Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 10 June 2024 – Friday, 14 June 2024
Monday, 17 June 2024 – Wednesday, 19 June 2024

Virtual Hearing

Name of Registrant:	Ifeanyi Kenechukwu Paul
NMC PIN:	21K0572O
Part(s) of the register:	Registered Nurse Mental Health Nurse – November 2021
Relevant Location:	Kent
Type of case:	Misconduct
Panel members:	Dave Lancaster (Chair, Lay member) Shorai Dzirambe (Registrant member) Carson Black (Lay member)
Legal Assessor:	Andrew Granville Stafford
Hearings Coordinator:	Elizabeth Fagbo
Nursing and Midwifery Council:	Claire Stevenson (Monday 10 June – Friday 14 June 2024) Aoife Kennedy (Monday 17 June – Wednesday 19 June 2024)
Mr Paul:	Not present and not represented at the hearing.
Facts proved:	Charges 1, 2, 3(a), 4(a), 4(b), 4(c), 5(a), 5(b) 6(a), 6(b)
Facts not proved:	Charge 3(b)
Fitness to practise:	Impaired

Sanction:	**Suspension order (12 months)**
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 Mr Paul was not in attendance and that the Notice of Hearing letter had been sent to Mr Paul's registered email address by secure email on 25 April 2024.

Further, the panel noted that the Notice of Hearing was also sent to Mr Paul's representative on 25 April 2024.

Ms Stevenson, 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 that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Paul's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all of the information available, the panel was satisfied that Mr Paul 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 Mr Paul

The panel next considered whether it should proceed in the absence of Mr Paul. It had regard to Rule 21 and heard the submissions of Ms Stevenson who invited the panel to continue in the absence of Mr Paul. She submitted that Mr Paul had voluntarily absented himself.

Ms Stevenson referred the panel to the email dated 10 June 2024 from Mr Paul's representative which stated the following:

> *'…Our attempts to contact the registrant have been unsuccessful. Unfortunately we are unable to represent Nurses without prior Confirmation and agreements and we have nor [sic] been able to secure this with the registrant...'*

The panel was informed that emails sent to Mr Paul regarding this hearing on 31 May 2024 onwards had bounced back, with an error message saying that his inbox was out of storage space. However, the panel was assured that a check had been carried out and the email dated 25 April 2024 attaching the notice of hearing had not bounced back.

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 decided to proceed in the absence of Mr Paul. In reaching this decision, the panel considered the submissions of Ms Stevenson, 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 Mr Paul or his representatives;
- Mr Paul has not engaged with the NMC since 1 March 2024;

- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A number of witnesses are due to attend this hearing to give live evidence,
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Paul in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email address, he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his 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.

In addition, the panel do have some information regarding Mr Paul's response to the allegations including written representations from his representative dated 12 May 2023 and his complete Case Management Form dated 23 February 2024.

Furthermore, the limited disadvantage is the consequence of Mr Paul's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge

That you, a registered nurse:

1. On 6 December 2021, failed to ensure that continuous observations of Patient A were conducted in that on one or more occasions, you moved to an area where you were unable to continuously observe Patient A.

2. On 31 December 2021, you left a set of keys to the clinic room in the door of the clinic room.

3. On 31 December 2021 in relation to Patient C you:
a) failed to administer the 9pm dose of Depakote either at 9pm or at all;

b) at the conclusion of your shift, failed to tell Colleague A that the 9pm dosage of Depakote had not been administered;

4. On 29 January 2022, in relation to Patient B, you:

a) administered a 5mg tablet of Diazepam when 10 mg of liquid Diazepam was prescribed;

b) failed to ensure that the administration of the Diazepam was witnessed by a nurse or approved support worker;

c) failed to ensure that a nurse or approved support worker countersigned the Drugs Liable for Misuse Book for Liquid Diazepam.

5. On 29 January 2022, in relation to Patient B, you inaccurately recorded that:

a) 10 mg of liquid Diazepam had been administered when it had not been administered;

b) a tablet of Diazepam had been disposed of, when it had not been.

6. Your conduct at any and/or all of Charge 5 was dishonest in that you:

a) Knew that you had not:

i) Administered liquid Diazepam;

ii) Disposed of a tablet of Diazepam.

b) Intended to create the misleading impression that:

i)You had administered liquid Diazepam;

ii)You had disposed of a tablet of Diazepam.

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 Ms Stevenson under Rule 31 to admit the hearsay evidence of two support workers at the Hospital, Witness 5 and Witness 6, who are referenced in the witness statements of Witness 1, Witness 2, Witness 3 and Witness 4.

Ms Stevenson informed the panel that Witness 5, is referenced in the witness statements of Witness 1 and Witness 2, in relation to charge 1 and charge 2. Witness 5 brought concerns to both Witness 1 and Witness 2 which they subsequently investigated.

Ms Stevenson also made an application to admit the hearsay evidence of another support worker at the Hospital (Witness 6) who is referenced in Witness 1, and Witness 4's statements, in relation to part of charge 4, charge 5 and charge 6. Ms Stevenson told the panel that Witness 5 was not present at this hearing and, whilst the NMC had made sufficient efforts to secure her attendance, the attempts were unsuccessful.

Ms Stevenson reminded the panel that under Rule 31, the panel has the discretion to admit evidence in the proceedings, including hearsay evidence, as long as it meets the criteria of being relevant and fair. She further referred the panel to the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin).

Firstly, Ms Stevenson submitted that the hearsay evidence on which she sought to rely was not the sole or decisive evidence in relation to any of the charges and therefore, its exclusion would not meet the threshold for unfairness to Mr Paul. She further submitted that if the panel decided to admit this evidence, then it can determine what weight to attach to it.

Ms Stevenson submitted that the second feature to consider is the nature and extent of the challenge to the contents of the statements. She referred the panel to Mr Paul's written responses to the charges outlining his agreements and disagreements. She submitted that there is no suggestion that either Witness 5 or Witness 6 had reasons to fabricate their accounts and there is nothing before the panel to undermine the reliability of their evidence. Ms Stevenson further submitted that the charges are serious as there was a potential for harm, which was explained by Witness 1 and Witness 2 in their witness statements.

In the preparation of this hearing, the NMC had indicated to Mr Paul in the Case Management Form (CMF), that it was the NMC's intention for Witness 1, Witness 2, Witness 3 and Witness 4 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 1 and Witness 2, which made reference to other Support Workers at the Hospital during the time the charges arose, Mr Paul made the decision not to attend this hearing. On this basis Ms Stevenson advanced the argument that there was no lack of fairness to Mr Paul in allowing the hearsay evidence of Witness 5 and Witness 6.

Ms Stevenson therefore submitted that it would be fair and relevant to admit the hearsay evidence of Witness 5 and Witness 6 who are referenced in the statements of Witness 1, Witness 2 and Witness 4. She invited the panel to take this view.

After the panel heard evidence from Witness 1, Witness 2, it became evident that Witness 3 who was scheduled to give evidence would not be joining the hearing. The Hospital had informed the NMC that Witness 3 has moved abroad and it does not have a contact address for her. Ms Stevenson submitted that the NMC made sufficient efforts to ensure that Witness 3 was present at this hearing, and she had been engaging with the NMC to the point of providing a witness statement which is signed and dated 30 November 2022. She informed that a trace was undertaken, and further attempts were made to contact Witness 3 on 15 May 2024, however, were unsuccessful on each occasion. Therefore, Ms Stevenson made an application under Rule 31 to allow the written statement of Witness 3 into evidence. Ms Stevenson submitted that the evidence is relevant to charge 4(a) and may also be relevant towards charge 5 and charge 6 and it would be fair to admit the evidence.

Ms Stevenson submitted that the evidence of Witness 3 is not sole or decisive as there is evidence of the incident by way of CCTV footage and further supportive evidence from Witness 1, Witness 4, the hearsay evidence of Witness 6, and Mr Paul's Case Management Form. She submitted that the evidence is highly relevant, and its exclusion

would not meet the threshold for unfairness to Mr Paul. She further submitted that if the panel decided to admit this evidence, then it can determine what weight to attach to it.

Ms Stevenson further submitted that the second feature to consider is the nature and extent of the challenge to the contents of the statement. She referred the panel to Mr Paul's Case Management Form where he admits to charge 4(a), charge 5(a) and charge 6(a)(i) where he accepts that he failed to administer the liquid diazepam on 29 January 2022, which Witness 3's evidence also goes towards. In regard to the third factor, Ms Stevenson submitted that there is no suggestion that this witness had any reason to fabricate their allegations.

Furthermore, Ms Stevenson submitted that the charges are serious, involving under dosing a patient and also concerns of dishonesty. The NMC therefore made an application to adduce this written statement into evidence before the panel by way of hearsay.

Ms Stevenson informed the panel that should it allow Witness 3's evidence in as hearsay it would need to revisit its decision allowing Witness 6's evidence as their evidence relates to the same incident.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Witness 3, Witness 5 and Witness 6 serious consideration. The panel noted that all reasonable efforts were made by the NMC to secure their engagement, however, all attempts were unsuccessful. It noted that Witness 1 and Witness 2's statements had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and were signed.

The panel determined that the statements are not the sole and decisive evidence of the charges as there are 3 witnesses who are relevant and have been or will be considered as live evidence. There are also exhibits that the NMC say corroborate its case. The panel was of the view that neither Witness 3, Witness 5 or Witness 6, had any reason to fabricate their statements. It determined that any disadvantage to Mr Paul could be addressed by the weight the panel attach to the evidence.

The panel determined that Mr Paul would have been aware of the existence of all of the witness statements as they were included in the bundle of statements that were sent to Mr Paul and his representative in advance of the hearing. In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 3, and also accept into evidence the hearsay evidence of Witness 5 and Witness 6 but would give what it deemed appropriate weight once the panel had heard and evaluated all of the evidence before it.

Background

Mr Paul began employment as a registered nurse with Cygnet Hospital (the Hospital) on 9 November 2021 under a probationary period. At the time the allegations arose he was employed as a registered Staff Nurse at the Hospital on Albert Ward (the Ward), a male psychiatric Intensive Care Ward. He was referred to the NMC on 3 February 2022 by the Ward Manager.

The charges relate to concerns that occurred in December 2021 and January 2022, and are as follows:

On 6 December 2021, Mr Paul was covering 1:1 observations of Patient A for a colleague who was going on break. Patient A was on 1:1 observation due to concerns that they would self-harm. It is alleged that, while Patient A slept, Mr Paul left to make a number of drinks, meaning that Patient A was not being observed.

On 31 December 2021, Mr Paul was on the night shift and had completed the medication round when he finished and left the clinic. A support worker, Witness 5, states that she saw that the keys were in the clinic room door and the door had been left open. It is therefore alleged that Mr Paul left the door to the clinic room unsecured with the keys in it. It is further alleged that, during this shift, Mr Paul failed to administer Depakote to Patient C as prescribed for 9:00. At first Mr Paul stated that he had administered the dose. However, he later admitted that he must have missed it and did not administer this medication.

On the night shift of 29 January 2022, it is alleged that Mr Paul made a medication error, in that he dispensed a Diazepam 5mg tablet to Patient B, rather than the 10mg of liquid Diazepam that Patient B was prescribed.

In the Drugs Liable to Misuse book, it was recorded that 5mg of Diazepam in tablet form had been disposed of and 10mg liquid Diazepam was signed as administered. There was no evidence of disposal of the 5mg Diazepam tablet in the controlled drug bin, as per policy.

Patient B and support worker, Witness 3, witnessed Mr Paul administer the medication. There is CCTV footage of the incident which appears to indicate that Mr Paul administered a tablet, rather than a liquid as prescribed.

Mr Paul initially denied making any medication errors and was adamant that he had administered the Diazepam liquid correctly. When questioned later by the Ward Manager he admitted that he had administered a tablet rather than liquid Diazepam and that he had lied about it in the documentation.

Mr Paul was dismissed during his probationary period on 1 February 2022.

Decision and reasons on application to amend the charge

During the course of the hearing the panel heard an application made by Ms Stevenson, on behalf of the NMC, to amend the wording of charge 4(b) and charge 4(c).

The proposed amendment was due to the technicality of the wording. It was submitted by Ms Stevenson that the proposed amendments would provide clarity and more accurately reflect the evidence.

> "That you, a registered nurse:
>
> 4. On 29 January 2022, in relation to Patient B, you:
>
> a) administered a 5mg tablet of Diazepam when 10 mg of liquid Diazepam was prescribed;
>
> b) failed to ensure that the administration of the **liquid and/or tablet** Diazepam was witnessed by a nurse or approved support worker;
>
> c) failed to ensure that a nurse or approved support worker countersigned the Drugs Liable for Misuse Book for liquid **and/or tablet** Diazepam
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

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

The panel noted that the amendment does not alter the nature of the charge rather, it solely adds the words **liquid and/or tablet**. 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 Mr Paul 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.

Decision and reasons on facts

The panel heard the submissions from the NMC.

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, Mr Paul's responses to the incidents from his representative, dated 12 May 2023 and his Case Management Form dated 23 February 2024.

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

Charge 1

> "That you, a registered nurse:
>
> 1. On 6 December 2021, failed to ensure that continuous observations of Patient A were conducted in that on one or more occasions, you moved to an area where you were unable to continuously observe Patient A."

This charge is found proved.

In reaching this decision, the panel carefully considered the evidence presented to it, which included the witness statement provided by Witness 1, the Medication Management Policy, supervision record forms, and Mr Paul's response to the incident.

The panel took into account Witness 1's statement dated 23 March 2023, which mentioned that the incident of 6 December 2021 was reported to him by Witness 5 the following day. Witness 1 also stated the following in his statement:

'…I watched the CCTV footage that was recording at the time of the incident, and I could see Paul leave Patient A's bedroom while he was on one-to-one observations. I believe he left and returned on four occasions. The CCTV footage is not stored for more than six months and I did not feel the need to save this footage as I was not intending to escalate the incident further, therefore I am no longer able to access this footage.

By leaving his post when he was meant to be conducting observations, Paul risked that Patient A may come to harm, or cause harm to others…'

The panel took into account the supervision record forms which stated the following:

'…Observation of patients – Discussed concerns raised via staff about leaving observations and his role during this – referring back to the policy. Made Paul aware that CCTV has been checked and he left his eye sight observation 4 times to make drinks. Advised that this is a disciplinary issue and it will not happen again. Please ask if he needs toilet break, if he is tired etc, but under no circumstances should the patient being observed, be left…'

The panel also considered the Medication Management Policy which outlined the required monitoring procedures on the Ward that the registered nurses were expected to follow. The panel was of the view that the policy clearly states that if a nurse needs to leave a patient who is under observation at any point, that nurse needs to ensure that there is somebody else to cover them and observe the patient whilst they are away.

The panel also took into account Mr Paul's response to charge 1 from his representative, which contained partial admissions as the following was stated:

'…The registrant witnessed that the patient was asleep and he went to quickly get water…'

The panel also noted that Patient A was a known risk to himself and a risk to other patients on the Ward. It was of the view that it was Mr Paul left the patient unattended when he had a duty not to and that it was his responsibility to ensure that he sought cover before leaving the patient alone.

Having taken all of the above into consideration the panel concluded that on the balance of probabilities Mr Paul left the observations on four occasions and therefore found charge 1 proved.

Charge 2

> "That you, a registered nurse:
>
> 2. On 31 December 2021, you left a set of keys to the clinic room in the door of the clinic room."

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witness 1 and Witness 2, the hearsay evidence of Witness 5, alongside Mr Paul's response to the incident, which contained partial admissions.

The panel took into account Witness 1's statement which stated the following:

> *'…One of the clinical leads on the Ward informed me of the incident.*
>
> *I was told that a support worker [Witness 5] , walked past the clinic room during the night shift and noticed that the keys to the room were in the door. These keys open the clinic room, the medication cupboard and the doors to the Ward. It was reported that Paul had carried out the medication round that evening and that he left the*

keys in the door after completing the round. I am not aware of how long the keys were left in the door for…'

The panel also took into account Witness 2's statement dated 14 February 2023 which stated the following:

'…As I was not working on this shift, this incident was reported to me by a support worker who witnessed it [Witness 5]. [Witness 5] stated that the clinic room door had been left wide open with the clinic keys on the side and the medication cupboards open. There was reportedly no nurse near the clinic. [Witness 5] stated that when she saw this she grabbed the clinic keys and gave them to Paul, who was the nurse on shift.

There was a significant risk of fatality as a result of this incident. We have a variety of medications, in excess of 60, stored in the clinic room. There are benzodiazepines in there which, if taken in significant amounts, can cause someone to fall unconscious. There are also a number of controlled drugs in there in a locked cupboard. There was a significant risk that a patient could have gone into the clinic room and eaten tablets. As the ward is a psychiatric intensive care ward, many of our patients are thoroughly psychotic and have issues with substances…'

The panel also took into account Mr Paul's response to charge 2 from his representative which stated the following:

'...On this shift the Registrant was the only registered nurse on duty looking after 7 patients. A fight broke out between 2 patients and an emergency bell rang and he had to attend to them. One of the patients was bleeding and the Registrant had to get dressings from the clinical room because he was rushing. He closed the clinical room door but forgot the keys on the door…'

The panel heard in evidence that even in the event of an emergency, the responsible staff member must secure the clinical room before responding. The panel also noted that Mr Paul admitted this allegation in his Case Management Form.

The panel determined that the statements of Witness 1 and Witness 2 highlighted Mr Paul's failure to ensure that the door to the clinical room was properly secured and the keys were accessible to passersby.

For these reasons, the panel found that the incident in charge 2 had occurred and therefore found charge 2 proved.

Charge 3(a)

That you, a registered nurse:

3. On 31 December 2021 in relation to Patient C you:

a) failed to administer the 9pm dose of Depakote either at 9pm or at all;

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2, the Incident Form, Patient C's medication administration record, the Medication Stock Book and Mr Paul's response to the incident, containing his partial admissions.

The panel took into account Witness 2's statement regarding the incident of 31 December 2021, which stated the following:

'…Paul was working on the night shift on 31 December 2021 and I was working the following day sift on 1 January 2022. On the morning of 1 January 2022, I went to administer medication to Patient C at 9am. Patient C was prescribed 750mg of

Depakote twice a day at 9am and 9pm, as a mood stabiliser. When I checked Patient C's titration MAR chart... I could see that there was no signature in box for the 9pm administration on 31 December 2021. The purpose of a signature is to indicate that the dose has been administered.

I then looked through the stock book for 31 December 2021 to see if perhaps the Depakote had been administered and recorded as such in the stock book, but Paul had failed to sign the MAR chart in error...There is no Depakote recorded for Patient C at 9pm on 31 December 2021…'

The panel also took into account Mr Paul's response to the incident from his representative where the following was stated:

'…The Registrant admitted to missing the medication because he was on his own unsupervised on the night shift of the 30/31st of December 2021…'

Based on the evidence above and Mr Paul's admission to being responsible for the error, the panel determined that this incident had occurred and found charge 3(a) proved.

Charge 3(b)

That you, a registered nurse:

3. On 31 December 2021 in relation to Patient C you:

b) at the conclusion of your shift, failed to tell Colleague A that the 9pm dosage of Depakote had not been administered;

This charge is NOT found proved.

In reaching this decision, the panel took into account all of the evidence considered in regard to charge 3(a) which included the witness statement of Witness 2, the Incident Form, the Medication Stock Book and Mr Paul's response to the incident, containing his partial admissions.

The panel took into account Witness 2's statement regarding Mr Paul's response to her confronting him about this missed medication. She stated the following:

> *'…At first, Paul stated that he had administered the dose. I then told him that the titration MAR chart was not signed. He then suggested that he might have forgotten to sign it, but still administered the medication. I asked him if he was sure because I checked the stock book and counted the remaining Depakote tablets. Paul then said that he must have missed it and did not administer the Depakote to Patient C. Paul did not provide any further explanation…'*

Although the panel noted that Mr Paul admitted to charge 3(b) in his response to the incident, presumably on the basis that he did not tell his colleague that he had administered the Depakote. However, the panel was of the view that the NMC has not discharged the burden of proof to satisfy that Mr Paul was aware of his mistake before he handed over to colleague A (Witness 2) at the conclusion of the shift. Therefore, it found charge 3(b) not proved.

Charge 4(a)

That you, a registered nurse:

4. On 29 January 2022, in relation to Patient B, you:

a) administered a 5mg tablet of Diazepam when 10 mg of liquid Diazepam was prescribed;

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witness 1, Witness 3 and Witness 4, Patient B's medication chart, the CCTV footage and Mr Paul's response to the incident of 29 January 2022.

Witness 3's statement regarding the incident stated the following:

> *'….Patient B was prescribed liquid Diazepam to assist with his challenging behaviours. I recall that he had been on this medication for nearly the whole time that he was on the Ward. As I was undertaking observations of Patient B, I went with him to the clinic room hatch and watched him take his medications.*
>
> *Paul handed the medication to Patient B in a pot. I believe Patient B questioned how many tablets were in the pot, but with a little encouragement he took the tablets. Myself and Patient B waiting for the liquid Diazepam to be administered. I knew it had not been administered because it is given in two syringes. Patient B called the Diazepam ' the pink stuff' because it is a pink coloured liquid. Patient B questioned where the pink stuff was and I asked Paul if he had been given all of his medication. Paul confirmed that he had been given all of his medications in the pot.*
>
> *I was a little confused at this because I had been on shift for the previous few nights and had seen Patient B be administered liquid Diazepam in syringes, however Patient B did not receive any liquid medications on this occasion. Usually a support worker would be aware of any medication changes for patients…Paul confirmed that he had received all of his medication, I thought Patient B had been administered Diazepam in tablet rather than liquid form.*
>
> *When I finished the 2.1 observations on Patient B, I went to speak to [Witness 4], clinical team leader, about what I had seen. I asked if there had been any medication changes and he said not as far he was aware…'*

The panel also took into account Mr Paul's response to the incident from his representative which stated the following:

> *'…The Registrant initially in fear denied the allegations he later on admitted, admitted on page 20 [sic] about a mistake and raised concerns of fear of repercussions to the Ward Manager D.S. Since the patient was fast asleep he had not wanted to disturb them to give them the remaining 5mg…'*

The panel also considered the CCTV footage dated 29 January 2022 and the coinciding medication chart. The panel was of the view that it appeared as though when Mr Paul realised that he had administered the 5mg Diazepam tablet in error, he then altered the records to cover up that he had taken a 5mg Diazepam tablet from the medication room. Mr Paul then claimed to have destroyed the table and instead administered the 10mg liquid Diazepam. However, there was no evidence that the tablet had been destroyed. The panel also noted that Mr Paul had failed to ensure that the 5mg Diazepam tablet had been countersigned when taken from the medication room.

Based on the evidence above and Mr Paul's admission to the error, the panel determined that this incident had occurred and therefore found charge 4(a) proved.

Charge 4(b)

> That you, a registered nurse:
> 4. On 29 January 2022, in relation to Patient B, you:
>
> b) failed to ensure that the administration of the liquid and/or tablet Diazepam was witnessed by a nurse or approved support worker.

This charge is found proved.

In reaching this decision, the panel carefully considered the evidence before it, which included the witness statements provided by Witness 1 and Witness 4, the Medication Management Policy, the relevant Drug Charts, the CCTV footage, and Mr Paul's response to the incident of 29 January 2022

The panel took into account Witness 1's statement regarding the incident:

> *'…When a controlled drug is administered, best practice is to have a nurse or approved support worker co-sign the Ward's Drugs Liable for Misuse ("DLM") book to confirm that two people have seen the drug be dispensed and administered to the patient.*
>
> *It was alleged that Paul had failed to ensure a second check when he administered medication to Patient B. It was reported that he asked [Witness 4] to sign the DLM book after he dispensed the medication, but [Witness 4] refused as he had not seen it dispensed. The DLM book for recording administrations of liquid Diazepam is exhibited at Exhibit JL/02. On the first row of Exhibit JL/02, Paul has initialled to indicate that he had administered 10mg of liquid Diazepam to Patient B at 9:20pm. There is no signature in the 'Witnessed by' column, indicating that Paul failed to have a colleague check the administration.*
>
> *If a medication administration is not second checked, it increases the risk that the medication will be administered incorrectly. The nurse could administer the wrong medication or the wrong dose of the medication, leading the patient to be under or over dosed. It also leaves the nurse open to accusations if there is any discrepancy in the medication count...'*

The panel took into account Witness 4's statement regarding the incident which stated the following:

'… I thought this documentation indicated that Paul had made an error because he failed to ensure there was a second checker to witness the administration of the liquid Diazepam. I could tell this because there is no signature in the 'Witnessed by' column. Additionally, the balance he recorded as remaining was incorrect. I know this because liquid Diazepam comes in a 300ml bottle. Therefore, there should have been two bottles of Diazepam in order for there to be 312.5ml remaining, but there was no second bottle in the clinic room to house the extra 12.5ml. I recall checking to see if I could find this second bottle, but I did not…'

The panel also took into account Mr Paul's response to his error, from his representative, which stated the following:

'…The Registrant upon reflection has learnt the importance of recognising his own limitations in practice. He has been able to complete a course with RCN on safe medicines administration especially on the importance of a second checker, checking the drug chart. The most important thing he has learnt is to escalate issues concerning patient safety in a timely manner…'

The panel was satisfied that there was no documentary evidence to suggest that the administration of the Diazepam was witnessed by a nurse or approved support worker. For these reasons, the panel found that the incident had occurred and therefore found in charge 4(b) proved.

Charge 4(c)

That you, a registered nurse:
4. On 29 January 2022, in relation to Patient B, you:

c) failed to ensure that a nurse or approved support worker countersigned the Drugs Liable for Misuse Book for Liquid and/or tablet Diazepam.

This charge is found proved.

In reaching this decision, the panel carefully considered the evidence before it, which included the witness statement provided by Witness 1 and Witness 4, the Medication Management Policy, the relevant Drug Charts, the CCTV footage, and Mr Paul's response to the incident from his representative.

The panel was satisfied that Mr Paul had failed to ensure that a nurse or approved support worker had countersigned the Drugs Liable for Misue Book as there was no documentary evidence to support that the Diazepam was countersigned for. Therefore, the panel found that the incident in charge 4(c) had occurred and found the charge proved.

Charge 5(a)

That you, a registered nurse:

5. On 29 January 2022, in relation to Patient B, you inaccurately recorded that:

a) 10 mg of liquid Diazepam had been administered when it had not been administered;

This charge is found proved.

In reaching this decision, the panel carefully considered the evidence before it, which included the witness statements provided by Witness 1 and Witness 4, and Mr Paul's response to the incident which included admissions to the incident of 29 January 2022.

The panel took into account Witness 1's statement regarding the incident which stated the following:

'…In addition to failing to ensure there was a second check for the administration and failing to administer the liquid Diazepam, it was alleged that Paul had administered a 5mg table [sic] of Diazepam in place of the 10mg liquid Diazepam. [Witness 4] had checked Patient B's medication chart, which can be seen at Exhibit JL/01, which confirmed that Patient B was prescribed liquid Diazepam.

In Patient B's medication chart (Exhibit JL/01), Paul has initialled on the 29 January 2022 at 9pm to indicate that he has administered 10mg of liquid Diazepam.

[Witness 4] checked the DLM book for Diazepam in tablet form for 29 January 2022 (Exhibit JL/03). In this book, an administration of a 5mg tablet of Diazepam to Patient B was initialled for by Paul. This has then been crossed out and the 5mg tablet has been recorded as disposed of.

There is no real risk associated with administering medication in tablet rather than liquid form. However, sometimes Patient B would spit out medication, so the liquid form ensures that the medication is absorbed. Further, the tablet is only 5mg, rather than the 10mg prescribed to Patient B. This is therefore an under dosing and increased the risk that Patient B would become violent or unpredictable. I do not believe any harm came to Patient B or those around him…'

The panel took into account Mr Paul's response to the error at the time, detailed in Witness 1's statement:

'…After checking the evidence, I spoke to Paul on 30 January 2022. He initially denied making any error and was adamant that he administered the Diazepam liquid correctly. He was annoyed that I was questioning him. I then asked [Witness 4] to join us and put the evidence that I had seen to Paul, which included copies of the DLM book, what the support workers had reported and what I had seen regarding the Diazepam tablet. At that point, Paul admitted that he had administered a tablet rather than liquid Diazepam and that he had lied about it in

the documentation. He said words to the effect of "I covered it up because I was worried about the repercussions…'

The panel took into account Witness 4's statement regarding the incident, which stated the following:

'…I exhibit the CCTV footage at Exhibit JL/04. In the footage, I could not clearly see what medications Patient B Is given, but I could hear Patient B and the support workers question where the "pink stuff" is. In response, I heard word from Paul to the effect of "oh no you're on this now, its right.' Patient B steps back when he is given the medication and I could see there was no pink liquid.

I found it suspicious that what Paul had recorded on the medication chart and in the DLM book contradicted what the support workers and Patient B had said. I suspected that Paul had made a mistake and administered Diazepam in tablet form and then tried to cover it up by documenting that he had administered it in liquid form and disposed of the tablet so that the tablet count would tally up…

…

I know Paul did not get a second check as he was doing the medication round on his own. There was also no signature to indicated that on the liquid Diazepam DLM book (Exhibit JL/02)…'

Based on the evidence above and Mr Paul's admission to not having administered the liquid Diazepam, the panel determined that this incident had occurred and therefore found charge 5(a) proved.

Charge 5(b)

That you, a registered nurse:

5. On 29 January 2022, in relation to Patient B, you inaccurately recorded that:

b) a tablet of Diazepam had been disposed of, when it had not been.

This charge is found proved.

In reaching this decision, the panel carefully considered the evidence before it, which included the witness statements provided by Witness 1 and Witness 4, the relevant Drug Charts and Mr Paul's response to the incident in his Case Management Form, which included an admission to not having disposed of the Diazepam tablet.

The panel took into account Witness 1's statement:

> *'…As Paul had recorded that he had disposed of a 5mg tablet of Diazepam, I also checked the medication disposal bin in the clinic room. When we dispose of a medication that is liable for misuse, we put it in a pot and mix it with water so that, if found, it is no longer effective. We then dispose of the pot in a specific bin. There 19 8 Signed: Dean Sharkey Dated: 22/03/2023 Page 8 of 9 were none of these pots in the disposal bin when I went to check, indicating that nothing had been disposed of prior to my arrival. I could therefore assume that Paul had falsified the record to make it appear that he had not administered a tablet of Diazepam to Patient B when in fact he had…'*

The panel also took into account Witness 4's statement:

> *'…I also checked the DLM book for Diazepam in tablet form, which I exhibit at Exhibit JL/0. On the page for 29 January 2022, an administration of a 5mg tablet of Diazepam was initially initialled for Patient B, that was then subsequently crossed out and recorded as the 5mg of Diazepam being disposed of. Paul got a support worker to co-sign the disposal. The support worker should have witnessed it but on*

that occasion she did not. I recall that I looked through the waste medication bucket, where the tablet would have been disposed of, but I cannot recall what I found…'

The panel also considered Mr Paul's response in relation to the disposal of the Diazepam tablet. He stated the following:

'…I DIDN'T DISPOSE ANY TABLET DIAZEPAM I ADMINISTERED THE 5MG AND SAME WAS COUNTER SIGNED BY A SUPPORT WORKER (NAME I CANT REMEMBER RIGHT NOW), I ONLY FOUND OUT THE PATIENT WAS ON LIQUID DIAZEPAM WHEN I WAS COUNTER BALANCING THE DDA BOOKS…'

The panel determined that initially Mr Paul had tried to cover up his error in administering a 5mg Diazepam tablet instead of 10mg liquid Diazepam by falsifying records to coincide with him allegedly disposing of the tablet. The panel noted that the destruction of the tablet was countersigned by a Support Worker who admitted that they had not directly observed the destruction of the tablet and had relied on trusting in Mr Paul telling them that he had disposed of the Diazepam tablet. Upon investigation it was later discovered that there was no evidence of the tablet having been disposed of. When questioned about this during a supervision meeting Mr Paul admitted that he did not dispose of the 5mg Diazepam tablet, and it had been administered. Therefore, the panel found charge 5(b) proved.

Charge 6(a)

That you, a registered nurse:

6. Your conduct at any and/or all of Charge 5 was dishonest in that you: a) Knew that you had not:

i) Administered liquid Diazepam;

ii) Disposed of a tablet of Diazepam.

This charge is found proved.

In reaching this decision, the panel carefully considered all of the evidence before it, which included the witness statements provided by Witness 1 and Witness 4, and Mr Paul's admission from his representative as to why he denied having administered the Diazepam tablet and attempted to cover up his error.

Mr Paul's representative stated the following on his behalf:

> *'…The Registrant initially in fear denied the allegations he later on admitted, admitted on page 20 [sic] about a mistake and raised concerns of fear of repercussions to the Ward Manager [Witness 1]…*
>
> *…*
>
> *The Registrant acted in fear and he was scared of the consequences and repercussions from his manager [Witness 1]. He highlighted multiple times regarding the issues with his preceptorship which he felt was a near miss. He was left unsupervised most of the time and felt he could not approach anyone for help since they did not trust him…'*

The panel found that Mr Paul knew at the time that he had not administered liquid Diazepam and had not destroyed the tablet, despite claiming that he had.

The panel found that this was dishonest by any interpretation and therefore found charge 6(a) proved.

Charge 6(b)

That you, a registered nurse:

b) Intended to create the misleading impression that:

i)You had administered liquid Diazepam;

ii)You had disposed of a tablet of Diazepam.

This charge was found proved.

In reaching this decision, the panel took into account all of the evidence outlined in charge 6(a) and considered it carefully.

The panel was of the view that Mr Paul knew that he had not administered the liquid Diazepam and once he knew this, he took a number of steps to cover up his error as he was afraid of the repercussions. The panel determined that Mr Paul went on to cover up this error by falsifying records to pretend that he had disposed of the 5mg tablet of diazepam and administered the 10 mg of liquid diazepam instead.

The panel found that Mr Paul did not give an alternative explanation and that by creating a false record he intended to mislead his managers and fellow registered nurses.

For these reasons, the panel determined that Mr Paul's conduct was dishonest by any interpretation and therefore found charge 6(b) proved.

Fitness to practise

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

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Paul'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.'*

Ms Kennedy 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. She outlined the relevant sections and invited the panel to consider those sections in making its decision.

Ms Kennedy identified the specific, relevant standards where she submitted Mr Paul's actions amounted to misconduct. She submitted that Mr Paul's conduct in relation to leaving a patient unattended, leaving keys to the clinic room in the door, failure to administer medication, and dishonesty in that Mr Paul falsified records to make it appear

that he had administered medication when he had not, have been found proven and were sufficiently serious to amount to misconduct.

Ms Kennedy told the panel that the role of nurses is to provide safe and effective care to patients, and Mr Paul was working with vulnerable patients on a male psychiatric intensive care unit. She submitted that Mr Paul's misconduct in this case put those patients at serious risk of harm, fell below the standards which are expected of a registered nurse and fell far short of what would be proper conduct.

Ms Kennedy submitted that in all circumstances of this case, Mr Paul's actions in the charges proved depart from good professional practice and are sufficiently serious to constitute serious misconduct.

Submissions on impairment

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

Ms Kennedy submitted that the following questions outlined by Dame Janet Smith in the fifth Shipman report can be answered in the affirmative in respect of this case, in that Mr Paul:

- *Has in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
- *Has in the past brought and/or is liable in the future to bring the profession into disrepute; and/or*

- *Has in the past committed a breach of one of the fundamental tenets of the profession and/or is liable to do so in the future and/or*
- *Has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

Ms Kennedy submitted that Mr Paul's misconduct did put patients at a risk of harm as nursing demands high standards of medication administration and patient observation for the purpose of patient safety. She said that the misconduct of Mr Paul failing to appropriately supervise patients, failing to appropriately administer medications in accordance with prescriptions and leaving the clinic room unlocked meant that patients were exposed to a risk of harm.

Ms Kennedy submitted that the public has a right to expect nurses to provide appropriate and confident care and Mr Paul's conduct has brought the profession into disrepute and breached fundamental tenets of the profession. She submitted that a number of the concerns raised are capable of remediation as they relate to identifiable areas of clinical practise. However, the issue of dishonesty is difficult to remediate.

Ms Kennedy referred the panel to Mr Paul's Case Management Form dated February 2024 where he stated the following:

> *'I DO NOT ACCEPT THAT MY FITNESS TO PRACTICE IS IMPAIRED BECAUSE AS AN INTERNATIONAL NURSE WHO WAS BARELY 4 MONTHS IN THE COUNTRY I WAS NOT GIVEN NECESSARY SUPPORT BY MY EMPLOYER DESPITE THE FACT THAT I RAISED THESE ISSUES WITH MY PRECEPTOR AND CLINICAL MANAGER … NOTHING WAS DONE TO HELP ME INSTEAD THEY SAID "AM THE FIRST INTERNATIONAL NURSE THEY DON'T KNOW WHAT TO DO WITH ME" I THINK I WAS THROWN UNDER THE BUS IMMEDIATELY I MADE MISTAKES INSTEAD OF TAKING TIME TO PUT ME THROUGH THE RIGHT PATH PROBABLY BECAUSE THEY ARE UNAWARE ON*

HOW TO PRECEPT INTERNATIONAL NURSES. I UNDERSTAND MY SHORT COMINGS DURING MY TIME IN THE UK AS A NURSE AND HAVE REFLECTED ON THESE ISSUES AND HAVE TAKEN STEPS TO MAKE NECESSARY IMPROVEMENTS, FOR INSTANCE: PERSONALLY, I HAVE COMPLETED FURTHER STUDIES AND PRACTICED SAFELY AFTER THE INCIDENTS AND NO COMPLIAN [sic] ABOUT MY PRACTICES OR STUDIES OF WHICH I CAN PRESENT CHARACTER REFRENCES IF NEED BE.'

She submitted that Mr Paul's actions were dishonest, and whilst he did make partial admissions to dishonesty, he does not accept that his fitness to practise is impaired. She told the panel that although Mr Paul has been working overseas without any further concerns and has provided a bundle of certificates and a reference from his local parish, there is nothing before the panel today to demonstrate that he has strengthened his practice or has any understanding of the potential patient harm that could have been caused as a result of his actions. She submitted that there is limited insight, and the documents are of limited relevance therefore, the panel cannot be satisfied that Mr Paul's conduct would not be repeated if he were permitted to practice unrestricted.

Ms Kennedy further submitted that a finding of impairment is required to maintain public confidence in the profession and to uphold proper professional standards. She submitted that public confidence in the profession and the NMC as its regulator would be undermined if such behaviour were not marked as unacceptable.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

The panel was of the view that Mr Paul's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Paul's actions reflected multiple breaches of the Code. Specifically:

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

1.2 make sure you deliver the fundamentals of care effectively

8 Work cooperatively

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

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

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

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

20 Uphold the reputation of your profession at all times

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered the charges individually and cumulatively as well as the circumstances of the case as a whole.

The panel was of the view that charge 2 and charge 3(a) in isolation would not have met the threshold for misconduct. For example, Witness 2 stated '*it is not a very serious incident, but it is not good practice.*' However, as there were multiple incidents that were so serious in nature that they would cross the threshold in their own right, the panel determined that the charges collectively amounted to misconduct and overall represent multiple failures that would be considered deplorable by fellow practitioners, thereby damaging the trust that the public places in the profession.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Paul'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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

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

The panel determined that although no harm was caused, patients were put at risk and could have suffered physical and emotional harm as a result of Mr Paul's misconduct. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. On this basis, the panel determined that limb *'a*' of the '*test'* was engaged.

Mr Paul's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel determined that limbs *'b'* and *'c'* in the above '*test*' were also engaged in this case.

The panel also determined that Mr Paul behaved dishonestly by falsifying records in an attempt to cover up that he had mistakenly administered a 5mg Diazepam tablet instead of

10mg liquid Diazepam. On this basis the panel determined that limb *'d'* of the above '*test*' was also engaged.

Regarding insight, the panel considered that Mr Paul made partial admissions in his Case Management Form and his responses made by his representative. It noted Mr Paul accepts that he acted dishonestly. The information before the panel with regard to his reflections and insight into the harm which could have been caused was insufficient and there was limited understanding of how his actions and dishonesty could negatively impact on the public perception of the nursing profession.

The panel was satisfied that the misconduct relating to Mr Paul's clinical failings in this case are capable of being addressed. It took into account Mr Paul's certificates that he has obtained overseas, however there was no information before it which demonstrated that he has strengthened his practice, particularly in the areas of concern in this case.

The panel was of the view that Mr Paul deliberately went out of his way to cover up his failure to administer the correct medication to a patient. It determined that the misconduct in this case evidenced behaviour that is inherently more difficult to put right, since it raises concerns around attitudinal issues that are difficult to remediate through training. The panel considered the evidence before it and concluded that it has not received any information to suggest that Mr Paul has taken any steps to address the specific concerns raised about his conduct as he did not provide a reflective statement addressing the consequences of his conduct. Therefore, the panel concluded that there is a risk of repetition due to Mr Paul's significant lack of insight and remorse and 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.

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 Mr Paul's fitness to practise impaired on the grounds of public interest. It was of the view that a member of the public in possession of all the facts in this case would be surprised if a finding of impairment was not made by this regulator given that it involved dishonesty.

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

Sanction

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

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

Ms Kennedy informed the panel that in the Notice of Hearing, dated 25 April 2024, the NMC had advised Mr Paul that it would seek the imposition of a suspension sanction for a proposed period of 12 months with a review at the end if it found Mr Paul's fitness to practise currently impaired. During the course of the hearing, the NMC submitted that it is a matter for the panel to consider whether to impose a suspension order or whether a striking off order is more appropriate in light of the panel's findings.

Ms Kennedy outlined the aggravating factors she identified in this case:

- Lack of insight;
- A pattern of misconduct over a period of time; and
- Risk of physical and emotional harm to patients as a result of Mr Paul's conduct

Ms Kennedy also outlined the possible mitigating factor she identified in this case:

- Some early admissions to the charges; and
- The incidents occurred when Mr Paul first started practising as a nurse in the UK, which contextual difficulties arose from

Ms Kennedy submitted that making no order would not be appropriate in light of the risk of repetition identified by the panel. She submitted that imposing a caution order would also not be appropriate due to the seriousness of this case.

Ms Kennedy submitted that imposing a conditions of practice order would be inadequate as such an order would only address the clinical concerns which may be remediable with support and training. However, the panel found dishonesty in this case, which raises attitudinal concerns that are inherently more difficult to address and are difficult to remediate through training. She submitted that the panel also found that Mr Paul's reflections and insight were insufficient and demonstrated a limited understanding of how his actions and dishonesty could impact on public's perception of nursing. Therefore, a conditions of practice order cannot be formulated that would adequately monitor and assess Mr Paul's dishonesty, whilst also protecting patients from the risks identified.

Ms Kennedy referred the panel to the NMC's SG. She further submitted that the panel did find that the dishonesty in Mr Paul's conduct did indicate attitudinal issues and although the dishonesty was an isolated incident, the other incidents of misconduct were not

isolated. She submitted that it is a matter for the panel to assess whether the dishonesty in this case can be addressed by the imposition of a suspension order, or whether a striking off order is more appropriate.

Decision and reasons on sanction

Having found Mr Paul'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:

- Multiple incidents covering a wide range of practice;
- Potential risk to patients;
- Limited insight; and
- The dishonesty in this case involved deliberately falsifying records to cover up a mistake

The panel also took into account the following mitigating features:

- Early admissions to some of the charges;
- A challenging time with Mr Paul acclimatising to working in the UK;
- The dishonesty was a one-off response caused by panic and fear of repercussions; and
- As far as the panel is aware no repetition of these failings

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 Mr Paul's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Paul'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 issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*

- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel was of the view that a conditions of practice order would only address the clinical concerns, however no practical or workable conditions could be formulated to address the dishonesty matter in this case as this misconduct is not something that can be addressed through retraining. The panel also noted that a conditions of practice order would also require cooperation with the NMC proceedings and whilst Mr Paul had engaged with the NMC previously, he failed to attend this hearing and therefore it is uncertain as to whether he would comply with a conditions of practice order if one were imposed. Furthermore, the panel concluded that the placing of conditions on Mr Paul's registration would not adequately protect the public or the public interest.

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

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

- *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 panel was of the view that a suspension order is appropriate in this case as such an order would reflect the seriousness of this case, provide public protection whilst also addressing public interest. Although there were multiple incidents reflected in the charges the dishonesty aspect was confined to a single event. It noted that Mr Paul has accepted responsibility for some of the charges and that there has been no repetition of the misconduct identified in this case from Mr Paul since the original referral was made. The panel was satisfied that a suspension order would also give Mr Paul the chance to address the clinical concerns identified and to reflect on his dishonesty and how this may have affected patients and the nursing profession.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and the mitigation provided, the panel concluded that it would be disproportionate. It was of the view that Mr Paul's dishonesty was a spontaneous action taken in order to cover up his medication administration error, due to the fear of repercussions from his employer at the time. Although the panel noted that Mr Paul's behaviour suggested attitudinal issues, it was of the view that there was insufficient evidence to determine they were deep seated. The panel also noted that there were contextual issues which surrounded Mr Paul's actions at the time. Whilst the panel acknowledges that a suspension may have a punitive effect, it was of the view that it would be disproportionate in Mr Paul's case to impose a striking-off order.

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

The panel considered that this order is necessary to protect the public and mark the importance of maintaining public confidence in the profession, and to send to the public

and the profession a clear message about the standard of behaviour required of a registered nurse.

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

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

Any future panel reviewing this case would be assisted by:

- Evidence of professional development, including documentary evidence of completion of relevant training courses relating to medications management and patient care.
- A reflective account on what happened, why it happened, the impact of those actions and what Mr Paul would do differently to ensure that the misconduct is not repeated.
- Testimonials from a line manager or supervisor that detail his current work practices.
- Engagement with a reviewing panel

This will be confirmed to Mr Paul in writing.

Interim order

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

protection of the public, is otherwise in the public interest or in Mr Paul's own interests until the suspension sanction takes effect.

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

Submissions on interim order

The panel took account of the submissions made by Ms Kennedy. She submitted that the NMC is seeking the imposition of an interim suspension order for a period of 18 months to cover any appeal period until the substantive suspension order takes effect.

Ms Kennedy submitted that given the seriousness of the charges found proved, an interim suspension order is necessary on the grounds of public protection and is also otherwise in the wider public interest.

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 protect the public and the wider public interest. Also to cover the 28-day appeal period and the duration of any appeal should Mr Paul decide to appeal against the panel's decision.

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

That concludes this determination.