Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Tuesday 28 May 2024 - Friday 7 June 2024
&
Monday 10 June 2024
&
Tuesday 18 June 2024 - Wednesday 19 June 2024

Virtual Hearing

Name of Registrant:	Marvin Sabado
NMC PIN:	19F0417O
Part(s) of the register:	Adult Nursing – Sub part 1 - RN1 Registered Nurse - June 2019
Relevant Location:	Surrey
Type of case:	Misconduct/Lack of competence
Panel members:	Caroline Rollitt (Chair, lay member) Allwin Mercer (Registrant member) Judith Webb (Lay member)
Legal Assessor:	Juliet Gibbon
Hearings Coordinator:	Rene Aktar
Nursing and Midwifery Council:	Represented by Hena Patel, Case Presenter
Mr Sabado:	Not present and unrepresented at the hearing
Facts proved:	Case reference: (078856): 1a(i), 1b, 2, 3a, 3b, 3c, 3d, 4a, 4b, 4c, 6a, 6b, 7a, 7b, 7c, 8a, 8b, 9a(ii), 9b(i), 9b(iii), 9b(iv), 9b(v) Case reference: (089691): 1a, 1b, 2a, 2b, 2c, 3a(i), 3a(ii), 3b, 3c, 3d, 3f, 4a, 4b, 4c, 5a, 5b, 5c, 5d, 7a, 7b, 7c, 8a, 8b, 8c, 10a, 10b, 10c

Facts not proved:	Case reference: (078856): 1a(ii), 5, 9a(i), 9a(iii), 9a(iv), 9a(v), 9b(ii) Case reference: (089691): 2d, 2e, 3e, 3g, 9a, 9b, 9c, 11
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Sabado was not in attendance and that the Notice of Hearing letter had been sent to Mr Sabado's registered email address by secure email on 26 April 2024.

Ms Patel, 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, that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Sabado'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 Sabado 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 Sabado

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

Ms Patel referred the panel to the email from Mr Sabado dated 26 April 2024 in which he stated:

"i am not interested. I already am not part of your nursing registry…"

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mr Sabado. In reaching this decision, the panel has considered the submissions of Ms Patel 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 Sabado;
- Mr Sabado has informed the NMC that he has received the Notice of Hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- 8 witnesses are due to attend the 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;
- Some of the charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Sabado in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address,

He has made no response to the allegations. 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. Furthermore, the limited disadvantage is the consequence of Mr Sabado'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 Sabado. The panel will draw no adverse inference from Mr Sabado's absence in its findings of fact.

Details of charge

Charge for case reference: 078856/2020

That you:

1) On one or more occasions between 29 November 2019 and 3 December 2019 slept whilst on duty, namely:

    a) On 1 December 2019:
        i. Between 22:00 hrs and 01:30 hrs;
        ii. Between 06:00 and 07:00 hrs;

    b) On 2 December 2019 between 04:45 and 06:15 hrs

2) On the night shift of 30 November to 1 December 2019 used headphones whilst on duty.

3) On or around 2 December 2019 in relation to an Patient A, failed to prepare Patient A's infant feed correctly, in that you;

a) Added a thickener to the Patient A's milk;
b) Did not measure the quantity of the thickener;
c) Did not read the information on the box containing the thickener before administering the infant feed.
d) Did not add a fortifier to the Patient A's infant feed.

4) On or around 2 December 2019 in relation to an Patient A, failed to:

a) Follow Patient A's prescription sheet and/or dietician chart;
b) Check and/or confirm the position of Patient A's nasogastric tube before administering an infant feed;
c) Carry out a pH test in relation to Patient A's nasogastric tube.

5) On an unknown date, prior to 9 December 2019, attempted to administer Captopril, Frusemide and Sildenafil together/at the same time to a patient.

6) Failed to communicate with colleagues, namely:

a) By providing complete information regarding patients in handovers at the end of a shift.
b) When you left a bay where you were attending to patients without informing colleagues.

7) On one or more occasions made record keeping errors in that you failed to:

a) Complete records in full;
b) Complete records in a timely manner;
c) Ensure your entries in records was legible.

8) On an unknown date between 9 December 2019 and 18 February 2020 offered to administer an intravenous medication:

a) Which was beyond your level of competency;

b) Which you knew you had been signed off to perform.

9) Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 registered nurse, in that you:

a) Failed to meet the target competencies set on or around 9 December 2019 by 11 February 2020, namely;

i. Safe preparation, storage and administration of infant feeds;
ii. Management of gastric tube;
iii. Medicine management;
iv. Professionalism;
v. Documentation.

b) Failed to meet and/or maintain the target competencies set on or around 18 February 2020 by 12 March 2020, namely;

i. Safe preparation, storage and administration of infant feeds;
ii. Management of gastric tube;
iii. Medicine management;
iv. Professionalism;
v. Documentation.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct in charges 1 to 8 and/or lack of competence in charge 9.

<u>Charge for case reference: 089691/2022</u>

That you, a band 5 registered nurse:

1) On 23 February 2022 in relation to Patient A failed to escalate to a doctor Patient A's:

a) Elevated heart rate;

b) Variable/Spiking temperature.

2) On 23 February 2022 in relation to Patient A administered medication namely, intravenous magnesium:

a) Without consulting a doctor prior to administration;

b) Without a prescription;

c) Contrary to a note stating the said medication was only to be administered in the Intensive Care Unit (ITU);

d) At a different dose to that administered in ITU;

e) Without obtaining a second check.

3) On 7 March 2022 in relation to Patient B administered medication namely, Heparin:

a) Without informing i. The Outreach Team and/or; ii. A doctor of difficulties obtaining blood prior to administration;

b) Without consulting a doctor prior to administration;

c) Without the Heparin being prescribed;

d) Without keeping a proper record of the administration of the Heparin.

e) Without informing Patient B:

f) Which was outside his level of competency;

g) At an unknown concentration.

4) On the shift from10 April to 11 April 2022 whilst conducting a procedure said the words "oh, I'll cover the patient's breast with a towel because I am straight" or a gist of words of similar effect which:

a) Were unprofessional;

b) Were of a sexual nature;

c) Indicated you did not treat the patient with dignity.

5) On 10-11 April 2022 you sent an email to Colleague A which contained the words “…….we keep it a secret…and eye mean no harm…I think you are very beautiful. Sorry eye mean no harm….can you keep this message a secret?” which was:

a) Inappropriate;

b) Of a sexual nature;

c) To a junior staff member;

d) Sent using your work email.

6) On the shift 10 April to 11 April 2022 stated the following or a gist of similar words: “oh I’ll cover the patients breasts with a towel because I am straight.”

7) On 11 April 2022 sent one or more emails set out in schedule 1 to Colleague A which:

a) Subjected Colleague A to shock and/or interference;

b) Were of a sexual nature

c) Made personal comments about Colleague A

8) On 12 April 2022 sent one or more emails set out in schedule 2 to Colleague A which:

a) Subjected Colleague A to shock and/or interference;

b) Were of a sexual nature;

c) Made personal comments about Colleague A.

9) On 14 April 2022 sent an electronic communication at 15:59 hrs to Colleague A which:

a) Amounted to harassment;

b) Were of a sexual nature;

c) Made personal comments about Colleague A.

10) On 10 May 2022 stated the following or a gist of similar words:

a) “….believed strongly that left-handed people have a link to the supernatural world….”

b) “……was doing some research in relation to this link……”

c) “…..assessing colleague a to see if she shared this belief (in relation to (a) above.

11) On 10 May 2022 refused to attend the [PRIVATE] at Kingston Hospital NHS Foundation Trust.

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

Schedule 1 – Emails on 11 April 2020 at:

a) 12:01 hrs

b) 12:05 hrs

c) 12:08 hrs

d) 12:21 hrs

e) 12:36 hrs

f) 18:47 hrs

g) 19:03 hrs

h) 19:10 hrs

i) 19:22 hrs

j) 19:24 hrs

k) 19:34 hrs

l) 20:06 hrs

m) 20:18 hrs

n) 20:45 hrs

Schedule 2 - Emails on 12 April 2020 at:

a) 02:34 hrs

b) 15:11 hrs
c) 15:46 hrs
d) 15:52 hrs
f) 18:24 hr

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Patel, to amend the wording of charge 6a) and 8b) in the (078856) case and charge 6 in the (089691) case.

The proposed amendment was to avoid duplication and to add additional words. It was submitted by Ms Patel that the proposed amendment would provide clarity and more accurately reflect the evidence.

Charge for case reference: 078856/2020

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d) Did not add a fortifier to the Patient A's infant feed.

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a) Follow Patient A's prescription sheet and/or dietician chart;
b) Check and/or confirm the position of Patient A's nasogastric tube before administering an infant feed;
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6) Failed to communicate with colleagues, namely:

a) By **not** providing complete information regarding patients in handovers at the end of a shift.
b) When you left a bay where you were attending to patients without informing colleagues.

7) On one or more occasions made record keeping errors in that you failed to:

a) Complete records in full;
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a) Which was beyond your level of competency;

b) Which you knew you had **not** been signed off to perform.

9) Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 registered nurse, in that you:

a) Failed to meet the target competencies set on or around 9 December 2019 by 11 February 2020, namely;

   i. Safe preparation, storage and administration of infant feeds;
   ii. Management of gastric tube;
   iii. Medicine management;
   iv. Professionalism;
   v. Documentation.

b) Failed to meet and/or maintain the target competencies set on or around 18 February 2020 by 12 March 2020, namely;

   i. Safe preparation, storage and administration of infant feeds;
   ii. Management of gastric tube;
   iii. Medicine management;
   iv. Professionalism;
   v. Documentation.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct in charges 1 to 8 and/or lack of competence in charge 9.

<u>Charge for case reference: 089691/2022</u>

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a) Without informing i. The Outreach Team and/or; ii. A doctor of difficulties obtaining blood prior to administration;
b) Without consulting a doctor prior to administration;
c) Without the Heparin being prescribed;
d) Without keeping a proper record of the administration of the Heparin.
e) Without informing Patient B:
f) Which was outside his level of competency;
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4) On the shift from10 April to 11 April 2022 whilst conducting a procedure said the words "oh, I'll cover the patient's breast with a towel because I am straight" or a gist of words of similar effect which:
a) Were unprofessional;
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AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

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j) 19:24 hrs

k) 19:34 hrs

l) 20:06 hrs

m) 20:18 hrs

n) 20:45 hrs

Schedule 2 - Emails on 12 April 2020 at:

a) 02:34 hrs

b) 15:11 hrs
c) 15:46 hrs
d) 15:52 hrs
f) 18:24 hr

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

The panel was of the view that the proposed amendments were in the interests of justice. Two of the proposed amendments arose as a result of typographical errors and clarified the charges. Charge 6 was the same charge as charge 4, and therefore duplicitous and should be deleted. The panel was satisfied that there would be no prejudice to Mr Sabado and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Patel under Rule 31 to allow the written statement of Ms 1 into evidence. Ms 1 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend today due to the NMC not being able to get a response from her.

Despite numerous attempts, the NMC had not been able to obtain a signed, written statement from Ms 1. Ms Patel submitted that the evidence is highly relevant and though not provided during the course of the NMC's investigation, was produced for the purpose of the internal investigation. Ms Patel invited the panel to include this evidence.

The panel considered the application. The panel noted that Ms 1's statement had been written during the course of the local investigation.

The panel considered that as Mr Sabado had been provided with a copy of Ms 1's local statement and, as the panel had already determined that Mr Sabado had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel took into account that although the NMC have not been able to get into contact with Ms 1, it considered that there was no reason for fabrication. The panel had sight of the communications log which detailed the NMC's attempts to locate Ms 1. The panel considered that Ms 1's statement and the transcript of her interview, during the local investigation, were relevant to one of the charges faced by Mr Sabado. It was of the view the evidence is not sole or decisive and could be used to support the context of the charge. The panel considered that any unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Ms 1 and the opportunity of questioning and probing that testimony. There was also a public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel was of the view that the hearsay evidence of Ms 1 was relevant, and it would be fair to admit it. The panel would consider what weight it would give to this evidence once it had heard and evaluated all of the evidence before it.

Background

Case reference: 078856/2020

The NMC received a referral about Mr Sabado's fitness to practise on 13 July 2020. The referral came from the Head of Children's Nursing at Royal Brompton Hospital ('the Hospital'). At the time of the concerns raised in the referral, he was working as a Band 5 Staff Nurse at the Hospital.

The regulatory concerns related to Mr Sabado's:

1. Failure to minimise risk to patients by sleeping on duty
2. Failure to maintain the level of skill and knowledge to carry out your professional role

Mr Sabado started working on Rose Ward ('the Ward') at the Hospital in May 2019 as a Supervised Practice Nurse, and on qualifying he became a Band 5 Staff Nurse on the ward.

The Ward provides care for paediatric patients before and after they have undergone procedures related to cardiac and respiratory diseases.

The alleged facts are as follows:

From September 2019 colleagues on the Ward started to report concerns about Mr Sabado's time management and prioritisation of care, as well as communication and completion of documentation.

On 30 November 2019, while Mr Sabado was on the night shift caring for infants and new born babies, he fell asleep on duty. Mr Sabado was also observed during this shift wearing earphones. Mr Sabado was on duty again on the night shift on 1 December 2019, and was observed to be asleep on duty again.

On 2 December 2019, Mr Sabado added thickener to a patient's milk feed rather than fortifier, then failed to check the position of the tube before administering the feed.

On 9 December 2019, an informal capability process was started and Mr Sabado was set targets to improve his practice. There followed a period of supervised practice.

Mr Sabado did not achieve the targets set and the Hospital started a formal capability process. An investigation meeting took place with him at the Hospital on 4 March 2020. Mr Sabado left the Hospital's employment in June 2020.

Case reference: 089691/2022

On 10 July 2022 the NMC received a referral from the Kingston Hospital NHS Foundation Trust (the Trust). On 11 and 12 April 2022, Mr Sabado used his Trust NHS.net email account to send a number of unsolicited emails to a junior colleague, Colleague A. Mr Sabado was suspended, and a full investigation took place.

At the time Mr Sabado was in his probation period at the Trust, concerns had been raised about his performance, attendance and [PRIVATE]. Mr Sabado had been called into a meeting where an action plan was to be put in place, but [PRIVATE] and the next meeting had been planned for the day of the suspension. The Trust informed the NMC that Mr Sabado did not attend the disciplinary hearing. Mr Sabado also declined an offer to be referred to [PRIVATE].

Following investigation Mr Sabado was dismissed from the Trust. The Trust stated Mr Sabado had also made two medication errors during his time at the Trust.

On 23 February 2022 Mr Sabado administered IV magnesium without a second checker, without a prescription and the wrong dose. There was a PRN prescription for IV magnesium however there were special instructions to only administer this in the Intensive Care Unit ["ITU"]. Mr Sabado informed the Nurse in Charge of the Shift, Witness 4 when Witness 4 returned from his break that Patient A had an elevated heart rate and spiking temperature, so he administered IV Magnesium.

On 7 March 2022, Mr Sabado administered a Heparin flush to a patient without a prescription.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mr Sabado.

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

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

- Witness 1: Clinical Nurse Educator at Royal Brompton Hospital
- Witness 2: HR Business Partner at Kingston Hospital NHS Foundation Trust
- Witness 3: Ward Sister on Rose Ward at Royal Brompton Hospital
- Witness 4: Band 6 Nurse at Kingston Hospital NHS Foundation Trust on Hamble Ward.
- Witness 5/Colleague A: Nursing Assistant at Kingston Hospital NHS Foundation Trust on Hamble Ward.

- Witness 6: Band 5 Nurse at Royal Brompton Hospital
- Witness 7: Junior Sister at Kingston Hospital NHS Foundation Trust
- Witness 8: Matron at Kingston Hospital NHS Foundation Trust

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

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

Charge 1a(i)

That you:

1) On one or more occasions between 29 November 2019 and 3 December 2019 slept whilst on duty, namely:

a) On 1 December 2019:

i. Between 22:00 hrs and 01:30 hrs;

This sub charge is found proved.

In reaching this decision, the panel took into account Witness 6's written and oral statement, the internal statement, alongside the documentary evidence before it.

The panel took into account the 'Statement of events-meeting 1630 4/12/19' which stated:

“I asked if there was a reason why he fell asleep, He said no, no reason, he didn’t mean to, he was putting 8pm obs in and fell asleep. [sic]

…

Marvin said no it was approximately 11pm- I was transferring my initial observations from the handover sheet [Witness 1] made me. I didn’t sleep long.”

The panel noted that Witness 6 in her oral evidence, stated that Mr Sabado slept whilst on duty before her first break. The panel took into account that Witness 6’s first break usually took place at 11:30 and the second set of breaks did not take place until 1:30 at the earliest.

On the basis of Witness 6’s oral evidence and the evidence stated in the ‘Statement of events meeting’ that Mr Sabado fell asleep for a few minutes, the panel was satisfied that it was more likely than not that Mr Sabado slept whilst on duty. The panel took into account that Mr Sabado also made partial admissions to falling asleep.

The panel concluded that the version given by Witness 6 as recorded in the ‘Statement of events meeting’ carried more weight as it was documented closer to the events and clarified any confusion that Witness 6 had about timing in her oral evidence.

The panel therefore found this sub charge proved.

Charge 1a(ii)

ii. Between 06:00 and 07:00 hrs;

This sub charge is found not proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 6 and all of the documentary evidence before it.

The panel took into account the Investigatory meeting minutes with Mr Sabado dated 4 March 2020:

> *"So about 9.00, 9.30, but he said he fell asleep at about 11.00 when he was doing his initial assessment. So for me, in education, that was a little bit concerning from that point of view, because you'd expect it to be done a bit earlier, but he said when he fell asleep he only fell asleep for a couple of minutes, and he said he looked at the clock, fell asleep and then woke up and looked at the clock and it was about 11.05 or something, but I think the witnesses that saw him sleeping, there was a number of occasions throughout both night shifts that they did see."*

The panel also took into account Witness 6's evidence where she stated:

> *"He was sleeping even though 2nd break havnt started yet. I was not able to tell NIC since I was busy with my patients. I told NIC after the shift.*
> *...*
> *Aprox. 6:30am. (Im not really sure of the exact time) I had to wake him up because his patient was crying and mum was asleep. I couldnt settled the patient since I was doing something else."* [sic]

The panel noted that Mr Sabado stated that he only fell asleep at 11.30 and that Witness 6 initially said in her internal statement that he fell asleep around 6:30. The panel however noted that in her NMC statement and oral evidence, she was not consistent with her evidence and did not mention that he slept at 6:30. When questioned by the panel, she was adamant that she had only seen Mr Sabado asleep on one occasion during the shift.

The panel found that there was insufficient evidence to prove on the balance of probabilities that Mr Sabado slept whilst on duty between 06:00 to 07:00 hrs on 1 December 2019.

The panel therefore found this sub charge not proved.

Charge 1b)

b) On 2 December 2019 between 04:45 and 06:15 hrs

This sub charge is found proved.

In reaching this decision, the panel took into account the hearsay evidence of Ms 1, Witness 6's written and oral evidence alongside the documentary evidence put before it.

The panel took into account the minutes of the Investigation Meeting held on 4 February 2020 in which Witness 6 stated:

> *"Second night, approx 5/6am (im not really sure about the exact time) I was with my patient and I saw him sleeping on the chair (near the weighing scale), Ms 1 went in to get the weighing scale and saw him sleeping he didnt even felt that Ms 1 was getting the scale, so I asked her if she could tell […] (runner) that he was asleep. After couple of minutes […] went in, to weigh urine pot, I was not sure if […] saw him sleeping."*

The panel also took into account what Ms 1 said in the Investigation Meeting held on 4 February 2020:

> *"So I went to go through him and just go – he was sitting down, so I went from the left-hand side to the left, and then when I went through, I see him sit down with arms crossed and closed eyes.*
> *…*
> *It's difficult to say because I wasn't there all the time. I've just been there for 20 minutes. At that moment, he was with closed eyes. When you have closed eyes, it means you are sleeping because you are nursing, so you're a nurse, so you never close your eyes if you're not really tired and you want to sleep."*

With regard to Witness 6's written and oral evidence, the initial statement, the internal interview, the panel concluded that Witness 6's evidence was clear and that there was no conflict between the evidence that was provided by her and the documentary evidence.

The panel therefore found this sub charge proved.

Charge 2)

> 2) On the night shift of 30 November to 1 December 2019 used headphones whilst on duty.

This sub charge is found proved.

In reaching this decision, the panel took into account Witness 6's written and oral evidence, alongside the documentary evidence put before it.

The panel noted that Witness 6 in her local statement, stated:

> *"I was doing my documentation and I saw him in bed space 4 I thought he was looking after my patient, but when I went to wash my hands I saw him using earphones and I told him off not to use earphones."*

The panel also took into account the Investigation meeting with Witness 6 where she was questioned:

> *"He was looking after patient one, two and three, and you were looking after patient four and five. So regarding the earphones, you report on your statement that Marvin was wearing earphones near a bed space."*

She responded by stating that Mr Sabado was sitting in the patient's bedspace, and he had earphones in that had a white wire.

The panel took into account that Witness 6 was consistent in her evidence as she also confirmed this in her oral evidence. The panel noted that during the local investigation, Mr Sabado denied using his headphones, although he admitted that his headphones matched the description given by Witness 6. He also commented that others wore headphones during their shifts.

The panel therefore found this sub charge proved.

Charges 3 to 9

The panel detailed the roles of the different witnesses and how their roles would be applicable to charges 3 to 9, including all the sub charges.

The panel noted that Witness 1's role was a Band 6 Clinical Nurse Educator at the Royal Brompton Hospital working on the ward and that she had started employment during mid-2019. Witness 1 worked closely with Mr Sabado in regard to his retention of clinical skills and his mathematics and calculation skills. Witness 1 worked on Mr Sabado's capabilities with Witness 3 when some of the alleged concerns came to light.

The panel noted Witness 3's role as a Clinical Ward Sister on Rose Ward at the Royal Brompton Hospital. Witness 3 would work with Mr Sabado more than once a week to address the concerns, Witness 3 became involved and regularly assessed Mr Sabado with Witness 1. Witness 3 and Witness 1 would allocate support to Mr Sabado throughout his shifts. Witness 1 correlated information from his clinical supervisors whilst he was supernumerary on the wards. This information was used towards assessing his clinical skills and retention of these competencies.

Charge 3)

3) On or around 2 December 2019 in relation to an Patient A, failed to prepare Patient A's infant feed correctly, in that you;

a) Added a thickener to the Patient A's milk;
b) Did not measure the quantity of the thickener;
c) Did not read the information on the box containing the thickener before administering the infant feed;
d) Did not add a fortifier to the Patient A's infant feed.

This charge is found proved in its entirety.

In reaching a decision for charge 3a, the panel took into account Witness 1's written and oral evidence, Witness 3's evidence and the documentary evidence put before it.

The panel took into account the 'Meeting notes with the Registrant on 4 December 2019':

> *"[…] and I also spoke with Marvin about the reports from a mother that Marvin gave a feed that was thickened to "ice cream consistency" (as reported by mum who is a SALT) instead of fortifying it with 2.5% cow and gate.*
> *…*
> *I asked him if he used to blue dietician chart to check the milk prescription, he said he had not. I reiterated the importance of this due to wastage of EBM and also risk to the patient when thickening a milk that is not needed. He said he understood and thought it was the same because the picture of carabel and cow and gate is the same. […] said we will discuss this further at a later date."*

The panel noted that Witness 1 had a good understanding of the duties that took place on the ward. The panel also took into account that Mr Sabado made partial admissions to having made a mistake with an infant feed.

The panel had sight of the improvement note dated 9 December 2019 where it stated:

> *"We therefore discussed your perspective on this on Wednesday 4th December and you stated that you were sure the nasogastric tube was in the correct place so*

you felt you didn't need to confirm it's position prior to administratthion, that you got Carobel and cow and gate confused and didn't check the dietician note in the patient's bedside folder to confirm their instructions before administration…" [sic]

The panel also took into account Witness 1's written statement where she stated:

"In December 2019, a patient's Mother noticed that the Registrant added a few scoops of thickener to the patient's milk, rather than fortifier… He also had not measured it out."

The panel also took into account that although Witness 1 and 3 gave evidence about Mr Sabado's competencies due to the role they were in, it was brought to Witness 1's attention by another member of staff. Despite Witness 1 having no first-hand knowledge of the event, it was her responsibility and duty to ensure that staff practise safely.

The panel took into account that when the issue was brought to the attention of Witness 3, Mr Sabado was called to a meeting with Witness 1. The panel noted that within the competency meeting with Mr Sabado, he admitted to adding thickener to the milk and not reading the information on the box, and as a result, did not add the fortifier.

The panel had regard to the hearsay evidence contained in Witness 1's written statement. The panel decided that it was more likely than not Mr Sabado did not add the fortifier as he had added the thickener instead.

The panel noted that in regard to charge 3b, there was no direct evidence, that Mr Sabado had not measured the quantity of the thickener prior to mixing it with Patient A's milk. It was of the view, however, that it was more likely than not that Mr Sabado had not measured the quantity of the thickener as reported by the Patient's mother, because he had not read the instructions on the box.

The panel therefore found this charge proved in its entirety.

Charge 4)

4) On or around 2 December 2019 in relation to an Patient A, failed to:

a) Follow Patient A's prescription sheet and/or dietician chart;

b) Check and/or confirm the position of Patient A's nasogastric tube before administering an infant feed;

c) Carry out a pH test in relation to Patient A's nasogastric tube.

In respect of charge 4, the panel noted that some of the charges allege a failure. The panel took into account the job description by virtue of which, Mr Sabado was under a duty to keep his competencies up to date as well as to practise safely. The panel noted that although there has been mention of the policies, it had only seen one of them.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account Witness 1's written and oral evidence, alongside the documentary evidence put before it.

The panel took into account Witness 1's written statement where she stated:

"The Registrant was set a competency in infant feeding, surround the safe preparation, storage and administration of infant feeds, as well as safe nasogastric tube insertion, management and removal. This was a result of a feed error that he had made. The Registrant had passed his competency in August 2019, but it had not been maintained."

The panel noted that following this error, Witness 1 created an informal capability process to help Mr Sabado to improve in the areas he was failing in. The panel also had sight of Witness 1's statement where she stated a complaint had been made by the mother of a patient:

"The Mother also noticed and reported that the Registrant did not test the tube before administering the feed. The feeding tube and breathing tube are adjacent to one another and secured onto the patient's face with tape. Babies can vomit and there is a risk that the feeding tube slips into the lungs. Feeding into the lungs could cause aspiration, leading to significant pneumonia."

The panel also took into account the 'Meeting notes with Mr Sabado on 4 December 2019' which stated:

"We also briefly went through a statement from a nurse after reports from the same parent that Marvin had through a night shift not tested an NGT when giving medications, when questioned by mum (as mum had just completed her NG competencies) and so said she was concerned by the practice- Marvin had said that he didn't need to as he was sure it was in the right place and it's a medication so it is fine. Marvin said he had checked it 40 minutes prior when he had done feeds so he was sure it was in the right place. […] and I said we were concerned about this unsafe practice and we would speak about this further too at a later date."

The panel noted that Witness 1 went into thorough detail about the management of a nasogastric tube. The panel took into account that the information provided by the mother of the patient was clear, which was fed back to Witness 1, despite there already being a competency plan in place. The panel took into account that Mr Sabado should have known what to do prior to administering the infant feed via the nasogastric tube.

The panel decided that Mr Sabado had not clearly checked and confirmed the nasogastric tube was in the correct position, he had not carried out the PH test and had not followed the prescription sheet or the dietician chart.

The panel considered these sub charges individually. The panel took into account the evidence and found charge 4 proved in its entirety.

Charge 5)

5) On an unknown date, prior to 9 December 2019, attempted to administer Captopril, Frusemide and Sildenafil together/at the same time to a patient.

This charge is found not proved.

In reaching this decision, the panel took into account Witness 1 and 3's written and oral evidence, alongside the documentary evidence put before it.

The panel took into account Witness 3's written statement where she stated:

"Captopril, Furosemide and Sildenafil are cardiac medications acting on the heart. They all have a similar effect on the blood pressure and therefore should not be given at the same time. The Registrant did not understand this and attempted to give all three together, but he was stopped. This was reported by a member of the team and fed back to me. I cannot recall specifically who this was raised by. These medications will lower the blood pressure very quickly if given all together, which can be detrimental to the patient's cardiac output."

The panel also took into account Witness 1's written statement where she stated:

"Additionally, a newly qualified nurse had been working in a bay with the Registrant and he asked her to check three medications: Captopril, Furosemide and Sildenafil, for him to administer them. All medications are double checked before administration. I cannot recall the name of the nurse. These three medications are not safe to give together, as they cause a drop in blood pressure. This could cause loss of cardiac output which could be detrimental to a child."

The panel took into account that it did not have any evidence from the nurse who reported it to Witness 1, and it had not been provided with a copy of the patient's prescription or

any DATIX report which may have detailed the alleged attempt by Mr Sabado to administer the three medications at the same time. The panel noted that this was anonymous hearsay evidence from a nurse on the ward, but when questioned, Witness 1 could not remember who had reported it.

The panel also took into account that when Witness 1 and 3 were asked about whether they had seen the prescription chart, they said that they had not had sight of this. Both witnesses also had no first-hand knowledge of this incident.

The panel decided that the NMC had failed to provide sufficient evidence to find this charge proved on the balance of probabilities.

Charge 6a)

6) Failed to communicate with colleagues, namely:

a) By **not** providing complete information regarding patients in handovers at the end of a shift.

This sub charge is found proved.

Before reaching a decision, the panel noticed an error in the charge during their deliberations. The panel clarified with Ms Patel that the error needed to be rectified by adding the word ‘not’ in the charge for further clarity.

In reaching this decision, the panel took into account Witness 1 and Witness 3’s written and oral evidence, alongside the documentary evidence put before it.

The panel took into account Witness 3’s written statement where she stated:

"Additionally, he did not communicate through handovers, missing out important information that needed to be shared. It was reported that his handovers were disjoined. He did not detail how often feeds were given to his patients, his final assessment paperwork was not completed, his fluid balance was difficult to read and the amounts documented were different to what was handed over."

The panel also took into account Witness 1's written statement where she stated:

"A competency was implemented for the Registrant to improve his communication. This was an area of concern reported by multiple staff, for example [Ms 2] and [Witness 3], who are both nurses. For example, communication with parents of patients was sometimes lacking and the Registrant could not grasp 'banter' with them. Additionally, he did not give appropriate handovers to colleagues when leaving bays, in that he did not tell the other nurse in the bay that he was leaving the room."

The panel had sight of a report written by Ms 2 about Mr Sabado in December 2019 which stated:

"handover was very disjointed. Marvin was flitting between all nursing cares.
…
Nursing paperwork was very difficult to read and a final assessment of care before handover in the paperwork was not completed."

The panel decided there was sufficient evidence before it to prove that Mr Sabado was not providing complete information regarding patients in handovers at the end of a shift.

The panel therefore found this sub charge proved.

Charge 6b)

b) When you left a bay where you were attending to patients without informing colleagues.

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 and 3, alongside the documentary evidence put before it.

The panel took into account the transcript of the Investigation meeting where Witness 1 stated:

> *"There's some reports from his supervisors that he will disappear off for a break and not tell anyone where he's going, which, if he's – he's supernumerary at the moment, so it's not so much of a problem, it's not dangerous, but if he were, for example, the only nurse in Woodlands and disappeared, that would be five babies on their own, which is against our policy, so a nurse needs to be there all the time."*

The panel also had sight of the improvement note dated 9 December 2019 which stated:

> *"Marvin must communicate effectively with his bay partner, runner and nurse in charge at key points throughout his shift (including but not limited to: after morning handover, afterward round, before taking any breaks and upon return from those breaks, prior to medication administration, when receiving admissions, when patients return from procedures and if a patient deteriorates)"*

The panel took into account that Witness 1 and 3 made reference to this in their oral evidence as they had raised this as an issue in their investigation.

The panel determined that there was sufficient evidence before it to prove on the balance of probabilities that Mr Sabado had left a bay where he had been attending patients without informing colleagues.

The panel therefore found this charge is found proved in its entirety.

Charge 7)

7) On one or more occasions made record keeping errors in that you failed to:

a) Complete records in full;
b) Complete records in a timely manner;
c) Ensure your entries in records was legible.

These charges are found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 and 3, alongside the documentary evidence put before it.

Witness 1 in her oral evidence stated that she undertook regular documentation rounds to check the standard of documentation and found incomplete and illegible records completed by Mr Sabado. In the local investigation, Mr Sabado said he fell asleep at 11pm whilst inputting 8pm observations. Further, failure in record keeping was also a common theme in his supervisors' reports.

The panel took into account the reports made about Mr Sabado by his supervisors in December 2019 which stated:

> *"Nursing paperwork was very difficult to read and a final assessment of care before handover in the paperwork was not completed."*

The panel also took into account the targets set for Mr Sabado dated 20 September 2019 which detailed the following:

"To ensure I carry out appropriate assessments and observations on my patients (i.e 4 hourly based on BPEWS score unless patient deteriorates or return from theatre and requires more frequent observations) and document findings from observations, fluid balance, VIP score, PURE score, nursing notes and any other relevant documentation properly."

The panel therefore found this charge proved in its entirety.

Charges 8a) and 8b)

8) On an unknown date between 9 December 2019 and 18 February 2020 offered to administer an intravenous medication:

a) Which was beyond your level of competency;
b) Which you knew you had not been signed off to perform.

These charges are found proved.

In reaching this decision, the panel took into account Witness 1 and 3's written and oral evidence, alongside the documentary evidence put before it.

The panel also took into account the signed supernumerary agreement dated 13 December 2019 in which Mr Sabado agreed to the following:

"During this time I must be supervised in all clinical tasks including but not limited to medication administration, nasogastric feeding and clinical procedures. I will not draw up or administer any IV medications and I will not be a second checker for medication administration."

The panel also took into account the record of meetings between December 2019 and March 2020 which stated:

"[Witness 3] stated it was the same shift as when [Mr Sabado] offered to do IVAB. [Mr Sabado] remembered it was a CF patient in Lagoon North (Forest) and he mentioned to his supervisor that he was in supernumerary so he was not clear that he should be making the feed and stated that [Witness 1] (Clinical Educator) told him "not to do anything in supernumerary". [Mr Sabado] did a set of observations but highlighted he is happy and confident making feeds."

The panel further took into account a review letter summarising the stage 1 meeting, dated 25 February 2020 which stated:

"We moved on to talk about a situation where you offered to do an IV even though you have not been signed off as being able to deliver them. You said that you were aware that some students can give IV medication under supervision. [Witness 1] confirmed to you that students cannot give IV's and that you have never been signed off as competent to give IV medication and that this is a significant area of concern. You said that that your intention was to learn and that you did not know that you could not learn. [Witness 1] said you have been explicitly told that you cannot give IV's, and this has been explained to you on numerous occasions and this was why there is a concern as the instruction has been ignored."

The panel acknowledged the chronology of the events that occurred between December 2019 and February 2020. The panel noted that during the timeline, SMART targets and a supernumerary agreement had been put in place which prevented Mr Sabado from administering intravenous (IV) medication or being a second checker.

The panel noted that on 25 February 2020, there was a letter outlining that Mr Sabado was now in the formal capability process and there was reference to the capability review meeting on 18 February 2020 in which it was discussed that he had offered to do an IV injection when he was not permitted to do so. The panel noted that this was one of the reasons why Mr Sabado was moved to formal capability process.

Taking into account all of the evidence before it, the panel was satisfied that it was more likely than not that Mr Sabado had offered to administer an IV medication which was beyond his level of competency and that he had not been signed off to perform.

The panel therefore found this charge proved in its entirety.

Charges 9a(i), 9a(iii), 9a(iv) and 9a(v)

> 9) Failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 registered nurse, in that you:
>
> a) Failed to meet the target competencies set on or around 9 December 2019 by 11 February 2020, namely;

i. Safe preparation, storage and administration of infant feeds;
iii. Medicine management;
iv. Professionalism;
v. Documentation

These sub charges are found not proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 3, alongside the documentary evidence put before it.

The panel took into account the record of meetings between December 2019 and March 2020 which stated:

> *"[Witness 3] started to conclude the meeting and highlighted that [Mr Sabado] still had an outstanding NGT competency left to do but all others had been signed off. However, the supervisor feedback was very mixed. [Witness 3] emphasised that this is [Mr Sabado's] last week of supernumerary and that going forward [Witness 3]*

would collate all the competencies, supervisor feedback and liaise with Human Resources and Management. Feedback would be sought from [Mr Sabado's] two supervisors this week and that we would leave [Mr Sabado] in supernumerary until Tuesday 11th February his next shift and then he would meet again with [Witness 3].

The panel took into account that there was evidence before it that Mr Sabado had achieved his medicine management competency. Witness 3, in her oral evidence, stated that Mr Sabado had achieved his competencies. The panel noted that there was no evidence of any specific objectives set for Mr Sabado in the professionalism area.

The panel concluded there was insufficient evidence to find these sub charges proved. The panel decided that although Mr Sabado had not satisfied his supervisors that he had maintained the competencies, Mr Sabado had met the competencies that were required at the time of the assessment.

The panel therefore found these sub charges not proved.

Charge 9a(ii)

ii. Management of gastric tube;

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence put before it.

The panel considered there was sufficient evidence before it to show that Mr Sabado had to complete the last of three observations to achieve his competency in the management of gastric tube, however this outstanding competency was not completed until 12 March 2020.

The panel was therefore satisfied that there was sufficient evidence before it to find this sub charge proved on the balance of probabilities.

Charges 9b(i), 9b(iii), 9b(iv) and 9b(v)

b) Failed to meet and/or maintain the target competencies set on or around 18 February 2020 by 12 March 2020, namely;

i. Safe preparation, storage and administration of infant feeds;
iii. Medicine management;
iv. Professionalism;
v. Documentation.

These sub charges are found proved in relation to maintaining the target competencies.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 and 3, alongside the documentary evidence put before it.

The panel took into account the review letter summarising the stage 1 meeting dated 25 February 2020, which stated:

"I said that the competencies that you have met now need to be maintained and so we will be setting you the previous objectives where this has not been displayed. I added that we cannot supervise you all the time when you are not being monitored and that we needed to have trust in you that you can safely deliver patient care.
…
I informed you that most of the targets that we are setting you at this stage are the same as what was set previously. I said that the key messages that I want to get across today is that you need to show consistency in your work, communicate and be more situationally aware. [Witness 1] said that we understand you are good at

carrying out tasks, but you can get so focused on completing the task that you forget about the patient. We gave you an example where a patient was upset, and observations needed to be taken. The expectation here is that you assess the patient and as they are upset its perhaps not the best time to be trying to take observations. Another example which we gave you is where a patient who is medication but who is asleep and so the expectation is that you would wait until they are awake. I said that it was about looking at the bigger picture and taking a more holistic approach to work. I added that I have received good feedback from the parents of patients about your work and which I have relayed to you but that there have also been complaints which we have discussed."

The panel also took into account Witness 1's written statement where she stated:

"The Registrant had not passed a number of the competencies he had been given as targets. I cannot recall which specifically were not met. Feedback from supervisors also assisted the decision to move the Registrant to a formal capability process."

The panel noted that supervisors stated that Mr Sabado was not competent in these areas. The panel placed weight on the supervisors' notes and decided that it was more likely than not that Mr Sabado failed to maintain the target competencies.

The panel therefore found these sub charges proved in relation to maintaining the target competencies.

Charge 9b(ii)

ii. Management of gastric tube;

This sub charge is found not proved.

In reaching this decision, the panel took into account the documentary evidence put before it.

The panel noted that in regard to this sub charge, Mr Sabado had only passed the competency requirement for the management of a gastric tube on 12 March 2020. The panel was of the view that Mr Sabado had not therefore had the opportunity to demonstrate that he could maintain this competency.

The panel therefore found this sub charge not proved.

Case reference: 089691/2022

Before reaching a decision, the panel took into account some of the background of this referral. This second referral came from Kingston NHS Foundation Trust where Mr Sabado was employed as a Band 5 staff nurse on the Hamble ward at Kingston Hospital. The panel noted that Witness 2 was brought into the investigation towards the end. The panel also took note that Colleague A had been a nursing assistant for six months on the Hamble ward, and Witness 4 was a Band 6 nurse on the Hamble ward. Witness 4's responsibilities included providing leadership, including support to staff. Witness 8 was a matron.

Charge 1a) and 1b)

1) On 23 February 2022 in relation to Patient A failed to escalate to a doctor Patient A's:

    a) Elevated heart rate;
    b) Variable/Spiking temperature.

This charge is proved in its entirety.

In reaching this decision, the panel took into account the written and oral statement of Witness 4, along with the documentary evidence put before it.

The panel took into account the written statement of Witness 4 where he stated:

> *"At around 04.00am-05.00am I went on my break…Marvin told me that Patient A had an elevated heart rate and spiking temperature. Normally in this situation we would call the doctor to inform them and also seek advice on what to do. If a patient is really unwell the doctor would come and see them."*

It also took into account that Witness 4 stated:

> *"I asked Marvin if he had escalated Patient A to the doctor and he said he had not yet. He said that because of the temperature and elevated heart rate he said there was PRN [as required] medication written up and he hold me he had administered intravenous ["IV"] magnesium. I was shocked because we do not give magnesium on the Ward without the doctors. I asked Marvin why he had done this and he said that due to the elevated heart rate he checked the magnesium level which we low so he gave the patient magnesium. I asked him if there was a prescription, he said there was no advice from the doctors but he saw there was a prescription.[sic]"*

With regard to the alleged failure, the panel had sight of the 'Adult observations and recording and escalation policy'. The panel noted that the escalation policy stated that when a patient had an elevated heart rate, the nurse must escalate this to a doctor.

The panel noted that in Witness 4's written statement, he stated that Mr Sabado had made partial admissions to failing to escalate the concerns to a doctor, which included an elevated heart rate and a variable/spiking temperature.

The panel therefore found this charge proved in its entirety.

Charge 2a)

2) On 23 February 2022 in relation to Patient A administered medication namely, intravenous magnesium:
a) Without consulting a doctor prior to administration;

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence from Witness 4.

The panel noted that Mr Sabado's admission during the local investigation, that he had administered the magnesium to Patient A without consulting a doctor prior to the administration.

The panel therefore found this sub charge proved.

Charge 2b) and 2c)

b) Without a prescription;
c) Contrary to a note stating the said medication was only to be administered in the Intensive Care Unit (ITU);

These sub charges are found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 4 and 8, along with the documentary evidence put before it.

The panel took into account the magnesium prescription for Patient A produced by Witness 4. The panel also noted that there was a clear instruction on the prescription that the magnesium was only to be administered in ITU. Witness 4 also stated that the

prescription should have been discontinued on the ward but had not been. This was corroborated by Witness 8's oral evidence.

The panel determined that there was sufficient evidence before it to prove on the balance of probabilities that Mr Sabado administered medication to Patient A without a valid prescription.

The panel therefore found these sub charges proved.

Charge 2d)

d) At a different dose to that administered in ITU;

This sub charge is found not proved.

In reaching this decision, the panel took into account the documentary evidence put before it.

The panel noted that there was a 20mmols dose documented and administered by Mr Sabado and that on the ITU prescription, it was a sliding scale dose between 1 to 20mmols. Therefore, Mr Sabado had not administered a different dose to what could have been administered in ITU.

The panel therefore found this sub charge not proved.

Charge 2e)

e) Without obtaining a second check

This sub charge is found not proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 8, along with the documentary evidence put before it.

The panel took into account the oral evidence of Witness 8 that Mr Sabado did not need to have a second checker at the time as he was competent. She stated that there had been an addendum to the medication policy to that effect. The panel also noted Witness 8's evidence that Mr Sabado was competent to administer IV medications peripherally at the time.

The panel therefore found this sub charge not proved.

Charge 3a(i) and 3a(ii)

3) On 7 March 2022 in relation to Patient B administered medication namely, Heparin:

a) Without informing
i. The Outreach Team and/or;
ii. A doctor of difficulties obtaining blood prior to administration;

These sub charges are found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7 and the documentary evidence put before it.

The panel took into account Witness 7's written statement where she stated:

> *"I asked Marvin if he had escalated that he could not get blood from Patient B to the Outreach Team or the Doctors as he had not informed me of this. He said he had not. I asked him if the Heparin flush was prescribed and he said it had not been but was usual practice in the previous hospital he had worked in. I asked how much heparin he had administered and he said 5000 units. I explained that this was not*

practice we did at Kingston Hospital. Marvin had not followed all the "rights" of medication administration."

The panel noted that Mr Sabado told Witness 7 he did not inform the Outreach Team and/or a doctor of any difficulties obtaining blood prior to administration. The panel further noted that although Mr Sabado stated that this was usual practice at his last hospital, this was not the procedure at Kingston Hospital.

The panel therefore found these sub charges proved.

Charge 3b)

b) Without consulting a doctor prior to administration;

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7, along with the documentary evidence put before it.

The panel took into account the written statement of Witness 7 where she stated:

"I asked Marvin if he had escalated that he could not get blood from Patient B to the Outreach Team or the Doctors as he had not informed me of this. He said he had not. I asked him if the Heparin flush was prescribed and he said it had not been but was usual practice in the previous hospital he had worked in. I asked how much heparin he had administered and he said 5000 units. I explained that this was not practice we did at Kingston Hospital. Marvin had not followed all the "rights" of medication administration."

The panel determined that Witness 7's evidence was credible, and that there was sufficient evidence to prove that Mr Sabado did not consult a doctor prior to administration. The panel therefore found this sub charge proved.

Charge 3c)

c) Without the Heparin being prescribed;

This sub charge is found proved.

In reaching this decision, the panel took into account the written evidence provided by Witness 7 and 8, along with the documentary evidence put before it.

The panel took into account Patient B's prescription list provided by Witness 7 where it indicated that there was no prescription for Heparin. The panel also took into account the medicines management policy provided by Witness 8 which stated:

> *"Heparin flushes should only be used for ARTERIAL and CENTRAL VENOUS CATHETERS. They must be prescribed or covered by a PGD."*

The panel took into consideration Mr Sabado had admitted to administering the Heparin during the local investigation. It was satisfied that there was sufficient evidence for it to prove that the Heparin had not been prescribed to Patient B.

The panel therefore found this sub charge proved.

Charge 3d)

d) Without keeping a proper record of the administration of the Heparin.

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7, along with the documentary evidence put before it.

The panel took into account the written statement of Witness 7 where she stated:

> *"Marvin should have documented the Heparin flush in the patients notes however there is no mention in Exhibit …/3. This could have been included under the disability heading or exposure heading. Or Marvin could have made a separate entry in the document for it."*

The panel noted that Witness 7's oral evidence was credible and correlated with her written statement. It was of the view that there was no record of the administration of the Heparin to Patient B.

The panel therefore found this sub charge proved.

Charge 3e)

e) Without informing Patient B:

This sub charge is found not proved.

In reaching this decision, the panel took into account the oral and documentary evidence put before it.

The panel noted that there was no evidence before it, to prove on the balance of probabilities, that Mr Sabado did not inform Patient B that he was administering the Heparin.

This sub charge is therefore found not proved.

Charge 3f)

f) Which was outside his level of competency;

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7 and 8, along with the documentary evidence put before it.

The panel took into account that Witness 7 and 8, in their oral evidence, stated that Mr Sabado was competent to give IV medication through a peripheral line. Witness 7, during panel questions, said that Patient B's midline access was only peripheral, not a central access line. This was contradicted by Witness 8's oral evidence as she went into detail about the differences between a peripheral line and a central line. Witness 8 stated that in this particular case, Patient B's midline access was classed as a central line. Therefore, according to Witness 8, Mr Sabado was not competent to give IV medication through the midline, and only a few people in the Outreach team were trained to give medication through a central line.

The panel decided to place more weight on Witness 8's oral evidence as she had a better understanding of the access devices and competencies required.

The panel therefore found this sub charge proved.

Charge 3g)

g) At an unknown concentration.

This sub charge is found not proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7, along with the documentary evidence put before it.

The panel took into account that Witness 7, in her oral evidence, stated that Mr Sabado had admitted to giving 5000 units of Heparin with saline and this was also recorded by Witness 7 in her DATIX entry in relation to this incident.

The panel therefore found this sub charge not proved.

Charge 4a)

4) On the shift from 10 April to 11 April 2022 whilst conducting a procedure said the words “oh, I’ll cover the patient’s breast with a towel because I am straight” or a gist of words of similar effect which:

    a) Were unprofessional;

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague A, along with the documentary evidence put before it.

The panel took into account the written statement of Colleague A dated 26 April 2022, which stated:

> *“During the night shift I didn’t think anything was to odd. He was very chatty although in the morning of the night shift we was doing an ECG on a female patient and he covered her breasts with a towel and said to me I do this because I’m straight.”* [sic]

The panel also took into account Colleague A’s oral evidence where she stated that in her view, the comment made was unnecessary and unprofessional. The panel determined that what Mr Sabado said in front of the patient and Colleague A was unprofessional.

The panel therefore found this sub charge proved.

Charge 4b)

b) Were of a sexual nature

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague A, along with the documentary evidence put before it.

The panel took into account the written and oral evidence of Colleague A. The panel noted that Colleague A stated, that in her view, these comments were unnecessary and inappropriate. The panel also noted that the comment made was a statement of a sexual preference and was said in front of a patient and a junior colleague. In the panel's view, the words said by Mr Sabado were clearly of a sexual nature and inappropriate.

The panel therefore found this sub charge proved.

Charge 4c)

c) Indicated you did not treat the patient with dignity.

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague A, along with the documentary evidence put before it.

The panel took into account Colleague A's witness statement where she stated:

"During the actual night shift the only thing that made me feel a little uncomfortable was when I was doing an ECG for a patient and he was guiding me as I had not done it before. He said something like "oh I'll cover the patients breasts with a towel because I am straight". I did not see the need for him to say that and I thought it was a bit weird. This was around 06:00/07:00 am."

The panel took into account Colleague A's oral evidence where she stated that these comments were unnecessary and irrelevant. The panel was of the view that Mr Sabado did not treat the patient with dignity and respect as these comments had been made in their presence.

The panel therefore found this sub charge proved.

Charges 5a), 5b), 5c) and 5d)

5) On 10-11 April 2022 you sent an email to Colleague A which contained the words "…….we keep it a secret…and eye mean no harm…I think you are very beautiful. Sorry eye mean no harm….can you keep this message a secret?" which was:

    a) Inappropriate;
    b) Of a sexual nature;
    c) To a junior staff member;
    d) Sent using your work email.

This charge is proved in its entirety.

In reaching this decision, the panel took into account the written and oral evidence of Colleague A, along with the documentary evidence put before it.

The panel took into account the email sent from Mr Sabado to Colleague A dated 11 April 2022 and time stamped 12.01:

> *"Hi good morning…It's me Marvin. You still awake? Sorry…eye don't know how to say this but eye hope we can keep it a secret…and eye mean no harm….Eye think you are very beautiful. Sorry eye mean no harm….can you keep this message a secret…?"*

The panel was of the view that this was an inappropriate email that Mr Sabado sent to Colleague A and it was of a sexual nature, because it made reference to her being "very beautiful", and that it had been sent when Colleague A was resting at home after her night shift, specifically at 12.01. The panel noted that Colleague A was clear and consistent in her oral and written evidence.

The panel took into account that Colleague A had only worked closely with Mr Sabado on a few occasions and that she was a junior member of staff to him. It noted that she had been surprised when she received this email.

The panel noted that Colleague A was a nursing assistant, and that Mr Sabado had a more senior role as a nurse on the ward.

The panel was satisfied that Mr Sabado's email had been sent from his work email address.

The panel therefore found this charge proved it its entirety.

Charges 7a), 7b) and 7c)

7) On 11 April 2022 sent one or more emails set out in schedule 1 to Colleague A which:

a) Subjected Colleague A to shock and/or interference
b) Were of a sexual nature
c) Made personal comments about Colleague A

These sub charges are found proved.

In reaching this decision, the panel took into account Colleague A's written statement dated 26 April 2022 which she provided in the local investigation, along with the documentary evidence put before it.

In her statement, Colleague A stated:

> *"I wouldn't like to work with him again as I'd feel very uncomfortable and I wouldn't be able to focus to do my job to the best of my ability."*

The panel took into account an email from Mr Sabado to Colleague A dated 11 April 2022 and time stamped 20:06:

> *"You are nice with an wow so beautiful so eye presented this offer which are in…"*

The panel also acknowledged an email dated 11 April and time stamped 19:22:

> *"another one is that never stop showing me your face….."*

Further, an email from Mr Sabado dated 11 April 2022 and time stamped 19:34:

> *"Thank you for showing me your face from time to time..it's like you understand me,..please don't stop doing that…"*

It also took account of an email from Mr Sabado dated 11 April 2022 and time stamped 12:21:

“Sorry….In short eye think you are so beautiful …
Don’t stop talking to me okay? Secret…”

The panel noted that Colleague A in her oral evidence stated that she was shocked and confused to receive these emails. The panel noted that on this particular day, Colleague A received a large number of emails from Mr Sabado. Colleague A was at home resting after a night shift when she received these emails, which then continued to be sent when she was working on the next night shift. The panel was of the view that these emails interfered with Colleague A’s private life and her work. The panel considered that many of the emails sent by Mr Sabado to Colleague A made personal comments about her and were of a sexual nature.

The panel therefore found this charge proved in its entirety.

Charge 8a)

8) On 12 April 2022 sent one or more emails set out in schedule 2 to Colleague A which:
   a) Subjected Colleague A to shock and/or interference;

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague A, along with the documentary evidence put before it.

The panel took into account the ‘notes of interview with [Witness 8] dated 27 April 2022 where Colleague A was asked:

“Would you be happy to work with [Mr Sabado] again? How did the messages make you feel?

To which she responded:

> *No, even on the same shift it would be really uncomfortable and awkward. I definitely do not want to be on the same bay working with him.*
>
> *The more he sent, the more uncomfortable I felt. They were getting weirder, and it didn't make any sense. He sent so many and one of them was at 02:00am whilst I was on a night shift the next night. I was shocked, it was so unexpected. He is a Nurse so especially being in that role. He wasn't leaving me alone, so I felt uncomfortable."*

The panel decided there was sufficient evidence before it to prove on the balance of probabilities that the emails sent by Mr Sabado caused shock and interference to Colleague A.

The panel therefore found this sub charge proved.

Charges 8b) and 8c)

b) Were of a sexual nature;
c) Made personal comments about Colleague A.

These sub charges are found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague A, along with the documentary evidence put before it.

The panel took into account the email from Mr Sabado dated 12 April 2022 and time stamped 15:46:

"You have to obey me that is the rule……Do not worry eye am not some dirty old man….."

The panel also took into account Colleague A's oral evidence that she found Mr Sabado's emails very weird, personal and that some of the messages related to Colleague A obeying him. The panel was satisfied that Mr Sabado included comments about Colleague A's beauty in some of the emails and that these were of a sexual nature. The panel was of the view that there were a lot of personal comments made about Colleague A in the emails.

The panel therefore found these sub charges proved.

Charges 9a), 9b) and 9c)

9) On 14 April 2022 sent an electronic communication at 15:59 hrs to Colleague A which:

a) Amounted to harassment;
b) Were of a sexual nature;
c) Made personal comments about Colleague A.

This charge is found not proved in its entirety.

In reaching this decision, the panel took into account the written and oral evidence of Colleague A, along with the documentary evidence put before it.

The panel took into account the 'Management Statement of Case' dated 23 November 2021 where it stated:

"As such, [Mr Sabado]'s behaviour is in breach of section 20 of the NMC Code as his actions can be seen as a form of harassment crossing clear professional boundaries and caused his colleague to feel distress."

The panel acknowledged that Colleague A, in her oral evidence, said that she had been informed by HR that Mr Sabado was suspended, when he had sent this email on 14 April 2022, and that she had been "surprised" to receive it.

The panel had sight of the email from Mr Sabado dated 14 April 2022 and time stamped 15:59 in which he stated:

"Hi [Colleague A]… They spoke with me about the emails…Sorry eye meant no harm…. Eye am suspended at the moment..it's okay….Eye am so sorry.

.it was nothing.sexual as you had seen. Have a great day…." [sic]

The panel decided that despite the fact that Mr Sabado had inappropriately contacted Colleague A when he was suspended and had been instructed not to, there was nothing to suggest that the content of this email amounted to harassment. It appeared to the panel that Mr Sabado may have been attempting to apologise to Colleague A. The email made no personal comments about Colleague A and, in the panel's view, it was not of a sexual nature.

The panel therefore found this charge not proved in its entirety.

Charge 10a)

10) On 10 May 2022 stated the following or a gist of similar words:

a) "….believed strongly that left-handed people have a link to the supernatural world…."

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 2 and Colleague A, along with the documentary evidence put before it.

The panel took into account the witness statement of Witness 2 where she stated:

> *"We asked him about the content of the emails and why he had sent them. His response was that while they had worked together he noticed that [Colleague A] was left handed and he believes strongly that left handed people have a link to the supernatural world."*

The panel also took into account the Investigation Meeting dated 10 May 2022 which recorded that:

> *"[Mr Sabado] stated that he started his 'assessment' of [Colleague A] by email after she had removed her face mask in his presence as if it 'meant something' and also told him that she was left-handed so [Mr Sabado] thought [Colleague A] was trying to send him a message for example was she asking for help or a member of another organisation with similar beliefs or 'brought here naturally by a supreme power'. [Mr Sabado] stated that he is 'not crazy' as there is proof to support his belief."*

The panel decided there was sufficient evidence before it to prove on the balance of probabilities that Mr Sabado had said that he "believed strongly that left-handed people have a link to the supernatural world" or words to that effect.

The panel therefore found this sub charge proved.

Charge 10b)

b) "……was doing some research in relation to this link……"

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague A, along with the documentary evidence put before it.

The panel took into account the 'Investigation Meeting' notes dated 10 May 2022 which stated:

> *"[Ms 3] stated that [Mr Sabado]'s emails to [Colleague A] where friendly to start with but that the content became more graphic and asked if [Mr Sabado] was aware of this and the reason for sending the emails. [Mr Sabado] stated that the reason he had started emailing [Colleague A] was because he had noticed whilst working together that she was left handed, as was he, and that his emails were an assessment of [Colleague A]."*
>
> *"[Mr Sabado] stated that there was no sexual intent in sending [Colleague A] the emails and that he was trying to establish whether [Colleague A] shared a similar belief as he did, that left-handed people ([Colleague A] was left-handed the same as [Mr Sabado]) had a link to the supernatural world. [Mr Sabado] further stated that he was part of a 'confidential organisation' that was undertaking 'scientific research' into the link between left-handed people and the supernatural. [Mr Sabado] stated that when he worked with M8 on 10/11'h April he felt that [Colleague A] was 'trying to send him a message' and that his emails to her were an attempt to 'assess whether they shared the same belief'. [Mr Sabado] stated that if [Colleague A] did not share his beliefs, then he acknowledged that his emails to her could be construed as harassment but that was a risk he was willing to take to support his research. [Mr Sabado] stated that he could not elaborate further on the organisation and research he was undertaking for reasons of confidentiality."*

The panel noted the evidence of Witness 2 that during the meeting on 10 May 2022, Mr Sabado had implied that he was doing some research in relation to a link to the supernatural. The panel was satisfied on the evidence before it, that Mr Sabado had stated that he "was doing some research in relation to this link", or words to that effect. The panel therefore found this sub charge proved.

Charge 10c)

c) "…..assessing colleague a to see if she shared this belief (in relation to (a) above.

This sub charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague A, along with the documentary evidence put before it.

The panel took into account the 'Management Statement of Case' dated 23 November 2021 which stated:

> *"[Mr Sabado] stated that he started his 'assessment' of [Colleague A] by email after she had removed her face mask in his presence as if it 'meant something' and also told him that she was left-handed so [Mr Sabado] thought [Colleague A] was trying to send him a message for example was she asking for help or a member of another organisation with similar beliefs or 'brought here naturally by a supreme power'. [Mr Sabado] stated that he is 'not crazy' as there is proof to support his belief."*

The panel also took into account the 'Investigation Meeting' dated 10 May 2022 which recorded that:

"When asked how his emails might appear to [Colleague A] if she didn't share his belief of the supernatural, [Mr Sabado] stated that he appreciated it would risk looking like harassment but that he knowingly took that risk as he needed to assess whether they shared the same belief. [Mr Sabado] stated that as such he would accept whatever the outcome of this investigation. [Mr Sabado] stated that he has a fiancé who also shares his belief of the link between left-handed people and the supernatural and that his interest in [Colleague A] was linked to his beliefs and not sexual."

The panel decided that there was clear and concise evidence to prove that Mr Sabado had stated that he was "assessing Colleague A to see if she shared this belief with him", or words to that effect.

The panel therefore found this sub charge proved.

Charge 11)

11) On 10 May 2022 refused to attend the [PRIVATE] at Kingston Hospital NHS Foundation Trust.

This charge is found not proved.

In reaching this decision, the panel took into account the oral and written evidence of Witness 2 and the documentary evidence put before it.

The panel took into account that in Witness 2's oral evidence, she informed the panel that she had offered Mr Sabado a referral to the [PRIVATE], which Mr Sabado had "politely declined." The panel noted that Mr Sabado did not consider that he needed to attend and that the referral to [PRIVATE] was offered as a supportive gesture and not something Mr Sabado had to do. When he declined the referral, he was given advice on how to self-refer

to [PRIVATE]. The panel did not consider there was a duty on Mr Sabado to attend [PRIVATE].

The panel therefore found this charge not 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 Sabado'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 suitability to remain on the register unrestricted. The most recent guidance from the NMC suggests that the question that will help the panel decide whether a professional's fitness to practise is impaired is "can the nurse, midwife, or nursing associate 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 and/or lack of competence. Secondly, only if the facts found proved amount to misconduct and/or lack of competence, the panel must decide whether, in all the circumstances, Mr Sabado's fitness to practise is currently impaired as a result of that misconduct and/or lack of competence.

Submissions on misconduct/lack of competence

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

Ms Patel invited the panel to take the view that the facts found proved amount to misconduct and/or lack of competence. 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.

Ms Patel referred the panel to the first referral (078856/2020), and the second referral (089691/2022). She referred the panel to a number of sections of the code which the NMC say Mr Sabado has breached codes 6.1 and 6.2, 7.4 and 7.5, 8.1, 8.2, 8.3, 8.4, 8.6, 8.6, 9.2, 9.3, 10.1, 10.2, 10.3, 13, 15.1, 15.2, 16.1, 16.2, 16.5, 18.1, 18.2, 18.3, 19.1, 19.2, and most of section 20 except 20.9.

Ms Patel submitted there were four relevant categories that the facts found proved related to:

1. Clinical shortcomings
2. Failure to administer correct medication
3. Clinical communication/record keeping
4. Professionalism

Ms Patel submitted that charges 4b and 4c from the first referral, and charges 1a and 1b from the second referral related to Mr Sabado's clinical shortcomings.

Ms Patel submitted that these are extremely serious charges, and that the standards of Mr Sabado had fallen far below what is expected of a nurse. She submitted that falling asleep on a shift and wearing headphones is unprofessional and dangerous, especially because Mr Sabado was working on a Paediatric ward on a night shift. Ms Patel submitted that Mr Sabado had failed to check the patient's nasogastric tube, and this could have resulted in

the patient aspirating. Ms Patel submitted that Mr Sabado's failure to escalate clinical concerns around a deteriorating patient fell far below the standards expected of a nurse and his actions put patients at risk of harm.

Ms Patel submitted that charges 3a-d, 4a and 8 from the first referral, and charges 2a-c, 3a-d and 3f from the second referral, all relate to Mr Sabado's failure to administer the correct medication.

Ms Patel submitted that Mr Sabado failed to administer the correct feed/medication, he failed to check the prescription and he did not measure the feed.

Ms Patel submitted that Mr Sabado showed lack of insight about what a nurse can safely do, and he offered to administer IV medication when he was not competent to do so. He put a patient at risk of harm having been told on several occasions he was not allowed to administer IV medication.

Ms Patel submitted that Mr Sabado administered Magnesium and Heparin when there were no valid prescriptions. She submitted that this was extremely serious as administering Heparin was outside of Mr Sabado's competence and he showed disregard for what a nurse is entitled to do.

Ms Patel submitted that charges 6 and 7 in its entirety from the first referral, relate to Mr Sabado's clinical communication and record keeping.

Ms Patel submitted that Mr Sabado's communication and record keeping failures placed patients at risk as other nurses could not tailor their care to individuals. She submitted that he did not do proper handovers and communicate effectively when passing on information to colleagues. Ms Patel submitted that Mr Sabado did not complete the basic record keeping required of a nurse and he was under an informal capability plan at the time.

Ms Patel submitted that the entirety of charges 4, 5, 7, 8 and 10 from the second referral relates to Mr Sabado's professionalism. Ms Patel submitted that in relation to charge 4, Mr Sabado was acting as a mentor and teaching a junior nursing assistant on how an ECG was to be performed but he added unnecessary and irrelevant comments about his sexual orientation during the procedure. She submitted that this was unacceptable and unprofessional, especially because they were in the presence of a patient. Ms Patel submitted that Colleague A was "shocked" and that Mr Sabado's actions were not professional.

In relation to charges 5, 7, 8 and 10, Ms Patel submitted that nurses have to maintain professional boundaries and that the emails that Mr Sabado sent to Colleague A shocked her and made her feel unsafe. She submitted that this was a serious breach of trust in Mr Sabado's role as a Band 5 nurse. She reminded the panel that Colleague A thought that some of the messages were sexual and had said that she did not want to work with Mr Sabado again.

Ms Patel submitted that individually and collectively, Mr Sabado's actions and omissions amounted to misconduct and fell far below the standards expected of a registered nurse.

Submissions on lack of competence

Ms Patel submitted that Mr Sabado is unfit to practise safely and effectively. She invited the panel to find the facts found proved in charge 9 in the first referral amounted to a lack of competence.

Ms Patel submitted that there were specific standards where Mr Sabado's actions amounted to a lack of competence. This included safe preparation, storage, administration of infant feeds, medication management professionalism, documentation and the management of the gastric tube.

Ms Patel submitted that Mr Sabado was put on an informal capability process which set targets. Mr Sabado knew that there were issues surrounding his competencies. She submitted that Mr Sabado was given an opportunity to improve on his competencies when on supernumerary status.

Ms Patel submitted that Mr Sabado was made aware of the issue surrounding his lack of competence and that there was evidence to suggest that Mr Sabado was subjected to repeat processes and that there were extensive measures put in place to support him. This included regular meetings with clinical educators to assess his progress. On review Mr Sabado was moved to a formal capability plan but left before completing this.

Ms Patel submitted that there were standards expected of Mr Sabado as a Band 5 registered nurse and that the facts found proved in relation to charge 9 amounted to a lack of competence.

Submissions on impairment

Ms Patel 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).

Ms Patel submitted that Mr Sabado's fitness to practise is impaired by reason by reason of his misconduct and his lack of competence. Ms Patel submitted that the first three limbs of Grant are engaged. She submitted that Mr Sabado has in the past acted and/or is liable in the future to act so as to put patients at unwarranted risk of harm; he has in the past brought and/or is liable in the future to bring the nursing profession into disrepute and he has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the nursing profession.

Ms Patel submitted that when considering at Mr Sabado's clinical shortcomings, there is no evidence before the panel that he has remedied his actions. She submitted that Mr Sabado has not demonstrated any meaningful insight into the concerns or understood the potential impact to the public confidence and the profession.

Ms Patel submitted that in relation to Colleague A, Mr Sabado has not understood the severity of his actions and his conduct was a complete derogation of the Code. She submitted there was a risk of repetition in the future. She further submitted that nurses occupy a position of trust, and a member of the public would be gravely concerned if a nurse who had most of these charges proved against him in two referrals is able to practise safely without any restrictions on his practice.

Ms Patel submitted that a finding of impairment should be made on both public protection and public interest grounds.

Decision and reasons on misconduct/lack of competence

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

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 Sabado's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Sabado's actions and omissions amounted to 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*
>
> ***2 Listen to people and respond to their preferences and concerns***

2.1 working partnership with people to make sure you deliver care effectively

6 Always practise in line with the best available evidence

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

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

7 Communicate clearly

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

8 Work co-operatively

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

8.2 maintain effective communication with colleagues

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

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

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

8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10 Keep clear and accurate records relevant to your practice

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

13 Recognise and work within the limits of your competence
13.2 make a timely referral to another practitioner when any action, care or treatment is required
13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
13.5 complete the necessary training before carrying out a new role

15 Always offer help if an emergency arises in your practice setting or anywhere else
15.1 only act in an emergency within the limits of your knowledge and competence
15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

16 Act without delay if you believe that there is a risk to patient safety or public protection
16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

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

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

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

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

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

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

20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

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

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

22 Fulfil all registration requirements

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel noted that there were clinical shortcomings in Mr Sabado's practise as he was sleeping on duty. Specifically in charges 1a(i) and 1b in the first referral, the panel was of the view that Mr Sabado would have been unable to respond to vulnerable patients on the Paediatric ward when he was either asleep or wearing headphones. In relation to charges 4b and 4c, the panel was of the view that checking the position of a patient's nasogastric tube and carrying out a pH test in relation to the position of the tube were basic skills required of a nurse.

In relation to the second referral, the panel took into account charges 1a and 1b and noted that Mr Sabado chose not to escalate concerns to a doctor when it was required to do so. The panel also took into account that this this was a patient recently discharged from ITU. Escalation after identifying abnormal clinical observation, i.e. the heart rate and temperature, is a fundamental skill of a nurse. The panel concluded that this could have put the patient at serious risk of harm.

In relation to medication errors, the panel took into account charges 3a-d, 4a and 8a in the first referral. The panel noted that in charges 3a-d, Mr Sabado had added thickener instead of fortifier to the patient's feed and had not measured the quantity before adding it. In relation to charge 4a, Mr Sabado failed to read the prescription which could have put

the patient at serious risk of harm. In relation to charge 8a, the panel noted that Mr Sabado was supernumerary, and that he offered to administer IV medication despite having discussions with his clinical educator and signing a form to say he would not administer IV medication. The panel was of the view that this showed a complete lack of insight on the part of Mr Sabado into what he could and could not do safely whilst under a capability plan.

In relation to medication errors, the panel took into account charges 2 and 3 in the second referral. The panel noted that in charge 2, Mr Sabado was on the ward caring for a patient who had just come out of ITU. It further noted that Mr Sabado chose to administer Magnesium medication without consulting a doctor and that this could have potentially put the patient at serious risk of harm. The panel noted that in relation to charge 3, Mr Sabado did not escalate concerns and administered unprescribed Heparin. The panel determined that Mr Sabado failed to follow appropriate procedures. This is not a case of accidental medication errors but of a nurse actively choosing to administer unprescribed medication.

In relation to Mr Sabado's failure to communicate with colleagues, the panel took into account charges 6a-b and charge 7 in the first referral. The panel noted that in charges 6a-b, Mr Sabado did not provide sufficient information to his colleagues after a shift or conduct a proper handover. It was of the view that as this was a paediatric ward with vulnerable patients, effective handovers were extremely important for the continuing care of the patients. It also considered that walking away from patient bays without informing another nurse put the patients at a serious risk of harm. The panel was of the view that this was repeated behaviour over a period of time. In relation to charge 7 the panel noted that patient records were not completed fully, were not completed in a timely manner and were difficult for others to read. This had been raised with Mr Sabado, but the concerns continued. The panel decided that the risk of harm was high as Mr Sabado's poor record keeping would have put patients at risk.

In relation to Mr Sabado's professionalism, the panel took into account charges 4, 5, 7, 8 and 10 in the second referral. The panel noted that in relation to charge 4, Mr Sabado

acted unprofessionally as the comments he made were of a sexual nature and were not necessary. It noted that these words were said in front of a patient and a junior member of staff. The panel decided that Mr Sabado did not act as a role model and acted well below the standards expected of a nurse.

The panel took into account charges 5, 7 and 8, and considered each charge individually. The panel noted that all of the charges relate to Mr Sabado using his work email address inappropriately to send personal comments to a junior colleague. The panel took into account that these emails were of a sexual nature which resulted in Colleague A being made to feel uncomfortable and unsafe to work with Mr Sabado again. The panel decided that Mr Sabado's actions fell well below the standard expected of a nurse.

The panel decided that in relation to charge 10, there was no misconduct. The panel noted that the words Mr Sabado used were in the investigatory interview when he was explaining why he had communicated with Colleague A.

In relation to Mr Sabado's lack of competence, the panel noted that in relation to charge 9a(ii) in the first referral, the panel had evidence before it that Mr Sabado had successfully completed two observations and that he completed the final observations successfully and achieved the competency on 12 March 2022. In the circumstances, the panel considered that this did not amount to a lack of competence.

In relation to charges 9b(i), 9b(iii), 9b(iv), 9b(v) in the first referral, the panel was of the view that despite being supported on the ward and being set targets to improve, there had been a failure by Mr Sabado to maintain standards over a period of time. He had been made subject to an informal capability plan and made a supernumerary. On review of this capability plan however, he had not been able to maintain those skills and had made further errors that resulted in him being put on a formal capability plan. The panel was of the view that this amounted to a lack of competence on the part of Mr Sabado as he had failed to maintain the standards expected of a Band 5 registered nurse.

The panel found that Mr Sabado's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct and, in relation to charge 9, a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct and/or lack of competence, Mr Sabado's fitness to practise is currently 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;'*

The panel considered the first three limbs to be engaged.

The panel had found patients in Mr Sabado's nursing care to have been exposed to an unwarranted risk of harm. Further, a junior colleague had been subjected to inappropriate and unprofessional behaviour on the part of Mr Sabado that made her feel "shocked" and unsafe to work with him. It had also found Mr Sabado to have breached fundamental tenets of the nursing profession and to have brought its reputation into disrepute by virtue of Mr Sabado's acts and omissions.

The panel noted that the acts and omissions were serious, multiple and wide-ranging, and some related directly to Mr Sabado's clinical nursing practice. It noted that Mr Sabado's misconduct and lack of competence also continued for a period of time, as the charges date from 2019 through two separate referrals which were made in 2020 and 2022.

The panel was of the view that Mr Sabado had not provided any evidence of any strengthened practice. The panel did not consider that Mr Sabado had reflected on how his misconduct may have impacted upon patients, colleagues, and the wider public. There did not appear to be any real appreciation by Mr Sabado's of his responsibilities as a

registered nurse. The panel noted that some of the concerns that arose in the 2020 referral were also present in the 2022 referral with another employer.

The panel had regard to the case of *Cohen*, and considered whether the concerns identified in Mr Sabado's nursing practice are capable of remediation, whether they have been remediated, and whether the misconduct and lack of competence are highly unlikely of being repeated in the future.

The panel noted that whilst some of the clinical concerns are capable of remediation, there was no evidence before it that they had been remedied and, therefore, it could not be satisfied that the misconduct and lack of competence were highly unlikely to be repeated in the future.

In light of all the above, the panel had insufficient evidence before it to allay its concerns that Mr Sabado may currently pose a risk to patient safety. In relation to Mr Sabado's unwelcome and inappropriate conduct towards Colleague A, it considered that he had shown no insight into the impact his conduct had upon a junior member of staff. It considered there was a real risk of repetition of the misconduct and lack of competence and therefore an ongoing risk of significant harm to patients and colleagues. Therefore, the panel 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 are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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 the public interest to be engaged in the consideration of this case. It was of the view that a fully informed member of the public would be sufficiently concerned by Mr Sabado's misconduct and his lack of competence, as set out in the panel's findings.

It concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mr Sabado's fitness to practise as a registered nurse is currently impaired on the grounds of public protection and public interest, both in relation to Mr Sabado's misconduct and his lack of competence.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Sabado off the register. The effect of this order is that the NMC register will show that Mr Sabado has been struck-off the register.

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

Submissions on sanction

Ms Patel submitted that the NMC considers a striking-off order to be the most appropriate and proportionate sanction. She referred the panel to the NMC Guidance on Sanctions, SAN-1 to SAN-3.

Ms Patel submitted that the aggravating factors in this case included an abuse of the position of trust, which made a junior colleague feel shocked and unsafe to work around Mr Sabado. She submitted that there was also a lack of insight from Mr Sabado about his failings and no appreciation of his nursing responsibilities. Mr Sabado refused to understand why he could not administer medication when he was not signed off as competent to do so.

Ms Patel submitted that there is also a pattern of misconduct over a period of time which continued from 2019 through two separate referrals in 2020 and 2022. She submitted that the conduct included a number of medication errors and clinical skill deficiencies. Ms Patel submitted that there was a real risk of repetition of the misconduct and lack of competence. She submitted that there is therefore an ongoing risk of significant harm to patients and colleagues.

Ms Patel submitted that taking no further action would be inappropriate in this case. She submitted that as nearly all of the charges were found proved, more must be done by way of sanction to protect the public and to maintain public confidence in the profession. Ms Patel submitted that the same argument was applicable to a caution order.

In relation to a conditions of practice order, Ms Patel referred the panel to the NMC Guidance SAN-3c.

Ms Patel submitted that whilst there are some identifiable areas for assessment and retraining in this case, there had been a number of errors that took place over a sustained period of time, which is indicative of a broader attitudinal problem. She submitted that this would be difficult to remedy by way of conditions.

Ms Patel referred the panel to charge 8 in the first referral where the charge was found proven in full. She submitted that Mr Sabado was told repeatedly that he was not competent to administer IV medication, yet he still offered to do so, and he had taken medical decisions without consulting doctors. Ms Patel submitted that the panel could not be satisfied that Mr Sabado would comply with any conditions of practise and that a higher sanction was required.

Ms Patel submitted that a suspension order would not be appropriate in this case, given the severity and seriousness of Mr Sabado’s actions. She referred the panel to the NMC Guidance SAN-3d.

Ms Patel submitted that Mr Sabado has not provided any evidence of strengthened practise, nor has he reflected on how his misconduct may have impacted patients, colleagues and the wider public. She submitted that Mr Sabado's acts and omissions were serious, multiple and wide-ranging and some related to clinical practise, had breached fundamental tenets of the nursing profession, and brought the profession into disrepute.

Ms Patel submitted that this was a case of serious misconduct over two referrals and a suspension order would not be appropriate in this case.

Ms Patel referred the panel to the NMC Guidance, SAN-3e. She submitted that a striking-off order should be imposed. Ms Patel submitted that Mr Sabado actions and omissions raised fundamental questions about his professionalism.

Ms Patel submitted that Mr Sabado failed to meet the standards that were required of him as a Band 5 nurse who had repeatedly acted outside of his competence. She submitted that his actions and omissions had fallen far below the standard that is required by the Code in order for nurses to practise safely and effectively. Ms Patel submitted that his actions and omissions were so serious that they put patients at risk of harm. Ms Patel submitted that Mr Sabado has not addressed any of the concerns.

Ms Patel therefore submitted that the misconduct is so serious and difficult to put right. She submitted that a striking-off order is the only appropriate and proportionate sanction in this case.

Decision and reasons on sanction

Having found Mr Sabado'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:

- Abuse of trust
- Pattern of misconduct with a number of omissions and actions that occurred over an extended period of time
- A high risk of repetition
- No evidence of any insight or remorse and Mr Sabado showed a complete disregard of the impact of his actions
- Patients were put at risk of harm
- Two referrals took place with similar patterns of behaviour

The panel did not identify any mitigating features in this case.

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 Sabado'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 Sabado's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Sabado's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. It noted that Mr Sabado had not responded positively to retraining in the past and that despite being on a capability plan and having supernumerary status, the clinical concerns had continued. Further, the panel could not be satisfied that Mr Sabado would comply with any conditions of practice imposed. The panel also concluded that the placing of conditions on Mr Sabado's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel was of the view that the misconduct in this case was a significant departure from the standards expected of a registered nurse. In particular the panel noted the following:

- This was not a single incident of misconduct
- The concerns were multiple and wide-ranging and some had been repeated by Mr Sabado at a different Hospital, resulting in a second referral
- There was evidence of harmful attitudinal problems

- There was no evidence of insight or remorse
- There was no evidence of strengthened practise or reflection

In the circumstances, the panel was of the view that there remains a real risk of repetition and harm to patients and colleagues. The panel concluded that a temporary period of suspension would not sufficiently protect the public.

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

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

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order in order to protect the public. It was of the view that Mr Sabado's misconduct was fundamentally incompatible with him remaining on the register.

The panel also considered that regarding the wider public interest, a striking-off order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standards of behaviour required of a registered nurse.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of

this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or is in your own interest until the suspension order takes effect.

Submissions on interim order

Ms Patel invited the panel to impose an interim suspension order for a period of 18 months. She submitted that this interim order is necessary on the grounds of public protection, and it is also in the public interest, having regard to the panel's findings.

Decision and reasons on interim order

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

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. Owing to the seriousness of the misconduct and/or lack of competence in this case and the risk of repetition identified, it determined that Mr Sabado's actions were sufficiently serious to justify the imposition of an interim suspension order until the substantive striking-off order takes effect. In the panel's judgment, public confidence in the regulatory process would be undermined if Mr Sabado were permitted to practise as a registered nurse prior to the substantive order coming into effect.

The panel decided to impose an interim suspension order in the circumstances of this case. To conclude otherwise would be incompatible with its earlier findings.

The panel imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.