supervision by another registered nurse until you are signed off as competent by your supervisor/line manager, who should also be another registered nurse.

4. You must ensure that you are supervised any time that you are working. This supervision must consist of:
   - Always working on the same shift and the same ward/unit as, but not necessarily always directly observed by, another registered nurse. You must do this until signed off as competent by your line manager/supervisor. This competence assessment should include an assessment of your adherence to the duty of candour.
   - Monthly meetings with your supervisor/line manager to discuss your clinical caseload, including medication administration and management, wound care, record keeping and professional ethics/duty of candour.

5. You must work with a mentor (who could be the supervisor/line manager above) to create a personal development plan. Your PDP must address concerns about:
   - Medication administration and management.
   - Wound care.
   - Record keeping.
   - Professional ethics/the duty of candour.

6. You must meet monthly with your mentor to ensure that you are making progress towards aims set in your PDP. For the avoidance of doubt, this can be discussed in the same monthly meeting as described in Condition 4.

7. You must keep a reflective practice profile. The profile will:
   - Detail examples of cases where you administered and managed medication successfully.
   - Detail examples of cases where you completed wound care successfully.
   - Detail examples, if and where relevant, of when you have upheld the duty of candour.
   - Be signed by your supervisor/line manager each time.

8. You must provide a further reflective piece that focusses on the duty of candour and which clearly identifies how you would prevent being dishonest in future situations when under pressure at work.

9. You must obtain from your line manager/supervisor and send the NMC a report seven days in advance of the next NMC hearing or meeting. The report should comment on your performance and conduct, including your:
   - Medication administration and management.
   - Wound care.
   - Record keeping.
   - Professional ethics/adherence to the duty of candour.

10. In addition to the above report, and before the expiry of this order you will send your case officer evidence of your compliance with these conditions, including:
    - Evidence of completed training.
    - Your reflection piece (as referred to in condition 7 above).
    - Your PDP.
    - A report from your line manager.
    - Your reflective profile (as referred to in condition 8 above).

11. You must keep the NMC informed about anywhere you are working by:
    a) Telling your NMC case officer within seven days of accepting or leaving any employment.
    b) Giving your NMC case officer your employer's contact details.

12. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

13. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).
    c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

14. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

15. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

    a) Any current or future employer.

b) Any educational establishment.
c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 18 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order with another order.

Interim order

As the conditions of practice 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 your own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Mr Dowling-Hussey invited the panel to impose an 18 month interim conditions of practice order to cover the appeal period.

Ms Maqboul did not oppose this application.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the 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 has found that there is a risk of repetition of the misconduct so that an interim conditions of practice order is necessary to protect the public as well as being in the public interest.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to ensure that you cannot practise unrestricted before the substantive conditions of practice order takes effect. This will 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 conditions of practice order will be replaced by the substantive conditions of practice order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.