Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 3 June 2024 – Friday, 7 June 2024

Virtual Hearing

Name of Registrant:	Afzal Sharif
NMC PIN	05B0218O
Part(s) of the register:	Nurses part of the register Sub part 1 RN1: Adult nurse, level 1 (7 February 2005)
Relevant Location:	Worcestershire
Type of case:	Misconduct
Panel members:	Sarah Lowe (Chair, Lay member) Rashmika Shah (Registrant member) Frances McGurgan (Lay member)
Legal Assessor:	Charles Apthorp
Hearings Coordinator:	John Kennedy
Nursing and Midwifery Council:	Represented by Debbie Churaman, Case Presenter
Mr Sharif:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 5, 6, 7, and 8 (a – d)
Facts not proved:	Charge 4
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 Sharif was not in attendance and that the Notice of Hearing letter had been sent to Mr Sharif's registered email address by secure email on 22 April 2024.

Further, the panel noted that the Notice of Hearing was also sent to Mr Sharif's representative at the Royal College of Nursing (RCN) on 22 April 2024.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Sharif'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 Sharif 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 Sharif

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

Ms Churaman referred the panel to the documentation from Mr Sharif's representative from the RCN which included an email dated 21 February 2024 which stated:

'***RE: Our member: Afzal Sharif***
NMC Ref: 087678

I refer to the above matter and your below email correspondence with my colleague Hemisha Patel.

Please note that I have taken our members instructions and confirm the following:-

- *Our member does not intend to partake in the NMC proceedings.*
- *Our member is not working as a nurse and has no desire to work as a nurse in the future.*
- *Our member does not accept the NMC charges.*
- *Our member does not agree the evidence contained with NMC witnesses/exhibit bundles.*

Please be advised that the RCN will not be attending or providing representation at the NMC hearing. As referenced above, our member does not wish to engage.'

There was a second email from Mr Sharif's RCN representative dated 6 March 2024 which stated:

'As per my previous email of 21st ult

- *Our member does not intend to partake in the NMC proceedings.*
- *Our member is not working as a nurse and has no desire to work as a nurse in the future.*
- *Our member does not accept the NMC charges.*
- *Our member does not agree the evidence contained'*

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 and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

The panel has decided to proceed in the absence of Mr Sharif. In reaching this decision, the panel has considered the submissions of Ms Churaman 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* 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 Sharif;
- Mr Sharif has informed the NMC that he has received the Notice of Hearing and confirmed that he does not intend to attend these NMC proceedings and has not engaged since;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A number of witnesses have attended 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;
- The charges relate to events that occurred in 2022;
- 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 Sharif in proceeding in his absence. Although the evidence upon which the NMC relies has 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 Sharif's decision 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 Sharif. The panel will draw no adverse inference from Mr Sharif's absence in its findings of fact.

Details of charge

That you a registered nurse

On 6 January 2022, in relation to Resident E

1. Did not use the emergency bell in order get help for them.

2. Did not designate staff to help with the situation.

3. Did not perform CPR on the resident when you were supposed to.

4. On becoming aware that the resident had died, did not carry out the correct procedure to verify the death.

5. Did not communicate effectively with the paramedics during your second call to them in that you did not tell them that her level of consciousness had changed /or that she had died.

6. Told paramedics when they attended, that you had performed CPR on the resident when you had not.

7. Your actions at charge 6 were dishonest in that you sought to create the impression that you had performed CPR on the resident when you knew you had not.

8. Did not record and/or did not carry out one or more of the observations listed below which you were required to do:

    a. Pulse.

    b. Blood Pressure.

    c. Temperature.

    d. Neurological

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

Background

The charges arose whilst Mr Sharif was employed as a registered nurse by Heritage Manor working at the Astley Hall Care Home (the Home).

On 6 January 2022, Mr Sharif was working a night shift as the sole registered nurse in charge with four carers assisting. A carer reported around 06:15 in the morning to Mr Sharif that she had found Resident E on the floor with a graze and bruise above her right eye and that Resident E was conscious. It was suspected that Resident E had suffered a fall.

When Mr Sharif arrived in Resident E’s bedroom, he observed and documented in the accident report that there was a skin graze on Resident E’s right eye.

Mr Sharif then called emergency services at approximately 06:26 to inform them of Resident E’s fall and injury and again at 06:38 to advise them of her deteriorating condition.

At some point between 06:15 and 06:38 Mr Sharif moved Resident E into her bed. The deputy manager arrived for the day shift at approximately 06:48, she was met at the door by Mr Sharif who informed her that there was an incident with Resident E.

The ambulance crew arrived between 07:00 and 07:12 by which point the resident had passed away.

Decision and reasons on facts

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

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

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: Registered Manager of the Home at the time of the incident.
- Witness 2: Deputy Clinical Manager at the Home at the time of the incident.
- Witness 3: Registered Manager at the Heritage Manor group who conducted the disciplinary investigation.

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 both the NMC and Mr Sharif. The panel noted that in Witness 2's local statement the date at the top says "0*6/01/2021*"; however, having heard evidence under affirmation the panel are satisfied that this is a typographical error and that the statement was made on 6 January 2022.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Churaman under Rule 31 to allow the hearsay testimony of Witness 4 into evidence. Witness 4 was an agency care assistant working on the night shift on 6 January 2024. Despite numerous attempts, the NMC had not been able to obtain a signed, written statement from Witness 4. Ms Churaman referred the panel to the documentary evidence produced by the NMC Case Officer detailing multiple attempts from August 2023 to January 2024 to contact Witness 4 to obtain their signature on the witness statement. She referred to further phone call logs between 19 December 2023 and 17 January 2024 where the NMC Case Officer attempted to call both Witness 4 and their employer to help get in contact but was informed that Witness 4 is no longer employed by them. Ms Churaman 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 a police investigation.

Ms Churaman referred to the cases of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), *NMC v Ogbonna* [2010] EWCA Civ 1216, and *R (on the application of Shaikh) v General Pharmaceutical Council* [2013] EWHC 1844 (Admin) in support of her application.

In the preparation of this hearing, the NMC had indicated to Mr Sharif in the Case Management Form (CMF), dated 19 December 2023, that it was the NMC's intention for Witness 4 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 4, Mr Sharif made the decision not to attend this hearing. On this basis Ms Churaman advanced the argument that there was no lack of fairness to Mr Sharif in allowing Witness 4's hearsay testimony into evidence.

The panel heard and accepted the advice of the legal assessor. The legal assessor made reference to the relevant case law referenced above and in addition to the case of *El Karout and NMC* [2019] EWHC 28 (Admin), as well as Rule 31(1).

The panel gave the application to admit the statement of Witness 4 consideration. The panel noted that Witness 4's statement had been prepared for a police investigation and the statement of truth was signed by the Witness for that proceeding but has not been signed and produced for the NMC hearing.

The panel considered whether Mr Sharif would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 4 to that of allowing hearsay testimony into evidence.

The panel considered that as Mr Sharif had been provided with a copy of Witness 4's statement and, as the panel had already determined that Mr Sharif 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 is also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 4 and the opportunity of questioning and probing that testimony. The panel noted that the evidence of Witness 4 is not sole and decisive and is consistent with both the documentary evidence and the evidence given in live session.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Witness 4 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

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

Charge 1

‘That you, a registered nurse, on 6 January 2022, in relation to Resident E

1. Did not use the emergency bell in order get help for them.’

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Witness 1 and Witness 3 that they both individually checked the alarm system. Witness 1 checked the system on the day of the incident and confirmed that the system was fully operational. The panel noted that Witness 3 also confirmed the alarm could be adequately heard all over the building. The panel heard from Witness 1 that the emergency alarm system would also create a log record of every time it was activated and what button had activated it. The panel noted that in evidence Witness 1 stated they had downloaded this after the incident and found there had been no entry to say the alarm had been activated in Resident E’s room on the morning of 6 January 2022.

The panel heard from multiple witnesses that it was standard operating procedure in the Home to use the bell to get help for a resident in an accident situation and that Mr Sharif would have been aware of this and knew how to use the emergency bell. The panel noted that Resident E’s care plan stated that in the event of a fall the emergency alarm bell should be activated and that Mr Sharif had access to the care plan, most recently reading them on 4 January 2022. The panel noted that Witness 3 said in the disciplinary investigation Mr Sharif admitted that he did not press the emergency alarm bell.

Therefore, the panel found this charge proved.

Charge 2

‘That you a registered nurse on 6 January 2022, in relation to Resident E

2. Did not designate staff to help with the situation.’

This charge is found proved.

In reaching this decision, the panel took into account the written evidence from Witness 4 that Mr Sharif told them to remain in the nursing office while he attended to Resident E; however, Mr Sharif did not ask the witness to call the emergency services or to remain with the resident while he called 999.

The panel noted the Home's Falls and Head Injury policy states that at least one staff member should remain with a resident in the event of a fall or head injury and that this was confirmed by Witness 1. The panel considered that as the registered nurse on duty during the night shift Mr Sharif would have been aware of this policy. However, despite knowing this the panel noted that in the disciplinary investigation report Mr Sharif stated that he left Resident E alone to make 999 calls and to get the equipment required for observations.

The panel noted that both Witness 1 and 2 gave evidence that in the circumstances help was essential to manage both the CPR and to coordinate tasks and provide support for other residents whilst attending to Resident E. The panel heard from Witness 2 that when they arrived at the Home Mr Sharif went to answer the door and that this was surprising as the expectation was that Mr Sharif would have remained with Resident E to perform CPR and that one of the carers on shift should have been designated to help with the door. Witnesses 1 and 2 also expressed concern that Mr Sharif had placed the two calls to 999 which would have meant he stopped performing CPR while speaking and that he didn't ask other staff to make the call.

Therefore, the panel found this charge proved.

Charge 3

'That you a registered nurse on 6 January 2022, in relation to Resident E

3. Did not perform CPR on the resident when you were supposed to.'

This charge is found proved.

In reaching this decision, the panel took into account that Mr Sharif had been working at the Home for a sustained period and had received training both in his role as a registered nurse and at the Home in the provision of CPR and when to apply CPR. The panel noted that Resident E had been resident for some months. The panel heard evidence that Mr Sharif would have known about the RESPECT Form (Recommended Summary Plan for Emergency Care and Treatment) which contained information about each resident's do not attempt resuscitate (DNAR) status. The panel noted that in the disciplinary interview Mr Sharif stated that he was aware of Resident E's RESPECT Form and therefore should have been aware there was no DNAR in place. The panel heard evidence from all the witnesses that this information was also highly visible on the handheld PCS (patient centred system) patient record device that the Home used.

The panel heard evidence that as an experienced nurse working in the Home Mr Sharif would have been aware of how to quickly access this information to check if a DNAR was in place. The panel heard from all witnesses that in any event the expectation was that unless it could be clearly established there is a DNAR in place for a resident then CPR should be started immediately and not cease until either the paramedics or another staff member arrive to take over. The panel noted from both witness and documentary evidence that Mr Sharif had left the room on multiple occasions, to make a 999 call and to open the main door, and that at those times he knew CPR was not being carried out.

The panel heard from Witness 1 that Mr Sharif told him that he did not carry out CPR and that the paramedics said there was a lack of evidence of an attempt of CPR. Witness 3 stated in their evidence that during the disciplinary meeting Mr Sharif confirmed he did not attempt CPR or chest compressions.

While the panel noted Mr Sharif's written statements it preferred the evidence of Witnesses 1 and 3 on the basis of their consistency and having had the benefit of their evidence being tested by questions being put by the panel.

Therefore, the panel found this charge proved.

Charge 4

'That you a registered nurse on 6 January 2022, in relation to Resident E

4. On becoming aware that the resident had died, did not carry out the correct procedure to verify the death.'

This charge is found not proved.

In reaching this decision, the panel took into account the contradictory evidence that Mr Sharif had been trained to verify a death. The panel heard that Witness 3 stated the expectation was that all registered nurses would have been trained in the procedures to verify a death. Witness 3 gave evidence that verification of death could not be made before the paramedics had examined Resident E. However, Witness 1 said in their evidence that Mr Sharif had not yet received this training. The panel also had sight of a record of Mr Sharif's training completed at the Home and there is no course listed as Procedure to Verify Death, or equivalent clear wording.

The panel preferred the evidence of Witness 1 over Witness 3 in this regard. The panel noted that Witness 1 was the registered manager for the Home at the time of the incident and therefore would have known more accurately the training needs of the staff in the Home. While Witness 3 is a registered manager in a different Home who only met Mr Sharif during the disciplinary investigation.

Therefore, the panel decided that on the balance of probabilities Mr Sharif had not received the required training to verify a death.

In light of this, the panel considered that it would not have been correct procedure for Mr Sharif to have attempted to verify the death of Resident E and that he was not expected or responsible for following the verification procedures.

Therefore, the panel found this charge not proved.

Charge 5

'That you a registered nurse on 6 January 2022, in relation to Resident E

5. Did not communicate effectively with the paramedics during your second call to them in that you did not tell them that her level of consciousness had changed /or that she had died.'

This charge is found proved.

In reaching this decision, the panel took into account evidence from Witness 1 that paramedics should be updated in the event of a life threatening deterioration or if the resident became unconscious. The panel noted that in the care notes and Accident Report there is no record of Mr Sharif informing the paramedics of the deteriorating condition of Resident E. The panel heard the evidence of Witness 2 that when they arrived and asked Mr Sharif if he had informed the paramedics that Resident E was either unconscious or had died by this point, Mr Sharif stated that he had not told the paramedics yet.

The panel considered that it is part of the duty of candour to keep the emergency response services informed of any change in a patient's situation, such as a loss of consciousness or potential death, in order that they can adequately evaluate the seriousness of the response required. The panel found no evidence that Mr Sharif had done this. The panel noted that in the 999 incident report the paramedics noted they had expected to find Resident E in a semi-conscious state and still breathing, but on arrival they did not.

Therefore, the panel found this charge proved.

Charge 6

'That you a registered nurse on 6 January 2022, in relation to Resident E

6. Told paramedics when they attended, that you had performed CPR on the resident when you had not.’

This charge is found proved.

In reaching this decision, the panel took into account Witness 1’s evidence that when the paramedics arrived at the Home they found no evidence that CPR had been attempted and were prompted to raise a safeguarding concern following the incident because of this. Witness 2 also gave evidence that they were present when Mr Sharif told the paramedics he had performed CPR on Resident E.

The panel found that Mr Sharif’s statements were inconsistent between his initial statement, his interview as part of the Home’s investigation, and what he later said during the disciplinary interview. The panel noted that in both the investigation and disciplinary meeting Mr Sharif admitted that he had not attempted CPR and he lied as he was feeling panicked. The panel noted that it has found charge 3 proved and that CPR had not been attempted by Mr Sharif.

The panel heard from Witness 1 and Witness 2 that Mr Sharif had informed the paramedics that CPR had been attempted.

Therefore, the panel found this charge proved.

Charge 7

‘That you a registered nurse on 6 January 2022, in relation to Resident E

7. Your actions at charge 6 were dishonest in that you sought to create the impression that you had performed CPR on the resident when you knew you had not.’

This charge is found proved.

In reaching this decision, the panel took into account the case of *Ivey (Appellant) v Genting Casinos (UK) Ltd t/a Crockfords (Respondent)* [2017] UKSC 67 as authoritative in establishing the test for dishonesty. The panel noted that they are required to first ascertain (subjectively) the actual state of Mr Sharif's knowledge at the relevant time and then once his state of mind as the facts is determined the panel then go onto consider if an ordinary, reasonable person would consider an action to be dishonest, and that the person accused of being dishonest would have realised that by those objective standards what they were doing is dishonest. The panel had regard to the NMC guidance DMA-8 on making decisions in dishonesty charges.

In light of the findings at charge 3 the panel are satisfied that Mr Sharif would have known he had to perform CPR and to continue it until the paramedics arrived. The panel heard in Witness 3's evidence that at the disciplinary investigation Mr Sharif stated his mind was blank and confused during the incident, that he lied and sought to cover it up. The panel failed to find any evidence of an alternative explanation.

The panel considered that any ordinary, reasonable person would have expected a registered nurse with many years' experience working in a care home to have known the need to start CPR and to be clear with emergency services on what care had been provided when they arrived.

The panel considered that the evidence from Mr Sharif is contradictory and not consistent with itself. On the contrary the panel found the evidence from all witnesses and the documents provided to be of good quality and provided a reasonable explanation that Mr Sharif would have known about the obligation to perform CPR.

Therefore, the panel concluded that having known about the importance of performing CPR on Resident E, Mr Sharif would have known that by telling the paramedics he performed it, when he knew he had not, was dishonest and created a situation where the paramedics were not in full possession of the facts.

This charge is therefore found proved.

Charge 8

‘That you a registered nurse on 6 January 2022, in relation to Resident E

8. Did not record and/or did not carry out one or more of the observations listed below which you were required to do:

   a. Pulse.

   b. Blood Pressure.

   c. Temperature.

   d. Neurological’

This charge is found proved.

In reaching this decision, the panel considered all sub charges collectively as they would have been carried out as part of the same set of observations and would have been recorded at the same time. The panel had regard to the Home’s Falls and Head Injury Policy which states that observations including neurological should be carried out in the event of a suspected fall.

The panel had sight of the care records for Resident E which showed that there were regular observations entered up to the 5 January 2022; however, there is no record of any observations on the 6 January 2022. The panel heard from Witnesses 1 and 3 that nurses had access to a handheld device to carry with them which would be used to record observations as they were made, and these observations would be saved to the patient records. The panel noted that Witness 1 stated in evidence that when they entered Resident E’s room they did not find any of the equipment needed to make observations.

The panel further noted that in the Accident Report completed after the incident when the information from the recording system was reviewed there were no observations recorded for Resident E on 6 January 2022.

The panel heard from Witness 3 that during the disciplinary interview Mr Sharif stated that he did carry out the observations; however, he stated he did not record any observations.

The panel heard from Witness 1 that during the investigation meeting Mr Sharif stated that he had performed the blood pressure, temperature, and pulse observations but had not recorded them. Mr Sharif did state that he did not carry out the neurological observations.

While the panel noted Mr Sharif's written statements it preferred the evidence of Witnesses 1 and 3 on the basis of their consistency and having had the benefit of their evidence being tested by questions being put by the panel.

The panel concluded that on the balance of probabilities it is more likely than not that the observations were not carried out. Further the panel concluded that it is certain that there is no record of observations having been carried out.

Therefore, the panel finds that given the clause of the charge it can be found 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 Sharif's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

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

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

Ms Churaman identified the specific, relevant standards where Mr Sharif's actions amounted to misconduct. She particularly highlighted sections 1.1, 1.2, 1.3, 1.4, 1.5, 2.1, 2.2, 2.3, 2.4, 2.5, 3.1, 3.2, 4.1, 7.1, 7.2, 8.1, 8.2, 8.3, 8.5, 8.6, 10.1, 10.2, 10.3, 13.1, 13.2, 14.1, 14.2, 15.2, 16.1, 17.1, 19.1, 20.1, 20.2, 20.3, 20.5, 20.8, and 25.1 of the Code as being relevant to where Mr Sharif's actions amounted to misconduct.

Ms Churaman submitted that the acts and omissions of Mr Sharif that the panel have found proved are serious and constitute a significant failure of the expected standards of care. She submitted that these actions put patients at risk of harm. Ms Churaman submitted that the charge of dishonesty, which was found proved, is particularly serious and not at the lower end of the spectrum of levels of dishonesty.

In light of the above Ms Churaman submitted that Mr Sharif's conduct has amounted to misconduct.

Mr Sharif was not present and made no written representations on misconduct.

Submissions on impairment

Ms Churaman moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *R (on the application of Cohen) v GMC* [2008] EWHC 581.

Ms Churaman submitted that the actions of Mr Sharif that the panel found proved cover a wide range of areas which are fundamental to safe nursing practice. She submitted that Mr Sharif knew that Resident E had completed a RESPECT form but did not attempt CPR, that his failure to make observations were a serious risk of significant harm to Resident E. She further submitted that the act of dishonesty in what Mr Sharif told the paramedics is a major breach of the duty of candour that is expected of a registered nurse.

Ms Churaman submitted that in light of these significant breaches of the fundamental tenets of nursing practice Mr Sharif is impaired. She submitted that while some of the clinical practice areas identified are possible to be remediated, and noting that Mr Sharif did provide training certificates from 2022, his actions of dishonesty are attidutinal and therefore more difficult if not impossible to fully remediate. Ms Churaman submitted that because of this difficulty there is a risk of repetition.

Ms Churaman submitted that Mr Sharif has made no submissions on his insight into the incident and has not provided any reflection on how to strengthen his practice.

Ms Churaman made reference to the test set out in *CHRE v NMC and Grant* and submitted that all four limbs identified are engaged in this case.

In light of all the above, Ms Churaman submitted that Mr Sharif's fitness to practice is currently impaired.

Mr Sharif was not present and made no written submissions on impairment.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mr Sharif's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Sharif's actions amounted to a breach of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> ***To achieve this, you must:***
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.3 avoid making assumptions and recognise diversity and individual choice*

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

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

To achieve this, you must:

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

8 Work co-operatively

To achieve this, you must:

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

***To achieve this, you must**:*

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

To achieve this, you must:
14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm
14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

20 Uphold the reputation of your profession at all times
***To achieve this, you must**:*
20.2 act with honesty and integrity at all times,…'

In addition, the panel considered sections 1.5, 2.1, 4.1, 8.1, 8.2, 8.3, 8.4, 8.5, 20.1, 20.5, and 25.1 of the Code to be areas where Mr Sharif's conduct has fallen below the expected standards.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the misconduct is particularly serious and at the highest end of the spectrum within the NMC Guidance on Impairment given the range of charges found proved which covered all four themes within the Code and included:

- A breach of the duty of candour;
- Mr Sharif's direct responsibility for exposing Resident E, who was a vulnerable person, to neglect and actual harm;
- A dangerous attitude to patient safety and preservation of life; and

- Dishonesty

The panel found that Mr Sharif’s actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Sharif’s fitness to practise is currently impaired.

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

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

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

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

> *‘In determining whether a practitioner’s fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the*

practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

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

Given the charges found proved the panel finds that residents were put at risk and Resident E was caused physical and emotional harm as a result of Mr Sharif's misconduct. Mr Sharif's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges as a whole and in particular relating to dishonesty extremely serious.

The panel especially noted that the lack of providing CPR and dishonesty are both extremely serious breaches of the fundamental tenets of safe nursing practice. The panel considered that all four limbs mentioned above are engaged in this case.

Regarding insight, the panel considered that Mr Sharif has not provided any information before the panel to demonstrate any insight. The panel noted that there were a number of testimonials submitted by former colleagues and other recognised professionals speaking to Mr Sharif's character. However, the panel considered that these do not address the regulatory concerns and that a number of these date from two or three years ago, with one being from a colleague in 2019, and it is not clear if they knew the full details of the charges when these were written. Therefore the panel found these to be limited in scope.

The panel was satisfied that some of the misconduct in this case, relating to clinical practice, is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Sharif has taken steps to strengthen his practice. The panel took into account that Mr Sharif has submitted two certificates of training completed in 2022. However, it was concerned there were no further training records and that these appear to be limited and not addressing the full scope of the concerns identified in Mr Sharif's practice. The panel concluded that there remains a high risk of repetition of this conduct.

The panel also noted that Mr Sharif stated in the disciplinary hearing that:

> *'I lie when I panic.'*

The panel considered this to be an indication of serious attitudinal problems regarding dishonesty that is significantly difficult to remediate.

While the panel considered that the clinical concerns around provision of CPR, completing and documenting observations, and working collaboratively with colleagues could be remediated through adequate training and support but the attitudinal concerns of

dishonesty are not easily addressed. The panel noted that Mr Sharif repeated the dishonest attempts to cover up his failings in relation to performing CPR initially in the Home's investigation before accepting that he had failed to do so. However, the panel had regard to the email from Mr Sharif's RCN representative the charges were then again denied. Therefore, the panel concluded that there remains a risk of repetition, particularly in regards to dishonesty. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because the findings of dishonesty and failure to provide adequate care are fundamental tenets of nursing practice that an ordinary, reasonable member of the public would expect a registered nurse to adhere to. The panel considered that Mr Sharif's actions fell significantly below the expected standard and risk bringing the nursing profession into disrepute.

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

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

Sanction

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

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

Submissions on sanction

Ms Churaman informed the panel that in the Notice of Hearing, dated 22 April 2024, the NMC had advised Mr Sharif that it would seek the imposition of a striking-off order if it found Mr Sharif's fitness to practise currently impaired.

Ms Churaman submitted that the charges of dishonesty are significantly serious and that the NMC Sanctions Guidance says that the most serious sanction, namely a striking-off order, is always a possibility if a registrant has been found to be dishonest.

Ms Churaman submitted that given the number of sections of the Code that the panel found Mr Sharif had breached and his failings of the fundamental tenets of safe nursing practice a striking-off order is the most appropriate sanction. She noted that while some of the clinical aspects could have been addressed with a conditions of practice order or a period of suspension, given the attitudinal concerns of Mr Sharif's dishonesty these would not suitably protect the public.

Ms Churaman noted that Mr Sharif has not provided any insight or provided evidence of strengthening his practice. Therefore, there is a significant risk of repetition and that a striking-off order is necessary.

Mr Sharif was not present and made no submissions of sanctions.

Decision and reasons on sanction

Having found Mr Sharif'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:

- Dishonesty in a clinical setting
- Continuation of dishonesty in covering up failings
- Lack of insight into failings
- Resident E was a vulnerable resident
- Actual harm was caused to Resident E

The panel considered that there were no mitigating features in this case. The panel noted that Mr Sharif did submit a number of testimonials; however, as these did not address the regulatory concerns identified the panel did not find them satisfactory as mitigating features.

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 Sharif'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 Sharif'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 Sharif's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The dishonesty identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Sharif'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 conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel conclude that Mr Sharif demonstrated attitudinal problems by his dishonesty in a clinical setting. It also concluded that there was a lack of insight from Mr Sharif and there is a risk of repetition. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Sharif's actions is fundamentally incompatible with Mr Sharif remaining on the register.

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

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

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

The panel considered that Mr Sharif's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Sharif's actions were serious and raised fundamental concerns about his professionalism. Therefore to, allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mr Sharif in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Sharif's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Churaman. She submitted that an interim order is necessary to cover any potential appeal period.

Decision and reasons on interim order

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

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

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

That concludes this determination.