Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 17 June 2024 – Thursday, 27 June 2024
Wednesday, 6 November 2024 – Friday, 8 November 2024

Virtual Hearing

Name of Registrant:	**Nehaben Asutosh Desai**
NMC PIN	19J0627O
Part(s) of the register:	Registered Nurse – (Sub part 1) Adult Nursing (Level 1) – 16 October 2019
Relevant Location:	Bristol
Type of case:	Misconduct
Panel members:	Penelope Titterington (Chair, Lay member) Lisa Holcroft (Registrant member) Caroline Taylor (Lay member)
Legal Assessor:	Fiona Moore (17 – 24 June 2024) Robin Ince (25 – 27 June 2024, 6 – 8 November 2024)
Hearings Coordinator:	Stanley Udealor
Nursing and Midwifery Council:	Represented by Alban Brahimi, Case Presenter
Mrs Desai:	Present and represented by John Morrison, instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charges 1a, 1b (in part), 4, 5a, 5b, 9, 10, 11, 16, 17 and 18
Facts proved:	Charges 1b (in part), 1c (i), 1c (iii), 2, 6, 7a, 7b, 8, 12, 15, 19 and 21
Facts not proved:	Charges 1c (ii), 3a, 3b, 3c, 3d, 3e, 13, 14 and 20

Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse, whilst working at Arbour Walk Nursing Home ('the Home') on 19 March 2023;

1) Despite knowing that Colleague Z a Health Care Assistant, was not authorised/qualified to administer medication;
   a) Handed Colleague Z covert medication to administer to Resident B.
   b) Instructed/forced/pressured Colleague Z to administer covert medication to Resident B.
   c) After Colleague Z attempted to refuse the administration of medication to Resident B, you spoke/shouted at Colleague Z using words to the effect;
      (i) '*Go, go, go*.'
      (ii) '*You guys do not help at all.*'
      (iii) '*Do what I tell you.'*

After discovering that Resident A's medication had incorrectly been administered to Resident B;

2) On one or more occasion shouted at Colleague Z.

3) Failed to record/monitor/conduct observations for Resident B, in that you did not monitor/record Resident B's'
   a) Blood Pressure;
   b) Pulse;
   c) Oxygen saturation;
   d) Temperature;
   e) Blood sugar levels.

4) Did not inform/escalate the medication error to the Home Manager, Colleague Y, until the evening.

5) Did not record the medication error in Resident B's;
   a) MAR Chart;
   b) Patient Notes.

6) On one or more occasion, instructed Colleague Z to inaccurately state that Resident B only consumed 2-3 sips of medication.

7) At around 17:00 Inaccurately informed Colleague Y that;
   a) You had mistakenly administered Resident A's medication to Resident B;
   b) That Resident B had only consumed 2-3 sips of the medication;

8) At around 18:00 Inaccurately informed Colleague X, that Resident B had only consumed 2-3 sips of the medication.

9) Did not immediately/at the time of the incident complete an AFIN form for the medication errors.

10) Did not immediately/at the time of the incident complete a Medication Error Investigation Report (MEIR) form.

11) Did not immediately/at the time of the incident contact Resident B's GP.

12) Did not contact Resident B's family as soon as possible/as instructed.

On 20 March 2023;

13) Recorded inaccurate/incomplete information in the AFIN form, namely that Resident B only consumed 2-3 sips of medication.

14) Destroyed the AFIN form containing inaccurate information.

15) Between 20-29 March 2023 Did not return a completed AFIN form.

16) On an unknown date(s), on one or more occasions, asked Colleague W to administer medication, knowing they were not authorised/qualified to do so.

17) On an unknown date(s), on one or more occasions, asked Colleague V to administer medication, knowing they were not authorised/qualified to do so.

18) On unknown dates, on one or more occasions, asked staff members to administer medication knowing they were not qualified/authorised to do so.

19) Your actions in charge 6 above were dishonest, in that you sought coerce a junior colleague into providing a false account of a medication error/incident.

20) Your actions in charge 7 a) were dishonest in that you sought to conceal from the Home Manager, that you had instructed/forced an unqualified/unauthorised staff member to administer covert medication.

21) Your actions in one or more of charges 6, 7 b), 8 & 13 were dishonest in that you sought to conceal the amount of medication consumed by Resident B.

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

Background

The charges relate to an incident that allegedly occurred whilst you were employed as a registered nurse by Cedar Care Homes at Arbour Walk Nursing Home (the Home). On 14 April 2023, you were referred to the NMC by Cedar Care Homes.

On 19 March 2023, it was alleged that you instructed Witness 1, a care assistant who was untrained in medication administration, to administer covert medication to Resident B. You allegedly shouted at him to carry out your instructions. It was further alleged that when Witness 1 had administered the covert medication to Resident B, you claimed that you had instructed him to administer the covert medication to Resident A. Later, you allegedly told Witness 1 to tell anyone who asked him about the incident, to say that Resident B only drank two to three sips of the covert medication rather than almost all of it.

It was alleged that you failed to conduct appropriate observations on Resident B and to complete the necessary documentation in relation to the medication error, despite multiple requests by the Home. Although, you reported the incident to Witnesses 2 and 3, it was alleged that you did not provide an accurate picture of the incident to them.

During the Home's investigation meeting on 18 April 2023, you admitted that although you gave the covert medication to Witness 1 to administer, you instructed him to administer it to Resident A rather than Resident B. You explained that you intended to monitor Witness 1 while he administered the covert medication, but you got distracted by an incident with other residents. You stated that you did monitor Resident B afterwards but did not consider that harm was caused as they did not have any change to their vital signs when checked. You then denied that you instructed Witness 1 to say that Resident B had only consumed two to three sips.

Decision and reasons on application for special measures/reasonable adjustments

The panel heard an application made by Mr Brahimi, on behalf of the Nursing and Midwifery Council (NMC), for the provision of a special measure/reasonable adjustment for Witness 1. The application was made pursuant to Rule 23 (1) (f) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Brahimi submitted that Witness 1 had alleged that he was subjected to intimidation and aggressive behaviour from you at the time of the incidents and he would not be comfortable to give his evidence in your presence. Mr Brahimi stated that, given that this was a virtual hearing, Witness 1 had requested that your camera and audio should be turned off throughout the duration of his evidence.

Mr Brahimi submitted that Witness 1 falls under Rule 23 (1) (f) which classifies witnesses, who complains of intimidation, as vulnerable witnesses. He submitted that the panel should therefore grant his request as there was no injustice posed to you, and the special measure was necessary in order to enable Witness 1 give the best evidence to the panel.

Mr Morrison, on your behalf, did not oppose the application but submitted that you deny any allegation of intimidation and coercion of Witness 1.

The panel accepted the advice of the legal assessor.

The panel decided to grant the application. It was of the view that, given that Witness 1 had complained of intimidation from you at the time of the incidents, Witness 1 falls under the category of vulnerable witnesses under Rule 23 (1) (f). The panel therefore directed that you should turn off your camera and audio throughout the duration of Witness 1's evidence, in order to enable him to give the best evidence in these proceedings. It was satisfied that no injustice would be posed to you by such special measure. Furthermore, the panel noted that you denied the allegations of intimidation and coercion from Witness 1. It would therefore draw no inference from the request by Witness 1.

Mr Morrison started to make an application to withdraw your admissions to charges 1a and 1b. At the start of this application, it became clear that the panel first needed to consider an application to admit hearsay evidence.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Morrison, under Rule 31 to admit the Record of Investigative Interview of Mr 1 (the Record) into evidence. Mr Morrison referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). He highlighted that this case laid out the following factors to be considered in admitting hearsay evidence:

(i) 'Whether the statements are the sole or decisive evidence in support of the charges
(ii) The nature and extent of the challenge to the contents of the statements
(iii) Whether there was any suggestion that the witnesses had reasons to fabricate their allegations
(iv) The seriousness of the charge, taking into account the impact which adverse findings might have on the Registrant's career
(v) Whether there is a good reason for the non-attendance of the witness
(vi) Whether the NMC have taken reasonable steps to secure attendance
(vii) Whether the Registrant had prior knowledge that the witness statements were to be read'

Mr Morrison submitted that the Record is clearly relevant to this case and in many ways goes to the heart of the issues around charges 1a and 1a. He submitted that the Record originated from the investigative interview of Mr 1 in which he was interviewed about the alleged medication error on 19 March 2023. Mr Morrison highlighted that Mr 1 was a care assistant at the Home who was present during the incident, and it should be noted that the interview was conducted on 20 March 2023, which was a day after the incident.

Mr Morrison submitted that a close examination of the Record demonstrates that it is relevant to the issue as to whether or not you told Witness 1 to administer medication to Resident A or to Resident B.

Mr Morrison submitted that there appears to be no reason as to suggest that Mr 1 would fabricate his account of the incident as contained in the Record. Mr Morrison highlighted that the investigative interview was conducted on 20 March 2023, which was a day after the incident. It could therefore be said that the incident was still *"fresh"* in the mind of Mr 1 and there would be no reason to suggest that he would fabricate what had happened.

Mr Morrison highlighted that the hearsay application was quite different from how it was usually made as it was an application made by you on a document which was provided by the NMC and contained in its final exhibit bundle and in the Case Management Form (CMF). Therefore, you were under the impression that the Record would be relied by the NMC in this case. However, the contents of the Record do not generally support the NMC's case, and this could be a reason that a witness statement was not obtained from Mr 1 by the NMC

Mr Morrison noted that the charges against you are very serious, and any adverse finding could have a negative impact on your nursing career. Therefore, it would be fair for the panel to admit the Record, which supports your defence, into evidence.

With regards to whether there is any good reason for the non-attendance of Mr 1, Mr Morrison submitted that it could be said that it was unsatisfactory that your union, the Royal College of Nursing (RCN), did not make an application sooner or sought to understand why a witness statement was not produced for Mr 1. However, this is negated by the fact that the Record was contained in the NMC final exhibit bundle and in the CMF, and this may have led the RCN to believe that the Record would be relied upon, by the NMC in proving its case. Mr Morrison submitted that the panel should however consider that the Record could support your case as well as the NMC's case. He highlighted that although the Record could be of assistance to your defence in supporting your account on

which resident you directed Witness 1 to administer the medication, it does not support your claim that Resident B had only taken two to three sips of the covert medication.

In conclusion, Mr Morrison invited the panel to admit the Record of Investigative Interview of Mr 1 (the Record) into evidence.

Mr Brahimi stated that the NMC opposed the hearsay application. He submitted that the Record was produced as part of the investigation into the allegations by the NMC and which was therefore disclosed to you on the basis of fairness. He submitted that the fact that the Record was included in the NMC exhibit bundle and in the CMF, it should not be construed as an acceptance of its contents by the NMC.

Mr Brahimi submitted that although the Record is relevant to the case, the panel should not consider that this would mean that it would automatically be fair for it to be admitted into evidence. He submitted that, in terms of the factors set out in the case of Thorneycroft, the panel should consider that, apart from your evidence, the Record is the sole and decisive evidence in support of your account of the incident. However, this would depend on whether the panel accepts the withdrawal of your admission to charges 1a and 1b.

With regards to the nature and extent of the challenge to the Record, Mr Brahimi submitted that there are a number of witness statements which contradicts the contents of the Record and therefore challenges it. He noted that these witness statements have been tested in evidence unlike the Record and therefore, it would not be fair to admit it into evidence as the NMC do challenge the contents of the Record.

With respect to whether there is any suggestion that the witnesses had reasons to fabricate their allegations, Mr Brahimi submitted that the Record was not a witness statement but merely a record of an investigative interview at the Home. He asserted that although there was nothing to suggest that there had been any fabrication, the panel

should take into consideration that the Record was not signed nor did it contain a declaration of truth, which therefore raises doubts about its accuracy.

With regards to the seriousness of the charge, Mr Brahimi submitted that although the Record would assist you in your defence, it should be noted that there was no dispute from you to the extent that you instructed and handed over covert medication to Witness 1 to administer to a resident. However, the only dispute was whether you had instructed Witness 1 to administer the covert medication to either Resident A or Resident B.

With respect to the non-attendance of Mr 1, Mr Brahimi submitted that it was never indicated by the NMC that Mr 1 would be called as a witness in this case and it was a matter for the RCN, having had notice of the Record within reasonable time, to have taken steps to ensure the attendance of Mr 1 or to inform the NMC that Mr 1 would be required as a witness in this case. Mr Brahimi highlighted that the Record was sent to the RCN, ahead of the twenty-eight-day period required for service of documents but there were no steps taken to secure the attendance of Mr 1.

In conclusion, Mr Brahimi invited the panel to refuse the hearsay application.

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

The panel considered the hearsay application.

The panel took into account that the investigative interview of Mr 1 was conducted on 20 March 2023, which was a day after the incident and therefore was a contemporaneous account. The account details Mr 1's observation of an incident that is the basis of some of the charges. Thus, the panel decided that the Record is potentially relevant to the charges.

The panel had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence. The panel considered whether the Record is the sole and decisive evidence with respect to charges 1a and 1b. It bore in mind that there is other evidence including witness statements, documentary and oral evidence, which had been presented by the NMC in support of charges 1a and 1b. It noted that the Record forms part of the evidence that supports your account of the incident. However, the panel concluded that the Record is not sole and decisive evidence.

The panel took into account that although there was no suggestion that Mr 1 had any reason to fabricate his account of the incident, the Record was unsigned and did not contain a declaration of truth. However, the panel noted that it was a record of a formal investigative interview conducted by an independent person in the Home as part of the Home's investigation into the incidents. Furthermore, the investigative interview of Mr 1 was conducted on 20 March 2023, which was a day after the incident and therefore was a contemporaneous account of the incident. The panel would therefore attach whatever weight it deems fit to it.

The panel considered the charges to be serious and any adverse finding could have a negative impact on your nursing career. It noted the submissions of Mr Morrison that due to the inclusion of the Record in the CMF, in a list of documents that the NMC would rely on as part of its case, you were under the impression that you did not need to secure the attendance of Mr 1 in these proceedings. The panel also noted the submissions of Mr Brahimi that the Record was included in the NMC exhibit bundle on the basis of fairness and disclosure to you. The NMC did not intend to rely on the Record to prove its case and therefore did not secure the attendance of Mr 1. Given the misunderstanding about the inclusion of the Record in the NMC exhibit bundle and in the CMF, and whether it would be relied upon by the NMC, the panel was satisfied with the reasons given by Mr Morrison for the non-attendance of Mr 1 in these proceedings and it would not draw any adverse inference from his non-attendance.

Having considered these factors, the panel determined that it is relevant and fair to admit the Record of Investigative Interview of Mr 1 into evidence. It was of the view that although the nature and contents of the Record were challenged by the NMC, it is a matter for the panel to compare and evaluate evidence from the NMC and you and attach any weight it may deem fit.

Decision and reasons on application to withdraw admissions to charges 1a and 1b

Mr Morrison then continued his application for the withdrawal of your admissions to charges 1a and 1b. He highlighted that you had made admissions to charges 1a and 1b in your completed CMF and had confirmed your admissions to those charges when they were read out at the commencement of these proceedings. However, after you had heard the evidence of Witness 1 in which he confirmed that you had specifically instructed him to administer the covert medication to Resident B, you were adamant that you had instructed Witness 1 to administer the covert medication to Resident A and therefore you could not make admissions to charges 1a and 1b as they were drafted.

Mr Morrison referred the panel to Rule 24 and submitted that it is an agreed position that the panel has the power to consider and grant an application for the withdrawal of an admission made by a registrant in the course of proceedings. He also referred the panel to the textbook: '*The Regulation of Healthcare Professionals: Law, Principle and Process'*. He submitted that the textbook provided that in order for a formal admission to be withdrawn, clear evidence of mistake or misunderstanding must be provided, and permission must be sought from the Court before such admission may be withdrawn.

Mr Morrison referred the panel to the Civil Procedure Rules which provide that the courts are given power to permit a party to amend or withdraw a formal admission made after the commencement of proceedings. He further referred the panel to the case of *Woodland v Stopford and others* [2011] EWCA CIV 266, which sets out factors to be considered by the Court in an application for withdrawal of admissions. They include the grounds upon which the applicant seeks to withdraw the admission; the conduct of the parties; the

prejudice caused to any person if the admission is withdrawn; the stage in the proceedings that the application is made; the prospects of success of the claim if the admission is withdrawn and then, the interest of the administration of justice.

Mr Morrison submitted that in weighing the prejudice to either party, the panel should consider that any prejudice to be suffered will be far greater for you if the application is not granted. It would amount to injustice and unfairness as you would not be given opportunity to defend yourself from the allegations contained in charges 1a and 1b.

Mr Morrison submitted that the charges are not mere simple charges as they contained two elements. The first element is whether you handed covert medication to Witness 1, an untrained staff member to administer. The second element is whether you had instructed Witness 1 to administer the covert medication to Resident B. Mr Morrison asserted that while you admit the first element, you now deny the second element of the charges.

Mr Morrison submitted that if the application is granted, there would be little or no prejudice to the NMC, given that it had earlier indicated it does not plan to recall Witness 1 unless the panel directs otherwise. He highlighted that Witness 1 was unequivocal during his oral evidence that you had instructed him to administer the covert medication to Resident B and this evidence would likely remain the same if Witness 1 is recalled.

Mr Morrison referred the panel to the Record of Investigative interview of Mr 1 and submitted that the account of the incident by Mr 1 supports your evidence that you had instructed Witness 1 to administer the medication to Resident A. He also highlighted that Witness 5, during her cross examination, accepted that it was possible that Witness 1 could have made the mistake as regards the resident name, as she had not heard whether you had said resident A or resident B. Mr Morrison submitted that all these culminates to the fact that this is not a spurious application as there is likely to be some prospect of success in your defence if you are allowed to withdraw your admissions.

Mr Morrison invited the panel to consider the circumstances surrounding the application. He submitted that the panel should consider that regulatory proceedings are generally stressful and overwhelming for registrants. [PRIVATE]. However, when you noted your mistake in making admissions to charges 1a and 1b, you immediately notified the NMC and the legal assessor at the earliest opportunity. Mr Morrison submitted that given that this hearing was still at its facts stage, and it was only one witness out of the five NMC witnesses that had given evidence at that time, the prejudice posed to the NMC would be minimal.

In conclusion, Mr Morrison invited the panel to grant your application in the interests of justice and fairness.

Mr Brahimi submitted that the NMC opposed your application to withdraw your admissions to charges 1a and 1b. He submitted that the panel should not accept any suggestion that there was any confusion or misinterpretation of charges 1a and 1b, given that the charges were exactly the same as they were in the CMF, which you signed.

Mr Brahimi reminded the panel that at the time the charges were read, you were given the opportunity to consult with your representative Mr Morrison, when it was highlighted that there may be some discrepancies with regards to charges 16 and 17. However, it was never highlighted by you or Mr Morrison that you wanted to change your plea to charges 1a and 1b or that they needed to be amended.

Mr Brahimi submitted that the textbook highlighted by Mr Morrison only referred to pre-action admissions which could be withdrawn but this does not apply to admissions being withdrawn after proceedings had commenced. He submitted that there was no new evidence that came to light, to necessitate the withdrawal of your admissions. He stated that there was nothing new in the oral evidence of the NMC witnesses as they were similar to those contained in their respective witness statements, which had been served on you before this hearing.

Mr Brahimi submitted that it would be highly improper for the panel to accept the submissions of Mr Morrison about Witness 5's evidence. He asserted that you had listened to the oral evidence of Witness 1 and decided to withdraw your admissions. However, this goes contrary to the order of proceedings. He submitted that it would amount to injustice for the panel to take into account any oral evidence you have heard, in making its decision on this application.

Mr Brahimi submitted that your admissions to charges 1a and 1b were unequivocal and you had the opportunity to seek legal advice before making your plea and you are ably represented in these proceedings. He also highlighted that you had the opportunity to have read the Record of Investigative interview of Mr 1 but you still made admissions to charges 1a and 1b. Therefore, it could not be said that you made a mistake in making admissions to those charges.

Mr Brahimi submitted that there is no reasonable explanation for your application as your decision to withdraw your admission was simply a change of mind on your part and the NMC had already called all its witnesses. He submitted that there would be prejudice to the NMC if this application is granted, given that, based on your admissions to charges 1a and 1b, Witness 1 was not re-examined on the issue that you had instructed him to administer the covert medication to Resident A rather than Resident B.

In conclusion, Mr Brahimi invited the panel to refuse your application for the withdrawal of your admissions to charges 1a and 1b.

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

The panel took into account that you are currently represented at these proceedings, and you have been provided with legal advice and support from the RCN throughout these proceedings. It noted that there was a case management conference held prior to this hearing, in which you informed the NMC that you admitted the allegations contained in charges 1a and 1b. These admissions were further entered into the CMF, which you

signed on 26 April 2024. The panel noted that you had the benefit of legal advice at the time this form was completed. The panel accepted that regulatory proceedings are stressful but completing the CMF was a documentary exercise which the panel found, meant that you would not have been under the pressure of time or immediate circumstances when you signed this document. It also considered that as a registered nurse, you would understand the importance of ensuring documents are correct before signing them.

The panel took into consideration that regulatory hearings are generally stressful and overwhelming for registrants. However, you had made admissions to charges 1a and 1b before this hearing and you were further provided with an opportunity to consult with your representative Mr Morrison at the time the charges were read. After your consultation and discussion of the charges with Mr Morrison, you decided to withdraw some of the admissions you had made to the charges in your CMF but at that time, you still did not withdraw your admissions to charges 1a and 1b.

The panel was of the view that the words contained in the charges were unambiguous and non-technical. It noted that there was no evidence to indicate any disability or special circumstances that would have prevented you from clearly understanding the charges at the time it was read in this hearing. The panel bore in mind its duty to balance the interests of both you and the NMC. It therefore decided that it would amount to prejudice and unfairness to the NMC if admissions which had been accepted and found proved by the panel, are allowed to be withdrawn at any stage of these proceedings without a reasonable basis. The panel did not accept your reasons for your withdrawal of your admissions given that you have been provided with legal support and advice, prior to, and in the course of these proceedings. You have also had the opportunity to withdraw your admissions before this hearing and before they were accepted and found proved by the panel in these proceedings.

The panel therefore decided to refuse your application.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Morrison, who informed the panel that you made full admissions to charges 1a, 1b (in part), 4, 5a, 5b, 9, 10, 11, 16, 17 and 18.

The panel therefore finds charges 1a, 1b (in part), 4, 5a, 5b, 9, 10, 11, 16, 17 and 18 proved in their entirety, by way of your admissions.

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

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/Colleague Z: Care assistant at the Home at the time of the incidents.
- Witness 2/Colleague Y: Home manager at the Home at the time of the incidents.
- Witness 3/Colleague X : Clinical manager at the Home at the time of the incidents.
- Witness 4/Colleague W: Named Carer at the Home at the time of the incidents.

- Witness 5/Colleague V: Senior care assistant at the Home at the time of the incidents.

The panel also heard evidence from you under affirmation.

The panel heard live evidence from the following witness called on your behalf:

- Witness 6: Wing Manager at the Home at the time of the incidents.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1b

1) Despite knowing that Colleague Z a Health Care Assistant, was not authorised/qualified to administer medication:

   b) Instructed/forced/pressured Colleague Z to administer covert medication to Resident B;

This charge is found proved.

The panel noted that you admitted that you instructed Witness 1/Colleague Z to administer covert medication to Resident B, however you denied that you forced or pressured Witness 1/Colleague Z to administer covert medication to Resident B. Therefore, the panel would make findings on the aspects of this charge you denied.

The panel took account of the witness statement of Witness 1/Colleague Z dated 8 October 2023, in which he stated:

> *'Neha called me over and requested that I administer medication to Resident B. She handed me a glass which contained the medication mix. I immediately informed her that I was not trained to distribute medication and she responded rudely, demanding that I do as she said, shouting "go, go, go".*
>
> *'As I was a new staff member, I felt pressurised to do as Neha asked…'*

The panel took into consideration that you denied that you pressured or forced Witness 1/Colleague Z to administer covert medication to Resident B. You stated that you had only asked Witness 1/Colleague Z to assist you and you intended to supervise him as he administered the covert medication to the resident. However, you were distracted by the needs of other residents.

The panel accepted the evidence of Witness 1/Colleague Z that he had initially refused to administer the covert medication. This is because his account of this incident was consistent throughout and was corroborated by other witnesses who observed the interaction. The panel found that your account that he only hesitated was not supported by their evidence. Witness 1/Colleague Z stated during his oral evidence that he felt intimidated and pressured by you to administer the covert medication. Furthermore, the panel heard evidence from Witnesses 4 and 5 that it was your usual practice to speak in a loud and direct manner, when giving instructions to junior staff at the Home and that you had pressured Witness 1/Colleague Z to administer the covert medication.

The panel accepted the evidence of Witness 1/Colleague Z as well as Witnesses 4's and 5's, which it considered to be cogent and compelling. The panel therefore found that it was more likely than not that despite knowing that Witness 1/Colleague Z a Health Care Assistant, was not authorised/qualified to administer medication, you pressured him to administer covert medication to Resident B. Accordingly, it found charge 1b proved.

However, the panel was of the view that there was no evidence before it to suggest that you had forced Witness 1/Colleague Z to administer covert medication to Resident B. It noted that there was no evidence that you had threatened or coerced Witness 1/Colleague Z to administer covert medication to Resident B.

Charge 1c (i)

1) Despite knowing that Colleague Z a Health Care Assistant, was not authorised/qualified to administer medication:

    c) After Colleague Z attempted to refuse the administration of medication to Resident B, you spoke/shouted at Colleague Z using words to the effect;

        i) 'Go, go, go'.

This charge is found proved.

The panel considered the witness statement of Witness 1/Colleague Z dated 8 October 2023, in which he stated:

> *'Neha called me over and requested that I administer medication to Resident B. She handed me a glass which contained the medication mix. I immediately informed her that I was not trained to distribute medication and she responded rudely, demanding that I do as she said, shouting "go, go, go".*

The panel took into account that you denied the allegation and stated that you only asked Witness 1/Colleague Z to go and administer the covert medication to the resident. The panel noted that you gave a similar account during your disciplinary hearing at the Home as contained in the Disciplinary Hearing Minutes dated 22 May 2023.

The panel took into consideration that Witnesses 3, 4 and 5 had stated during their respective oral evidence that you generally spoke in a loud and direct manner while giving instructions to junior staff especially when they did not carry out your instructions immediately. The panel noted that Witness 6, (a witness called on your behalf), confirmed this in her oral evidence and further stated that some of the care assistants had complained to her on several occasions that they did not like the manner/tone in which you spoke to them. The panel also considered that you stated in your oral evidence that you generally spoke to the junior staff in a straightforward and authoritative manner and would tell them if they did not follow your instructions or adhere to their training.

The panel was of the view that Witness 1/Colleague Z was clear and consistent in both his oral and documentary evidence that you had shouted the words *"go, go, go"* at him when he attempted to refuse to administer the medication to Resident B. It noted that Witnesses 4 and 5 were present at the time of the incident. However, while Witness 4 confirmed in her oral evidence that she heard you shout the words "*go, go, go*" to Witness 1/Colleague Z at the time of the incident, Witness 5 stated that she could not recall those words used. The panel noted that in the Record of Investigative interview of Mr 1, he had stated that you only asked Witness 1/Colleague Z to administer the medication to Resident A. However, the panel attached little weight to this evidence as it was not detailed on this point, it was not tested in these proceedings and it amounted to hearsay evidence. The panel found no reason for Witness 1/Colleague Z and Witness 4 to embellish their evidence and it therefore accepted their evidence.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that after Witness 1/Colleague Z attempted to refuse the administration of medication to Resident B, you shouted at Witness 1/Colleague Z using words to the effect: *"go, go, go*". It therefore found charge 1c (i) proved.

Charge 1c (ii)

1) Despite knowing that Colleague Z a Health Care Assistant, was not authorised/qualified to administer medication:

c) After Colleague Z attempted to refuse the administration of medication to Resident B, you spoke/shouted at Colleague Z using words to the effect;

ii) '*You guys do not help at all.*'

This charge is found NOT proved.

The panel considered the witness statement of Witness 5 dated 2 October 2023, in which she stated:

> *' (…Witness 1/Colleague Z…) told Neha that he is not was qualified to administer medication and that this is not the first time she asked him to do this. He repeated this several times to Neha but she shouted, "you guys do not help at all". (…Witness 1/Colleague Z…) took the glass and went into the lounge where Resident B was located to administer the medication.'*

The panel took into account that you denied the allegation and stated that you only asked Witness 1/Colleague Z to go and administer the covert medication to the resident.

The panel noted that Witness 1/Colleague Z stated during his oral evidence that he could not recall that you shouted the words "*you guys do not help at all"* at him. The panel also considered that Witness 4 could not confirm during her oral evidence if such words were shouted at Witness 1/Colleague Z at the time of the incident.

The panel was of the view that given that Witness 1/Colleague Z, who was the intended recipient of those words "*you guys do not help at all",* could not recall if such words were ever said to him by you, it decided to attach little weight to the account of Witness 5 that you had shouted the words "*you guys do not help at all"* to Witness 1/Colleague Z at the

time of the incident. It noted that Witness 5 gave evidence that you used those words at other times and noted that this could be a source of confusion. The panel noted that neither Witness 1/Colleague Z nor Witness 4 who were present at the time of the incident, did not corroborate Witness 5's account in both their oral and documentary evidence.

Therefore, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, it found charge 1c (ii) not proved.

Charge 1c (iii)

1) Despite knowing that Colleague Z a Health Care Assistant, was not authorised/qualified to administer medication:

    c) After Colleague Z attempted to refuse the administration of medication to Resident B, you spoke/shouted at Colleague Z using words to the effect;

        iii) *'Do what I tell you.'*

This charge is found proved.

The panel took account of the witness statement of Witness 1/Colleague Z dated 8 October 2023, in which he stated:

> *'Neha should have never asked me to administer medication to Resident B. She was very aware of the fact that I am not appropriately qualified to do so and she knew that medication administration is restricted to trained personnel only. Despite this, she pressured me into administering the medicine with comments like "do what I tell you", causing me to feel very nervous'.*

The panel took into account that you denied the allegation and stated that you only asked Witness 1/Colleague Z to go and administer the covert medication to the resident.

The panel took into account its findings on charge 1c (i) and applied the same reasoning to this charge.

The panel was of the view that Witness 1/Colleague Z was clear and consistent in both his oral and documentary evidence that you had shouted the words *"do what I tell you"* at him when he attempted to refuse to administer the medication to Resident B. It noted that Witnesses 4 and 5 were present at the time of the incident. However, while Witness 4 confirmed in her oral evidence that she heard you shout the words "*do what I tell you*" to Witness 1/Colleague Z at the time of the incident, Witness 5 stated that she could not recall those words used. The panel noted that in the Record of Investigative interview of Mr 1, he had stated that you only asked Witness 1/Colleague Z to administer the medication to Resident A. However, the panel attached little weight to this evidence as it was not tested in these proceedings and amounted to hearsay evidence. The panel found no reason for Witness 1/Colleague Z and Witness 4 to embellish their evidence and it therefore accepted their evidence.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that after Witness 1/Colleague Z attempted to refuse the administration of medication to Resident B, you shouted at Witness 1/Colleague Z using words to the effect: *"do what I tell you*". It therefore found charge 1c (iii) proved.

Charge 2

After discovering that Resident A's medication had incorrectly been administered to Resident B

2) On one or more occasion shouted at Colleague Z.

This charge is found proved.

The panel took account of the witness statement of Witness 4 dated 11 October 2023, in which she stated:

> *'A few minutes later after (…Witness 1/Colleague Z…) had returned to the dining room, Ms Desai started shouting at (…Witness 1/Colleague Z…) saying that the medication was for 'Resident 316' (Resident A) not 'Resident 301' (Resident B). Initially, (…Witness 1/Colleague Z…) didn't say anything at all as he seemed a bit shocked and was being shouted at by Mr Desai…' (sic)*

The panel considered the witness statement of Witness 5 dated 2 October 2023, in which she stated:

> *'….When I returned, I could hear Neha correct (…Witness 1/Colleague Z…), stating that the medication was for Resident A and not Resident B. She was shouting at (…Witness 1/Colleague Z…) trying to cover her mistake and started to blame (…Witness 1/Colleague Z…). Neha had a habit of shouting at staff whenever she felt they did not comply with her orders…..'*
>
> *'I heard Neha instructing (…Witness 1/Colleague Z…) to inform the investigation team that Resident B had only consumed 2-3 sips of the medication. This was the second time I heard her asking him to say this. Neha was raising her voice and shouting at (…Witness 1/Colleague Z)…'*

The panel noted that you denied this allegation and stated that you spoke to Witness 1/Colleague Z in a professional manner.

The panel took into account that Witness 1/Colleague Z stated during his oral evidence that you had shouted at him when you discovered that he had administered the covert medication to Resident B. It noted that in his witness statement, Witness 1/Colleague Z stated that he found that conversation really distressing.

The panel took into account its findings on charge 1c (i) and applied the same reasoning to this charge.

The panel was of the view that there was extensive corroborating evidence that suggests that you generally shouted at junior staff at the Home. It noted that Witness 1/Colleague Z, Witnesses 4 and 5 were clear and consistent in their oral and documentary evidence that you had shouted at Witness 1/Colleague Z after you discovered that he had administered the covert medication to Resident B. The panel therefore accepted their accounts of the incident.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that at least on one occasion, you had shouted at Witness 1/Colleague Z after discovering that Resident A's medication had incorrectly been administered to Resident B. It therefore found charge 2 proved.

Charge 3

After discovering that Resident A's medication had incorrectly been administered to Resident B

3) Failed to record/monitor/conduct observations for Resident B, in that you did not monitor/record Resident B's'

    a) Blood Pressure;
    b) Pulse;
    c) Oxygen saturation;
    d) Temperature;
    e) Blood sugar levels

This charge is found NOT proved.

The panel took account of the witness statement of Witness 4 dated 11 October 2023, in which she stated:

'I did not witness Ms Desai carrying out any observations on Resident B or taking any vitals for example until much later in the evening. I do not believe she carried out any observation of Resident B immediately following the medication error as she went off to make calls and do other things…'

The panel noted that you denied the allegation and stated that you monitored and conducted the required observations on Resident B. You further stated that you recorded your observations on an A4 sheet of paper on which you had created a chart and you intended to use it to complete the online records at the end of your shift.

In oral evidence, Witness 4 stated that they were moving around the Home and not continuously watching Resident B. The panel concluded that it was possible that you carried out observations without Witness 4's knowledge.

The panel took into account the witness statement of Witness 3 dated 2 October 2023, in which she stated:

'…On the 20 March 2023, Neha handed me a piece of paper detailing Resident B's observations, but this was not appropriate as all our processes are online, including the form for recording observations, which she failed to complete. Furthermore, when I checked for the observations online, they were missing despite me asking Neha to complete them.'

The panel also noted that Witness 2 confirmed both in his witness statement and oral evidence that you had conducted the required observations on Resident B. It further had sight of the completed Assessment Form for Resident B dated 20 March 2023, recording the telephone call you had with the General Practitioner (GP) which indicated that you had conducted and recorded the required observations for Resident B. The panel therefore accepted the evidence of Witnesses 2 and 3.

The panel found that even if you had not recorded the observations appropriately, the NMC had not shown that you had failed to record/monitor/conduct observations in accordance with the wording of the charge.

Accordingly, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charges 3a, 3b, 3c, 3d and 3e not proved.

Charge 6

After discovering that Resident A's medication had incorrectly been administered to Resident B

6) On one or more occasion, instructed Colleague Z to inaccurately state that Resident B only consumed 2-3 sips of medication.

This charge is found proved.

The panel first considered whether Resident B had only consumed 2-3 sips of medication. It took into account that Witness 1/Colleague Z, Witnesses 4 and 5 had stated in both their oral and documentary evidence that Resident B had consumed the majority of the covert medication at the time of the incident. The panel noted that Witnesses 4 and 5 were both present at the time of the incident and they had seen the remaining content of the covert medication when Witness 1/Colleague Z returned from administering it to Resident B. Furthermore, Mr 1 who was also present at the time of the incident, stated in the Record of Investigative Interview that Resident B had consumed more than half of the covert medication.

The panel took into consideration that you denied that Resident B consumed the majority of the covert medication and stated that Resident B only consumed 2-3 sips of the covert medication. You further stated that Witness 1/Colleague Z had also gone and topped up the drink at the time of the incident.

The panel noted that there were various discrepancies in the evidence of Witness 1/Colleague Z, Witnesses 4 and 5 on the type of drink used for the covert medication, the type and size of the utensil used for the drink containing the medication and the amount of covert medication drunk by Resident B. However, the panel was of the view that these discrepancies in the accounts of the witnesses were minor and may be attributed to the passage of time since the incident. It found that there was consensus in their evidence that more than half of the covert medication had been consumed by Resident B and not merely 2-3 sips. The panel took into account that there was no suggestion from you that Witness 1/Colleague Z, Witnesses 4 and 5 had colluded against you or that they had any personal grievance against you. Therefore, the panel found no reason for Witness 1/Colleague Z, Witnesses 4 and 5 to embellish their evidence.

The panel considered that you did not personally witness Resident B consume the covert medication but only saw the remaining content after Witness 1/Colleague Z had returned from administering the covert medication to Resident B. The panel further noted that your account of the incident was uncorroborated, and it found your account implausible for the following reasons:

The panel noted that in your CMF, it was suggested that '*Ms Desai said that the patient had only taken sips ….. Her account is that when the glass was returned - only a small amount was gone. It seems that the HCA topped up the drink before returning it…'.* Witness 1/Colleague Z denied this. In your oral evidence, you further explained how this could have happened.

The panel found your explanation to be implausible because Witness 1/Colleague Z would have to have topped up the drink either: before he saw you and therefore before he knew that an error had been made in which case there was no reason for him to top it up; or after he saw you, in which case, he would have had to top up the glass and get it back to Resident B before you got there, which would be implausible given your proximity. You gave evidence that the time between giving Witness 1/Colleague Z the covert medication

to take to Resident B and you arriving to find Resident B with a re-filled cup, was only 60-90 seconds. The panel also found this evidence implausible given the time required for Resident B to have to drink the covert medication and for it to be topped up.

The panel took into account that it was only Witness 1/Colleague Z, who administered the covert medication to Resident B, that witnessed its consumption and that his account of the incident was corroborated by Witnesses 4 and 5 as well as Mr 1. It found that Witness 1/Colleague Z was unlikely to have been mistaken in these circumstances and there was no reason for him to give false evidence.

In this regard, the panel attached significant weight to Witness 1/Colleague Z's account of the incident and accepted his evidence. Accordingly, the panel determined that it was more likely than not that Resident B had consumed more than half of the covert medication on 20 March 2023.

The panel then considered the details of this charge. It took account of the witness statement of Witness 1/Colleague Z dated 8 October 2023, in which he stated:

> *'Later in the afternoon, Neha pulled me aside in the corridor and instructed me to say that Resident B had only taken 2-3 sips of the medication if anyone asked. This was misleading as Resident B had consumed almost all of it…'*
>
> *'When Neha returned to work a couple of days later, Neha pulled me aside near the top floor lift and reiterated her previous instruction that I should only admit to Resident B taking a few sips if questioned. I did not say anything and did not respond to her request and simply went back to performing my duties. My colleagues (Witnesses 5 and 4) noticed her leading me away to talk, and afterwards I informed them about what Neha had told me…'*

The panel took into consideration that you denied the allegation and stated that you had only told Witness 1/Colleague Z at the time of the incident to give you his witness

statement of the medication error. However, the panel noted that this account was not put to any of the NMC witnesses. You also stated that you were trying to confirm how much was drunk by Resident B. The panel considered that this account was contrary to the accounts of other witnesses present at the time of the incident.

The panel took into account that Witnesses 4 and 5 confirmed in both their oral and documentary evidence that you had instructed Witness 1/Colleague Z to inaccurately state that Resident B only consumed 2-3 sips of medication. The panel noted that there was a discrepancy in their respective evidence with respect to the place where the incident occurred, however, it found this discrepancy to be minor and may be attributed to the passage of time since the incident. It also had sight of the email from Witness 1/Colleague Z to Witness 2 dated 20 March 2023 in which he reported to Witness 2 that Resident B had drank more than half of the covert medication and you instructed him to tell anyone that asked about the incident that Resident B took only two sips. The panel therefore accepted the accounts of the incident by Witness 1/Colleague Z as well as by Witnesses 4 and 5.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that you had instructed Witness 1/Colleague Z to inaccurately state that Resident B only consumed 2-3 sips of medication on at least one occasion. It therefore found charge 6 proved.

Charge 7a

After discovering that Resident A's medication had incorrectly been administered to Resident B

7) At around 17:00 Inaccurately informed Colleague Y that:
    a) You had mistakenly administered Resident A's medication to Resident B;

This charge is found proved.

The panel took account of the witness statement of Witness 2/Colleague Y dated 12 October 2023, in which he stated:

> *'On 19 March 2023, during my annual leave, I received a call from Neha around 17:00. She informed that she had mistakenly given Resident A's medication who was on a covert medication plan, to Resident B. Mrs Desai mentioned that she had already informed our Clinical Manager (Witness 3) about the incident.'*

The panel noted that in the Copy of the minutes from your interview dated 18 April 2023, you had stated the following in response to a question as to what you had told Witness 2 at around 17:00:

> *'I told him (Witness 2/Colleague Y) that I had made a medication error and it was given to somebody else and I said she is okay and how we monitored her and things like that….'*
>
> *'The reason I said that is because I knew I had made error by giving it to carer. (Witness 2/Colleague Y) was on A/L so I didn't want to disturb him and discuss everything'*

[PRIVATE].

Based on the evidence before it, the panel was satisfied that it was more likely than not that at around 17:00, you had inaccurately informed Witness 2/Colleague Y that you had mistakenly administered Resident A's medication to Resident B. Accordingly, the panel found charge 7a proved.

Charge 7b

After discovering that Resident A's medication had incorrectly been administered to Resident B

7) At around 17:00 inaccurately informed Colleague Y that:
   b) That Resident B had only consumed 2-3 sips of the medication;

This charge is found proved.

The panel took account of the witness statement of Witness 2/Colleague Y dated 12 October 2023, in which he stated:

> *'…She assured me that Resident B had consumed only a few sips of the medication and showed no noticeable changes in her physical condition…'*

The panel took into account that in the Copy of the minutes from your interview dated 18 April 2023, you admitted that you had told Witness 2/Colleague Y that Resident B only consumed two sips of the covert medication.

The panel bore in mind that it had earlier found that it was more likely than not that Resident B had consumed more than half of the covert medication. Therefore, the panel was satisfied that based on the evidence before it, it was more likely than not that at around 17:00, you had inaccurately informed Witness 2/Colleague Y that Resident B had only consumed 2-3 sips of the medication. Accordingly, the panel found charge 7b proved.

Charge 8

After discovering that Resident A's medication had incorrectly been administered to Resident B

8) At around 18:00 Inaccurately informed Colleague X, that Resident B had only consumed 2-3 sips of the medication.

This charge is found proved.

The panel took account of the witness statement of Witness 3/Colleague X dated 2 October 2023, in which she stated:

> *'On Sunday, 19 March, at around 18.00, I received a phone call from Neha. She sounded distressed and informed me of a medication error that had occurred….She informed that Resident B had only had a few sips of the medication. On hearing this, I asked about the wellbeing of Resident B and whether any observation had been taken.'*

The panel noted that you admitted that you told Witness 3/Colleague X that Resident B had only consumed 2-3 sips of the covert medication as that was what you believed had occurred at that time.

The panel bore in mind that it had earlier found that it was more likely than not that Resident B had consumed more than half of the covert medication. Therefore, the panel was satisfied that based on the evidence before it, it was more likely than not that at around 18:00, you had inaccurately informed Witness 3/Colleague X that Resident B had only consumed 2-3 sips of the medication. Accordingly, the panel found charge 8 proved.

Charge 12

After discovering that Resident A's medication had incorrectly been administered to Resident B

12) Did not contact Resident B's family as soon as possible/as instructed.

This charge is found proved.

The panel took into account that Witness 2/Colleague Y stated in his witness statement that when you called him on 19 March 2023 to inform him about the medication error, he instructed you to inform Resident B's GP and family. However, on 20 March 2023, when Witness 2/Colleague Y and Witness 3/Colleague X asked you whether you had contacted Resident B's GP and family, you confirmed that you had not. After multiple requests by both witnesses for you to contact Resident B's family and GP, you did it later in the day.

The panel took into consideration that Witness 3/Colleague X confirmed in her witness statement that you only contacted Resident B's family and GP on 20 March 2023 despite her instruction that you should contact them immediately on 19 March 2023.

The panel noted that you stated in your evidence that you did not contact Resident B's family on 19 March 2020 as you wanted to first speak with the GP and did not want to make Resident B's family worried about the incident since it was not an emergency. The panel did not hear evidence as to any particular reason why you were unable to contact Resident B's family on 19 March other than the Home being generally busy. The panel found the reason you did not contact them was because you had decided it was not required and not because it was not possible.

The panel had regard to the Home's Safe Handling and Management of Medication Policy (the Home's Policy) dated November 2022 which provides that in the event of a medication error, *'the Resident's relatives will be advised of the situation as soon as possible…'.* The panel noted that you were instructed by both Witness 2/Colleague Y and Witness 3/Colleague X on 19 March 2023 to immediately inform Resident B's family about the incident and despite repeated requests by them, you only contacted Resident B's family later in the day on 20 March 2023, contrary to the Home's Policy. Therefore, the panel was satisfied that based on the evidence before it, it was more likely than not that you did not contact Resident B's family as soon as possible and as instructed. Accordingly, the panel found charge 12 proved.

Charge 13

On 20 March 2023;

13) Recorded inaccurate/incomplete information in the AFIN form, namely that Resident B only consumed 2-3 sips of medication.

This charge is found NOT proved.

The panel took account of the witness statement of Witness 3/Colleague X dated 2 October 2023, in which she stated:

> *'I subsequently confronted Neha and asked her to come to my office regarding the different accounts and the missing AFIN form, which she had not completed as I had instructed. I gave her another AFIN form and a reflective account form. She assured me she would complete the forms and return them.'*
>
> *'Later that same day, around 14.00 – 15.00, Neha showed me the partially completed forms which were still missing vital information. It stated that Resident B had only drank 2-3 sips of the medication. I knew this contradicted (Witness 1/Colleague Z)'s account of the incident.'*

The panel took into consideration that Witness 2/Colleague Y had stated in his witness statement that Witness 3/Colleague X had showed him the AFIN form and pointed out the missing and inaccurate information. He stated that the AFIN form specifically stated that Resident B had only taken 2-3 sips of the medication.

However, the panel took into account that Witness 3/Colleague X had stated in her oral evidence that it was the MEIR form which was partially completed and contained the inaccurate information that Resident B had consumed 2-3 sips of the covert medication. Witness 3/Colleague X further stated that she never saw the AFIN form that was also required to be completed by you.

The panel took into consideration that you confirmed in your oral evidence that you never completed the AFIN form and it was the MEIR form that you had partially completed and recorded that Resident B consumed 2-3 sips of the covert medication.

The panel had regard to the Home's Policy which provides that in the event of a medication error:

> *'The Nurse and/or care coordinator must accurately complete a MEIR01 Medication Error Investigation Report Form immediately after the error has occurred and forward this form to the Clinical Manager or Home Manager for further investigation and management.'*

The panel further noted that in the WhatsApp messages between Witness 3/Colleague X and you dated 24 March 2023 and 28 March 2023 respectively, Witness 3/Colleague X had demanded for the MEIR form and reflection form to be completed by you and returned to the Home. However, on 29 March 2023, Witness 3/Colleague X had requested for the AFIN form and reflection form to be completed by you and returned to the Home.

Given the uncertainty and the inconsistency between Witness 3/Colleague X's witness statement and her oral evidence as to which form contained the inaccurate/incomplete information, the panel determined that there was insufficient evidence to demonstrate that you recorded inaccurate/incomplete information in the AFIN form, namely that Resident B only consumed 2-3 sips of medication. The panel was of the view that it was more likely than not that the AFIN form was never completed by you. It therefore found charge 13 not proved.

Charge 14

On 20 March 2023;

14) Destroyed the AFIN form containing inaccurate information.

This charge is found NOT proved.

The panel bore in mind that it had found that there was insufficient evidence to demonstrate that you recorded inaccurate/incomplete information in the AFIN form and that it was more likely than not that the AFIN form was never completed by you. On this basis, the panel determined that there was no evidence that you had destroyed an AFIN form containing inaccurate information. It there found charge 14 not proved.

Charge 15

15) Between 20-29 March 2023 did not return a completed AFIN form.

This charge is found proved.

The panel took into account that Witness 3/Colleague X stated in her witness statement that despite repeated reminders to you from her, you did not return a completed AFIN form to the Home. The panel had sight of the WhatsApp messages between Witness 3/Colleague X and you dated 29 March 2023, in which she had requested for the AFIN form and reflection form to be completed by you and returned to the Home.

The panel took into consideration that Witness 2/Colleague Y had also confirmed in his witness statement that you never returned a completed AFIN form to the Home.

The panel noted that you accepted that you never returned a completed AFIN form between 20-29 March 2023 [PRIVATE].

Based on the evidence before it, the panel was satisfied that it was more likely than not that between 20-29 March 2023, you did not return a completed AFIN form. It therefore found charge 15 proved.

Charge 19

19) Your actions in charge 6 above were dishonest, in that you sought coerce a junior colleague into providing a false account of a medication error/incident.

This charge is found proved.

Having found charge 6 proved, the panel went on to consider whether your conduct in charge 6 was dishonest. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this case, the panel took into account that you did not personally witness Resident B consume the covert medication but you did see the remaining content after Witness 1/Colleague Z had administered the covert medication to Resident B. The panel have found that there was more than half of the glass consumed and it would have been clear to you as it was to Witness 1/Colleague Z that Resident B had drunk more than 2-3 sips. The panel found that you knew that it was incorrect that Resident B drank only 2-3 sips.

The panel considered the evidence of Witnesses 4 and 5 that Witness 1/Colleague Z was distressed as a result of the conversation you had with him when you instructed him to inaccurately state that Resident B only consumed 2-3 sips. The panel found that your only possible motivation was to produce a false account from Witness 1/Colleague Z in order to

reduce the perceived severity of the medication error. The panel found that as you were senior to Witness 1/Colleague Z and asked him to provide a false account in a way that caused him distress, this therefore amounted to coercion.

Consequently, on the basis of all the evidence before it, the panel was satisfied on the balance of probabilities that you knew that Resident B had consumed more than 2-3 sips of the covert medication but you sought to coerce Witness 1/Colleague Z, a junior colleague into providing a false account of a medication error/incident.

In applying the second limb of the test to this case, the panel was satisfied that your conduct in charge 6 would be considered dishonest by ordinary decent people.

Accordingly, the panel determined that your conduct in charge 6 was dishonest and it therefore found charge 19 proved.

Charge 20

20) Your actions in charge 7 a) were dishonest in that you sought to conceal from the Home Manager, that you had instructed/forced an unqualified/unauthorised staff member to administer covert medication.

This charge is found NOT proved.

Having found charge 7a proved, the panel went on to consider whether your conduct in charge 7a was dishonest. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and

- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this case, the panel took into account that in the Copy of the minutes from your interview dated 18 April 2023, you had stated the following in response to a question as to what you had told Witness 2 at around 17:00:

> *'I told him (Witness 2/Colleague Y) that I had made a medication error and it was given to somebody else and I said she is okay and how we monitored her and things like that….'*
>
> *'The reason I said that is because I knew I had made error by giving it to carer. (Witness 2/Colleague Y) was on A/L so I didn't want to disturb him and discuss everything'*

[PRIVATE]. However, the panel took into consideration that you had earlier told Witness 3/Colleague X on the same day that a medication meant for Resident A had mistakenly been given to Resident B by a carer under your instruction.

The panel accepted your explanation for inaccurately informing Witness 2/Colleague Y that you had mistakenly administered Resident A's medication to Resident B. It was of the view that if you intended to conceal the accurate information from your Home Manager, you would not have given the accurate information to Witness 3/Colleague X that a medication meant for Resident A had mistakenly been given to Resident B by a carer under your instruction.

The panel therefore determined that your conduct in charge 7a was not dishonest and it therefore found charge 20 not proved.

Charge 21

21) Your actions in one or more of charges 6, 7 b), 8 & 13 were dishonest in that you sought to conceal the amount of medication consumed by Resident B.

This charge is found proved.

The panel was aware that it had found charges 6, 7b and 8 proved, however it did not find charge 13 proved. Therefore, in considering whether your actions in charges 6, 7b and 8 were dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this case, the panel bore in mind that it had found that you knew that Resident B had consumed more than 2-3 sips of the covert medication but you sought to reduce the perceived severity of the medication error. The panel was of the view that your actions in charges 6, 7b and 8 demonstrated a pattern of behaviour in which you sought to conceal the amount of medication consumed by Resident B.

In applying the second limb of the test to this case, the panel was satisfied that your conduct in charges 6, 7b and 8 would be considered dishonest by ordinary decent people.

Accordingly, on the balance of probabilities, the panel determined that your conduct in charges 6, 7b and 8 were dishonest and it therefore found charge 21 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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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. However, where the panel had to make findings of fact that it had not been required to make before (for instance, where an allegation had been admitted), it applied the same test as set out above when reaching its decisions at the facts stage, namely, that the burden of proof was on the NMC to prove its case to the standard of the balance of probabilities.

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

Submissions on misconduct

Mr Brahimi referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a

> '*misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of proprietary may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'*

Mr Brahimi also referred the panel to the case of *Calhaem v GMC* [2007] EWHC 2006 (Admin) where Mr Justice Jackson defined misconduct as:

> *'it connotes a serious breach which indicates that the doctor's fitness to practise is impaired.'*

Mr Brahimi further referred the panel to the case of *Nandi v GMC* [2004] EWHC 2317 (Admin) where Mr Justice Collins in defining serious misconduct, stated:

> '*the adjective 'serious' must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.'*

Mr Brahimi submitted that your conduct in the charges found proved was a serious departure from the standards expected of a registered nurse and such departure was sufficiently serious as to warrant a finding of serious professional misconduct in this case. He submitted that your conduct breached the following sections of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2018' ("the Code"): 1, 2, 4, 5, 7, 8, 10, 11, 19, 20, 21 and 25.

Mr Brahimi submitted your conduct in charges 1b and 2 may have caused particular distress to Witness 1/Colleague Z and such conduct falls short of what would be proper in the circumstances. He submitted that your conduct in not escalating and recording medication errors when required, demonstrates the non-importance you attached to the urgency of the situation. He submitted that your conduct connotes a serious breach of the fundamental tenets of the nursing profession. He submitted that the most significant concern was that after such errors, you sought to coerce junior staff into providing false accounts and then you also attempted to mislead senior staff in order to conceal your failings. Mr Brahimi asserted that your conduct would be regarded as deplorable by fellow practitioners.

In conclusion, Mr Brahimi submitted that your conduct has put into question whether nurses can be trusted to maintain their senior position and lead others in a way where they are educated to perform better rather than be coerced into conduct beyond their abilities. Such behaviour will also affect the public's trust in the nursing profession.

Mr Morrison referred the panel to the comments of Baker J in *Professional Standards Authority v General Dental Council and AB* [2016] EWHC 1539 where he stated:

> '*there is no doubt that a finding of dishonesty will, in general terms, justify a finding of professional misconduct, and consequential impairment of the individual's fitness to practise….that does not mean that such a finding is automatic and should be made in every situation where there has been a finding of dishonesty'*

Mr Morrison submitted that each case is fact specific, and he invited the panel to find that your actions did not amount to misconduct. He submitted that although there have been breaches of the Code, they do not go so far as to fall far short of what would be expected in the circumstances. He submitted that it should be noted that your dishonest conduct involved a single medication error which occurred over a short period of time. He asserted that was insufficient to amount to misconduct.

Mr Morrison submitted that you were a committed and caring nurse at the Home as there were positive testimonies from Witnesses 3 and 6 about your nursing abilities and [PRIVATE]. He submitted that you have been a dedicated health care professional for over twenty years, and you have demonstrated that you had the capabilities to be a competent nurse who can deliver safe, effective and kind care.

Mr Morrison submitted that the incidents did not occur in a vacuum as you were the only registered nurse working with no management on site at the time of the incidents. He submitted that although there was evidently a potential risk to Resident B, you did complete the necessary vitals observations and ensured that the resident's well-being and

safety was not compromised. In conclusion, he submitted that your actions, when viewed in the context of the working environment at the Home, are insufficient to amount to misconduct.

Submissions on impairment

Mr Brahimi referred the panel to the NMC Guidance on Impairment (DMA-1) 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'*.

Mr Brahimi referred the panel to the test set out in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). He submitted that the four limbs of the Grant test are engaged in this case. He made the following submissions:

13. *The first limb is engaged as a result of the Registrant putting patients in unwarranted risks of harm. The Panel have accepted the evidence in respect of the charges proven and it follows that individuals were put at risk of harm where (but not limited to):*

    a. *The Registrant put Resident B at risk of harm by being given the wrong medication. This was covert medication rather than general food which can lead to more complicated situations, such as need to continuously supervise Resident B in the event the current risk escalated to further problems.*

b. *It should also be noted that there have been other occasions where unauthorised/unqualified staff have been asked to do the same by the Registrant which could have posed a similar risk.*

14. *The second limb is engaged as a result of the Registrant's behaviour, as found proven, plainly brings the profession into disrepute:*

a. It is clear that what took place, as per the proven charges, will bring the profession into disrepute. There would be great concern that the Registrant, a registered nurse, sought to coerce junior staff and then conceal the amount given so as to downplay a serious problem. The residents at this home were described as elderly and would have relied upon the care and professionalism of nurses, and this system has entirely been brought into disrepute as a result of these incidents.

15. *The third limb is engaged, where the Registrant has plainly breached fundamental tenets of the profession in numerous areas of the Code of Conduct as referred to above, but in particular:*

a. *Treat people as individuals and uphold their dignity (1.1 and 1.4);*

b. *Be accountable for your decisions to delegate tasks and duties to other people (11.1 and 11.2);*

c. Uphold the reputation of your profession at all times (20.1 and 20.2).

16. *The fourth limb is engaged as a result of the Registrant having been found proven of acting dishonestly. This causes the following concerns (but not limited to):*

a. *There is a two-fold concern in coercing a colleague to provide a false account. The first is that the Registrant herself is acting dishonestly as she knows the account is not true and the second is that she is pressuring another to be placed in the same unethical position. This shows that the Registrant takes an approach of involving others with dishonest conduct which shows a liability that she will behave dishonestly in the future.*

b. *The Registrant knew that her conduct was wrong and that is why she sought to not only pressure junior staff into providing a false account but then also sought to mislead senior staff so as to cover up her conduct. By suggesting 23 sips, the Registrant sought to dishonestly make her position better at the expense of jeopardising the true account and status of Resident B. The fact she repeated this false account 3 times (…) again shows a liability to act dishonestly in the future.'*

Mr Brahimi submitted that your fitness to practise is impaired on grounds of public protection and public interest. He submitted that you are currently under an interim suspension order and you are working as a healthcare assistant which is not in a clinical capacity. He submitted that despite the number of positive testimonials made on your behalf, it should be noted that dishonesty is an attitudinal problem and difficult to correct even through training. He made the following submissions:

'19. ***Public protection***

a. *A real risk of harm is immediately apparent in this case where there is covert medication involved. This is made worse where the people being treated are those that may be appropriately described as vulnerable given their elderly age at a home. The notion of a real risk of harm is further strengthened by the lack of recording this error and delaying the process to escalate it to the GP. If instances such as this are not appropriately recorded or escalated then it means that residents cannot be appropriately treated in good time. Those senior to the Registrant are likely to know how to appropriately*

respond in situations of drug errors, however where they have false information then they may inadvertently provide wrong guidance as a result of wrong information given (2-3 sips rather than almost full glass).

b. *This case provides a strong demonstration of there being a risk of repetition. It has been found proven that the Registrant sought to have her 'own way' by shouting and pressuring at staff so that her orders are complied with. She has on at least 4 occasions instructed staff that were not authorised or qualified to administer medication (may be more were charge 18 is plural). Further to this the Panel will note that the Registrant sought to conceal the truth from two seniors (…) and then further maintained this false account during internal interviews. Her attempts to coerce (Witness 1) to conceal the true amount happened on two occasions over two days which shows that the Registrant will be persistent in securing an untrue position, thus a risk of repetition.*

20. **Otherwise in the public interest**

a. *The NMC will argue that the public would be greatly (and adversely) affected once they learn of these proven incidents. There will be less trust in the medication profession both in respect of the public's perception of how residents are treated as well as an impact on those wanting to assist as junior staff. The families of residents that are admitted into such care will be concerned as to whether the resident will have appropriate care provided if they're having unqualified staff administer medication. These cases become public knowledge and once written reasons are considered by future staff members they may be put off from coming to the UK to assist with the medical profession. In this case, some staff came to the UK on VISAs and they may now be less inclined to do so should they feel they might also be coerced into similar situations, jeopardising their own practice.*

b. *Matters of dishonesty are always treated as a more serious category of concern in NMC cases. This is because it has an impact on the structure of the medical profession, where others can no longer maintain trust that if errors are escalated, they will have doubts of whether they are handled appropriately. All medical mistakes are undesirable but the NMC submit that the public will pay particular attention as to how medical professionals react to mistakes and whether everything has been done to put things right. In this case not only has there been an error in medication but also a dishonest approach in covering mistakes so as to mislead others from the truth. While mistakes do happen and can be remedied – once you lose the trust of public as a result of being dishonest, it is hard to regain this trust, particularly when it relates to a sensitive area such as the medical profession. As a result of the Registrant's abuse of position, the NMC submit that the honesty and integrity of the medical profession has been challenged and evidently been put into disrepute.*

21. As such the NMC invite the Panel to find that the Registrant is currently impaired.'

Mr Morrison submitted that if the panel finds that the charges found proved amount to misconduct, it should be noted that not all findings of misconduct will lead automatically to a finding of impairment of fitness to practise as per *Cohen v General Medical Council* [2008] EWHC. He submitted that the panel would have to look towards the present, as was held in the case of *Meadow v GMC* [2007] EWCA Civ 1390 [at pg 32]:

'In short, the purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FTP first looks forward not back. However, in order to form a view as to the fitness of a person to practise today it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past.'

Mr Morrison submitted that the panel would have to consider two factors in deciding whether your fitness to practise is impaired. These factors are the nature of the concern and the public interest.

Mr Morrison submitted that your fitness to practise is not currently impaired when assessing either the nature of the concern itself or the public interest for the following reasons:

13. *'Firstly, this was clearly an isolated incident in which Ms Desai has made an error judgement and the panel found her to have acted dishonestly. No previous instances have been raised, Ms Desai has dealt with a large volume of incidents in the past and the panel have seen the results of her supervision with* (Witness 3) *on 10 March 2023. No concerns were raised which called into question Ms Desai's fitness to practice and in her live evidence* (Witness 3) *continued to maintain that Ms Desai was a "really good nurse" who went the "extra mile" . Her non completion of the paperwork was "out of character" and no previous issues had been raised regarding contacting family members or GP's. On the contrary there is written testimony from a family member who a Resident who described how Ms Desai "made sure the family were constantly updated of her condition". It is submitted therefore that this was an isolated incident which would not occur in the future and her fitness to practice is therefore not currently impaired.*

14. *Secondly, the context of the error. Ms Desai was the only registered nurse working in a care home with up to 83 vulnerable and elderly residents. She was working in a stressful and pressurised environment without the adequate support. There was no support on site from management or equivalently senior staff as it was a weekend. There was inadequate support from health care assistants who from Ms Desai's understanding were often inexperienced agency staff. This was perhaps best exemplified by* (Witness 4) *who did not know that she, as a carer, was able to administer medication in certain*

situations as explained by the evidence of (Witness 3) *and* (Witness 2)*. The panel are asked to conclude that it was the this set of circumstances which contributed to Ms Desai's actions and would not likely be repeated in the future. This is a view perhaps supported by the fact that* (Witness 2) *continued to trust Ms Desai to work as the sole registered nurse on a shift after this incident occurred.*

15. *Thirdly, Ms Desai has been subject to an interim order of suspension and has therefore been unable to practise as a nurse. This has to some degree hindered her ability to remediate her practice given the restrictions she has been under. However, Ms Desai has been working as a health care assistant since October 2023. She gave evidence to you that she has guilt for what has happened, but she continues to want to keep practising and working with vulnerable people; she is dedicated. She has not been idle but has continued to work with vulnerable residents as she has done for over twenty years. As part of her role she undertaken a number of training modules, many of which go to the heart of some of the issues highlighted in this case, namely:*

    a. *Communication and record keeping;*
    b. *Conflict resolution;*
    c. *Managing people;*
    d. *Medication administration;*
    e. *Stress awareness; and*
    f. *Understanding anxiety.*

16. *This completed training shows that Ms Desai has sought to learn from her mistakes and develop her skillset to ensure that a similar incident will not reoccur which could breach one of the fundamental tenets of the profession or put residents at unwarranted risk of harm.*

17. *Fourthly, Ms Desai gave evidence to you about the impact this incident may have on the wider healthcare professions and apologised for her actions. She was questioned about those she has apologised to, and it is submitted that she has acknowledged her actions and apologised to all concerned. She has shown an insight into the public interest in registered nurses not bringing the profession into disrepute and how this might affect others who may wish to join the profession. Despite this* (Witness 2) *continued to have Ms Desai work as the sole registered nurse on the floor. Taken together with the testimonials [from employers and family members of residents] this demonstrates that Ms Desai has shown insight and has not brought the profession into disrepute.'*

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

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically, the following sections of the Code:

'7 Communicate clearly
To achieve this, you must:
***7.1** use terms that people in your care, colleagues and the public can understand*
***7.4** check people's understanding from time to time to keep misunderstanding or mistakes to a minimum*

8 Work cooperatively

To achieve this, you must:

***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*

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

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

To achieve this, you must:

***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

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

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

To achieve this, you must:

11.1 *only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions*
11.2 *make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care*
11.3 *confirm that the outcome of any task you have delegated to someone else meets the required standard*

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.2 *make a timely referral to another practitioner when any action, care or treatment is required*

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*

16 Act without delay if you believe that there is a risk to patient safety or public protection
To achieve this, you must:
16.5 *not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern*

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'*

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

With respect to charges 1a, 1b, 1c(i) and 1c(iii), the panel took into account that Witness 2/Colleague Y and Witness 3/Colleague X both confirmed in their oral evidence that despite not being trained to administer medication, healthcare assistants at the Home could administer medication to residents when supervised by registered nurses. However, the panel found that the fact that Witness 1/Colleague Z was able to leave you and go to give medication to a resident in a different area of the Home, to the resident that required the medication, in a situation where Witness 1/Colleague Z had voiced that he was uncomfortable giving the medication, indicates that you never intended to fully supervise Witness 1/Colleague Z. The panel do not accept your account that he left you while you were distracted with an incident. The panel therefore found that you shouted at a junior colleague to pressure him to do something that he was not trained and not confident to do which caused a medication error and put patients at risk.

The panel found your conduct in these charges to amount to a dereliction of your nursing duties and that they fell far short of the fundamental obligations that registered nurses have to residents under their care. Although there was no evidence before the panel that any actual harm was caused to Residents A and B, the panel was of the view that your conduct posed a risk of harm to them. It noted that as a result of your actions, there was a potential risk to the health of Resident B as they had taken an unprescribed medication. Accordingly, the panel determined that your conduct in charges 1a, 1b, 1c(i) and 1c(iii) was serious and amounted to misconduct.

In relation to charge 2, the panel took into account that there was evidence that you regularly shouted at junior staff at the Home. The panel considered that this was not acceptable practice. The panel considered the context of this incident. You were alarmed about the medication error and then shouted at Witness 1/Colleague Z. However, the panel was of the view that the particular circumstances of this incident were such that it was even more important for you to manage the incident in a calm and appropriate manner. The panel considered your conduct in shouting at Witness 1/Colleague Z to be unacceptable and it demonstrated a lack of professionalism and ineffective communication. It also caused distress to him and could have caused distress to residents who were within earshot. The panel determined that your conduct constituted a serious breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. Accordingly, the panel determined that your conduct in charge 2 amounted to misconduct.

In relation to charges 4, 11 and 12, the panel took into consideration that you failed to immediately escalate the medication error to the Home Manager and to contact Resident B's GP and family as soon as possible, which was in breach of the Home's Policy. The panel was of the view that your failure to immediately contact Resident B's GP, placed Resident B at risk of harm as you were under a duty to obtain appropriate medical advice to minimise any risk from the medication error. The panel also noted that it was part of your duty of candour to Resident B's family to inform it about any incident involving Resident B as soon as possible.

The panel noted that your failure in immediately escalating the medication error to the Home Manager, when viewed in isolation, was, on the face of it, not so serious as to amount to misconduct. However, the panel was of the view that this conduct, when considered in light of your other failures in contacting Resident B's GP and family, indicates a pattern of behaviour in not informing the appropriate persons and taking appropriate advice about a serious medical incident. The panel therefore determined that your actions amounted to a serious failure in a fundamental aspect of nursing practice in which you, as an experienced nurse, was expected to demonstrate competence. The panel therefore determined that your conduct in charges 4, 11 and 12 was serious and amounted to misconduct.

The panel took into account that you failed to keep accurate records of the medication error when required. The panel considered accurate record-keeping as one of the fundamental tenets of the nursing profession. It noted that your conduct would have deprived your colleagues, the Home and the appropriate health professionals from being appraised with the relevant information pertaining to the medication administration incident and the potential risk of harm it posed to Resident B. Therefore, the panel determined that your actions in charges 5a, 5b, 9, 10 and 15 were serious and amounted to misconduct.

In relation to charges 6 and 19, the panel was of the view that your actions in this charge amounted to an abuse of position of authority. It noted that your instruction to Witness 1/Colleague Z would have potentially put his career in jeopardy as you had told a carer under your supervision to act dishonestly by concealing a medication administration error. It was concerned that you had set a bad example and failed to uphold the standards and values of the nursing profession. You were also yourself acting dishonestly to hinder the proper investigation and action required, after a serious incident that could have caused harm to a patient. The panel determined that your actions amounted to a breach of professional conduct and behaviour expected of a registered nurse. Accordingly, the panel determined that your actions in charges 6 and 19 amounted to misconduct.

With regard to charge 7a, the panel noted that although you inaccurately informed Witness 2/Colleague Y that you had mistakenly administered Resident A's medication to Resident B, Witness 3/Colleague X confirmed that you had told her on the same day that a medication meant for Resident A had mistakenly been given to Resident B by a carer under your instruction. The panel had earlier accepted your explanation for your conduct and it had found that your conduct was not dishonest. In this regard, the panel determined that your conduct in charge 7a was not so serious as to amount to misconduct.

The panel then considered charges 7b, 8 and 21. It was of the view that your deliberate attempt to conceal the amount of medication consumed by Resident B amounted to a breach of the duty of candour expected from a registered nurse. The panel considered honesty, integrity and trustworthiness to be the bedrock of the nursing profession and, in being dishonest, it found you to have breached a fundamental tenet of the nursing profession. It noted that your dishonest conduct posed a risk of harm to Resident B and demonstrated a lack of accountability and transparency on your part. The panel considered that to characterise your actions as anything other than misconduct would send the wrong message about the nursing profession. Therefore, the panel was in no doubt that your actions in being dishonest amounted to misconduct.

With respect to charges 16, 17 and 18, the panel took into account that Witness 4/Colleague V and Witness 5/Colleague W had stated in their respective evidence that you had asked them and other staff to administer medication, knowing they were not authorised/qualified to do so. However, they did not follow your instruction. The panel noted that Witness 2/Colleague Y and Witness 3/Colleague X both confirmed in their oral evidence that despite not being trained to administer medication, healthcare assistants at the Home could administer medication to residents when supervised by registered nurses. Nevertheless, the panel noted that there was no or insufficient evidence before it to suggest that you did not intend to supervise the health care assistants when you asked them to administer medication. In light of this, the panel concluded that there was insufficient evidence before it to make a finding of misconduct with respect to charges 16, 17 and 18.

Consequently, having considered all the charges individually and as a whole, the panel determined that your actions in charges 1a, 1b, 1c(i), 1c(iii), 2, 4, 5a, 5b, 6, 7b, 8, 9, 10, 11, 12, 15, 19 and 21, did fall significantly 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, your fitness to practise is currently impaired.

Registered nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional standards. 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.

The panel had regard to the NMC Guidance on Impairment especially the question which states:

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper*

professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

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

The panel first considered whether any of the limbs of the Grant test were engaged in the past. It found that your misconduct had placed both Residents A and B at an unwarranted risk of harm. The panel determined that your misconduct constituted a serious breach of the fundamental tenets of the nursing profession as you failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute. The panel had also found two charges of dishonesty proved against you and that they amounted to misconduct.

The panel therefore concluded that limbs a, b, c and d of the Grant test were engaged in the past.

The panel next considered whether the limbs of the *Grant* test are engaged in the future. In this regard, the panel considered the case of *Cohen v GMC* [2008] EWHC 581 (Admin) where the court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

In this regard, the panel also considered the factors set out in the NMC Guidance on Insight and strengthened practice (FTP-15).

The panel first considered whether your misconduct is capable of being addressed. In the NMC Guidance – Can the concern be addressed (FTP-15a), the panel noted the following paragraph:

> *'In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.*
>
> *Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*
>
> - *….*

- *dishonesty, particularly if it was serious and sustained over a period of time, or is directly linked to the nurse, midwife or nursing associate's professional practice*

Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include:

- *medication administration errors*
- *poor record keeping'*

The panel first considered whether your misconduct is capable of being addressed. The panel was of the view that your misconduct with respect to medication administration error, poor recordkeeping and improper escalation of incidents, could be addressed through a process of insightful reflections and retraining in the areas of concern. Therefore, the panel determined that they were capable of remediation.

However, in the panel's judgement, your dishonest actions as well as your conduct in shouting at junior staff and pressuring them to provide a false account of a medication error, are suggestive of deep-seated attitudinal concerns which are difficult to remediate.

The panel then went on to consider whether the concerns has been addressed and remediated. It had regard to the NMC Guidance – Has the concern been addressed (FTP-15b).

The panel also considered the context of the misconduct. It noted that, at the time of the incidents, you were the only nurse in charge, working on a busy day shift and you stated that this may have affected your behaviour at that time. You told the panel that there were staffing issues and that you had highlighted this to the Home's management. However, the panel was of the view that, given your experience as a registered nurse working within care home settings, you should have managed the issues professionally. Notwithstanding

that this was an isolated incident, the panel was of the view that stress is not a justification for dishonesty and mistreatment of junior staff.

Regarding insight, the panel took into account your oral evidence. The panel considered that you made admissions to some of the charges, had shown some remorse and apologised for your actions. However, the panel noted that you sought to deflect responsibility for some of your actions and tended to provide justifications for them. The panel was concerned that you failed to demonstrate sufficient understanding of the seriousness of your misconduct, nor did you show sufficient insight into the impact of your conduct on your colleagues, the nursing profession and the wider public. The panel was of the view that you did not provide adequate insight into detailed steps you would take to prevent any of the concerns from re-occurring in the future or what you would do in a similar situation. You said you had learned to manage your stress and had reflected on improvements to your reporting practice. However, you did not show sufficient insight into the dishonesty or behaviour to colleagues such that the panel was persuaded that you would have strategies to prevent this behaviour from reoccurring in future times of stress. The panel therefore determined that you failed to demonstrate sufficient insight into your misconduct.

In considering whether you have strengthened your nursing practice, the panel considered the various testimonials made on your behalf as well as the several training courses you had completed. The panel noted that whilst several of the training courses addressed the concerns in medication administration, recordkeeping, managing stress and working with others, you had not provided any evidence of how you have implemented this learning to strengthen your nursing practice. Further, the panel noted that you have not provided any reflections concerning dishonesty. It further noted that none of the testimonials were in relation to recent nursing practice and the panel was of the view that they did not specifically address the concerns. The panel therefore attached limited weight to your testimonials and training certificates.

In light of this, the panel was not satisfied that any of the concerns had been fully remediated nor had you sufficiently strengthened your nursing practice. Accordingly, the panel determined that your misconduct is highly likely to be repeated, and limbs a, b, c and d of the *Grant* test are engaged in the future.

The panel therefore concluded 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 had regard to the serious nature of your misconduct and the public protection issues it had identified. It determined that public confidence in the profession, particularly as the misconduct involved dishonesty, would be undermined if a finding of impairment were not made in this case. For these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

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

Sanction

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

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

Submissions on sanction

Mr Brahimi provided the following written submissions on sanction:

1. *'The Panel have now reached a stage of finding misconduct in respect of the Registrant's behaviour and have concluded that fitness to practice is currently impaired. The Panel should therefore consider what sanction is appropriate to address the proven charges.*

2. *The Panel should first take into account relevant factors before deciding on sanction, as set out by the NMC Fitness to Practice Library guidance SAN-1:*

3. *Proportionality*

    a. *Finding a fair balance between Registrant's rights and the overarching objective of public protection;*

    b. *To not go further than it needs to, the Panel should think about what action it needs to take to tackle the reasons why the Registrant is not currently fit to practise;*

c. *The Panel should consider whether the sanction with the least impact on the nurse practise would be enough to achieve public protection, looking at the reasons why the nurse isn't currently fit to practise and any aggravating or mitigating features.*

4. *Aggravating features*

   a. *Breaching the professional duty of candour;*

   b. *Position of responsibility;*

   c. *Abuse of position of trust;*

   d. *Arguably insufficient insight;*

   e. *Further observations:*

      i. *Refusal to cooperate with local investigations;*

      ii. *Pattern of misconduct.*

5. *Mitigating features*

   a. *Engagement with regulator;*

   b. *Registration effective from 16th October 2019.*

6. *Previous interim order and their effect on sanctions*

   a. *Interim Suspension Order effective until 1st March 2025.*

7. *Previous fitness to practice history*

   a. *No previous referrals or findings.*

Sanctions available

8. *NMC submit that taking no action and a caution order are not suitable options for this case due to the variety of concerns. Guidance is found at SAN-3a and 3b.*

    a. *Taking no action: this would not be an appropriate course of action as the combination of regulatory concerns of behaviour is serious. The public protection and public interest elements in this case are such that taking no action would not be the appropriate response;*

    b. *Caution Order: similarly, a Caution Order is also not suitable as this is a sanction aimed at misconduct that is at the lower end of the spectrum. In this case the concern is at the higher spectrum where it involves dishonesty.*

9. *With regards to a conditions of practice order (COPO), the NMC submit that this option does not adequately address and reflect upon the number of breaches in this case. NMC guidance is found at reference SAN-3c.*

    a. *The level of concern in this case would require a higher level of sanction than a COPO where there is a variety of issues. The guidelines refer to "When conditions of practice are appropriate" and the Panel may find that these conditions are not met.*

    b. *Measurable, workable and appropriate conditions can be put into place to address instances such as specific clinical failures, however, a COPO would not suitably address the multiple instances of dishonesty which is an attitudinal concern.*

10. *The NMC submit the Registrant's actions do warrant a suspension order (SO) but this would not be sufficient. Suspension guidance is found at reference SAN-3d, and includes some of the following (but not limited to):*

    a. *"Key things to weigh up before imposing this order include:*

        - *whether the seriousness of the case require temporary removal from the register?*

    b. *"Use the checklist below as a guide to help decide whether it's appropriate or not. This list is not exhaustive:*

        - *a single instance of misconduct but where a lesser sanction is not sufficient"*

c. *Seriousness of the case does require at least temporary removal from the case. However, suspension is not appropriate without full reflection and demonstration of developed insight into the seriousness of the charges and their impact on public confidence and professional standards. This is not a single instance of misconduct but a pattern of poor decision making, following acts of coercion of a junior colleague which includes calculated dishonesty in an attempt to conceal failures.*

11. *The NMC submit that a striking-off order is appropriate where dishonesty has been found, including other concerns. The Panel may be assisted by guidance provided at reference SAN-3e.*

12. *This is a case involving dishonesty which will always be serious in nature. Honesty is of central importance to a nurse and the medical practice. Therefore, allegations of dishonesty will always be serious and a nurse, who has acted*

dishonestly will always be at some risk of being removed from the register. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, should be allowed to remain on the register will involve (the following points are applicable in this case):

a. *misuse of power;*
b. *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients;*
c. *vulnerable victims;*
d. *direct risk to patients;*
e. *Premediated deception.*

13. *The regulatory concerns raise fundamental concerns about the registrant's professionalism and trustworthiness. The regulatory concerns relate to serious dishonesty. Only a striking off order will address the regulatory concerns as the registrant's actions are incompatible with continued registration.*

Sanction request:

14. *The concerns in this case may be described as being attitudinal in nature. For all the reasons previously argued, the NMC submit that the appropriate sanction is a:*

Strike Off

15. *The NMC have sought to assist the Panel by going through each of the possible sanctions and when weighing the evidence against the set guidance, it is justified that there be a strike off. The concern of practice was not limited to*

one isolated incident but a build-up of concerns including communication, record keeping, medicine administration and dishonesty. When collating the number of issues, this may raise fundamental questions about the Registrant's professionalism and the public confidence in the register. This sanction would reflect that the conduct of the Registrant has been properly addressed and maintain trust with the public that the NMC do take such allegations seriously and will take swift and appropriate action.

16. *The NMC respect that the Panel is entirely at liberty to proceed as they deem most suitable for this case.'*

Mr Morrison provided the following written submissions on sanction:

'<u>Proportionality</u>

4. As the panel will know there is a balancing exercise to be struck when imposing the appropriate sanction. The sanction must be proportionate. This is referred to in the NMC guidance entitled 'Factors to consider before deciding on sanctions' as "finding a fair balance between the nurse, midwife or nursing associate's rights and our overarching objective of public protection".

<u>Dishonesty</u>

5. *It is well established that dishonesty comes high on the scale of misconduct for a healthcare professional and will therefore attract a serious sanction. It is not however a monolithic concept and the questions of the degree and severity of dishonest will arise per Jay J in General Medical Council v Chaudhury [2017] EWHC 2561]. Jay J went on to say that dishonesty was not a an "immutable trait".*

6. *This concept of degree and severity was also referred to in Hassan v General Optical Council [2013] EWHC 1887 (Admin) by Leggatt J who held that:*

   [39.] "Dishonesty encompasses a very wide range of different facts and circumstances. Any instance of it is likely to impair a professional person's fitness to practise and in that sense is a serious matter. But it is wrong in my view to approach the question of sanction on the basis that there is only a small residual category of exceptional cases where erasure would be a disproportionate sanction and then to ask whether there are any exceptional factors which take the instant case into that residual category."

7. *A further example of this nuanced approach can be found in Igboaka v General Medical Council [2016] EWHC 2728 (Admin), where Simler J stated that:*

   [33.] "That does not mean that erasure is necessarily inevitable and necessary in every case of dishonest conduct by a doctor. There may be cases where the panel concludes in light of the particular circumstances of the case that a lesser sanction may suffice and is appropriate, bearing in mind the important balance of the interests of the profession and the interests of the individual. Factors that are likely to impact on such a decision are infinitely variable, but may include the nature of the dishonesty, the fact that in a particular case it appears to be out of character or isolated in its duration; or there may be very compelling evidence of insight and remorse that would justify a conclusion that the doctor could return to practice without the reputation of the profession being disproportionately damaged."

8. *These dicta are reflected in the NMC's guidance on 'Considering sanctions for serious cases' which provides examples of more and less serious example of*

dishonesty. It states that "Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*
- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception Dishonest conduct will generally be less serious in cases of:*
- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *incidents outside professional practice*

Competency

9. The panel are entitled to consider the registrant capabilities as a nurse in deciding on the proportionate sanction per the Court of Appeal in General Medical Council v Bawa-Garba [2018] EWCA Civ 1879 which held that an important factor weighing in favour of [the defendant] *was that she was "a competent and useful doctor, who presents no material danger to the public, and can provide a considerable useful future".*

SUBMISSIONS

10. *It is against this legal background that it is submitted on behalf of the registrant that she need not be erased from the register of nurses and that the proportionate sanction which strikes a fair balance between the registrant and the overarching objective of public protection is one of a period of suspension. This submission is made for the following reasons.*

11. *Firstly, that the dishonesty in this case is less serious than other cases of dishonesty which come before tribunals. It was evidently an isolated incident in which the registrant acted spontaneously; it was not a longstanding deception, invovled no personal gain and was not a misuse of power. As the panel know the registrant was working in a care home with up to 83 vulnerable and elderly residents; it was a stressful and pressurised environment without the adequate support as there was no management or equivalently senior staff on site as it was a weekend. It is submitted that these factors reduce the seriousness of the dishonesty and are remediable by a period of suspension.*

12. *Secondly, the registrant has shown clear remorse for her actions. This is evident from her account given to you on 27th June this year when she apologised to all the parties concerned:* [Witness 1], *her colleagues, the resident and their family as well as the wider profession. It is submitted that the registrant has shown insight into the impact her actions have had on her colleagues, the nursing profession and the wider public. In her previous evidence the registrant referred to being in uniform and representing the entire profession. She said "I'm a registered member, so I would rather apologise to my whole profession because I represent them as a whole because I do have like a responsibility when I wear that uniform towards the entire profession….it's not just a uniform. It is a Representation of who you are, you are accountable for the whole profession itself". The panel are invited to conclude that this is insight into the impact her actions have had on the wider profession and the trust that the public place in nurses.*

13. *Thirdly, the registrant has gone further than this and demonstrated how she has worked towards new training whilst working as a heath care assistant. This has occurred despite the registrant having been subject to an interim order of suspension since 3 May 2023.The panel gave limited weight to this when considering impairment as she "had not provided any evidence of how you have implemented this learning to strengthen your nursing practice". However, it is submitted that due to the interim order being in place she has been limited in her ability to demonstrate how she can strengthen her nursing practice. She has been suspended for 555 days the suspension was put in place a little over six weeks after the incident occurred. The registrant continued to work in a healthcare environment, undertook relevant training which was relevant to the issues surrounding this case and complied with the terms of her interim order. By doing so it is submitted that she has shown insight into remedying her fitness to practice.*

14. *Fourthly, you heard evidence from* [Witness 3] *and* [Witness 2] *as to the capabilities of the registrant as a nurse. The panel have seen the results of her supervision with* [Witness 3] *on 10 March 2023. No concerns were raised which called into question Ms Desai's fitness to practice and in her live evidence* [Witness 3] *continued to maintain that Ms Desai was a "really good nurse" who went the "extra mile" . Her non completion of the paperwork was "out of character" and no previous issues had been raised regarding contacting family members or GP's. These qualities as a nurse are supported by* [Witness 2] *continuing to have the registrant as the sole registered nurse working at the same care home the weekend after this incident occurred and her previous unblemished fitness to practice record.*

15. *This positive account of her capabilities is reinforced by the testimonials previously read by the panel. The testimonials may not be in relation to recent nursing practice, but the panel are reminded that the registrant has been suspended for over eighteen months pending the conclusion of these*

proceedings. The testimonials do speak of a competent, committed and caring healthcare professional. When read in conjunction with the positive comments from [Witness 2] *and* [Witness 3] *the panel are invited to find that they not show the registrant as having harmful deep-seated personality or attitudinal problems.*

16. *Fifthly, the registrant has personal mitigation which it is submitted make the proportionate response in this case one of suspension rather erasure.* [PRIVATE].

17. [PRIVATE]

18. [PRIVATE]

CONCLUSION

19. The seriousness of the charges found proved is not lost on the registrant who is well aware that the panel are being invited by the NMC to erase her from the register. However, it is submitted that a period of suspension will be sufficient to protect patients, public confidence in nurses and professional standards whilst allowing an otherwise competent nurse to, in course, continue with her profession.'

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

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be

punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel identified the following aggravating features:

- Your course of dishonest conduct.
- Your actions demonstrated an abuse of your position of authority in attempting to coerce a junior colleague to provide a false account of a medication error.
- Deliberate breach of duty of candour.
- Your actions placed residents at unwarranted risk of harm.
- Incomplete insight into your misconduct.

The panel also identified the following mitigating factors:

- Evidence of developing insight into your misconduct
- You have shown some evidence of remorse and apologised for your actions.
- Some evidence of steps taken to remediate the concerns through training courses in some areas of concern and positive testimonials made on your behalf.
- Your actions were related to a single incident that occurred over a short period of time, in an otherwise unblemished career as a registered nurse.
- [PRIVATE].
- You stated that the Home had staff resourcing issues which gave rise to stress at work, at the time of the incidents.
- You have continued to show commitment to the health and care sector.

The panel had regard to the NMC Guidance on Considering sanctions for serious cases, in particular, Cases involving dishonesty (SAN-2). The panel noted that you abused your position of authority by attempting to coerce a junior colleague to provide a false account of a medication error. You therefore deliberately breached the duty of candour by

attempting to cover up how things went wrong at the time of the incident. The panel further noted that you have failed to demonstrate any insight into your dishonest conduct.

Nevertheless, the panel noted that your dishonest conduct was not premeditated, systematic or longstanding and that it involved a course of action over a short period of time with no direct financial gain. In this regard, the panel found the dishonesty in this case not to be at the most serious end of the spectrum of dishonesty.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. It had found that there remains a risk of repetition, that you had breached fundamental tenets of the nursing profession, and your misconduct would undermine the public's confidence in the nursing profession if you were allowed to practise without restriction. The panel therefore determined that it would neither protect the public nor be in the public interest to take no further action.

The panel 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 your nursing 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 decided that your 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 therefore determined that a caution order would neither protect the public nor be in the public interest.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be relevant, proportionate, measurable and workable. The panel took into account the NMC Sanctions Guidance on Conditions of practice order (SAN-3c), in particular:

'Conditions may be appropriate when some or all of the following factors are apparent:

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

The panel was of the view that although some of the concerns in this case could be addressed through retraining, your dishonest conduct and the attitudinal concerns identified in this case could not be addressed through retraining and are difficult to remediate. The panel therefore determined that given the seriousness of the misconduct, the attitudinal concerns and your lack of sufficient insight into the severity and impact of your actions, there were no relevant, proportionate, workable and measurable conditions that could be formulated. Accordingly, a conditions of practice order would not address the risk of repetition, and this poses a risk of harm to patients' safety and the public. Consequently, the panel decided that a conditions of practice order would not protect the public, would not reflect the seriousness of your misconduct nor be in the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The NMC Sanctions Guidance on Suspension order SG (SAN-3d) 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 had found that your misconduct, particularly your dishonesty and your conduct in attempting to coerce a junior colleague to provide a false account of a medication error, amounted to a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. It noted that you failed to demonstrate sufficient insight into the severity and impact of your misconduct on your colleagues and the wider public. The panel also found that your misconduct was a serious breach of the fundamental tenets of the nursing profession which brought the nursing profession into disrepute.

Notwithstanding this, the panel was of the view that that this was a single instance of misconduct in that it involved a course of action over a short period of time. It took into account that there is no evidence of repetition of the concerns since the incident. [PRIVATE]. It noted that Witness 2/Colleague Y and Witness 3/Colleague X both gave positive testimonials about your good record as a nurse, during their respective oral evidence. The panel considered that you had demonstrated some developing insight into your misconduct and had taken some steps to strengthen your nursing practice.

The panel carefully considered the submissions of Mr Brahimi in relation to the imposition of a striking-off order in this case. It also considered following paragraphs of the SG (SAN-3e) with respect to imposing a striking-off order:

- *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 gave serious consideration to the imposition of a striking-off order given the serious nature of your misconduct. However, in taking account of all the evidence before it, including that this was a single instance of misconduct that occurred at a time of stress, the steps you had taken to begin to strengthen your nursing practice and your developing insight, the panel concluded that a striking-off order would be disproportionate.

Although your misconduct raises questions about your professionalism, it was, in the panel's view, not to the extent that required your removal from the register. The panel was not satisfied that a striking-off order was the only sanction sufficient to protect the public and to address the public interest considerations in this case. Whilst the panel acknowledges that a suspension order may have a punitive effect, it would be unduly punitive and disproportionate in this case to impose a striking-off order at this time. It was of the view that a striking-off order could deprive the public of a registered nurse who has the potential to sufficiently strengthen her nursing practice and return to safe and effective practice in the future. Therefore, a striking-off order would not serve the public interest considerations in this case.

Consequently, the panel was satisfied that, in this case, the misconduct is not fundamentally incompatible with remaining on the register and that public confidence in the nursing profession could be maintained if you were not removed from the register.

Balancing all of these factors, the panel concluded that a suspension order would be the appropriate and proportionate sanction to protect the public and address the public interest in this case. It was satisfied that a suspension order for a period of twelve months

is necessary in order to provide you with an adequate opportunity to reflect and thereafter demonstrate evidence of sufficient insight into your misconduct and that your fitness to practise is no longer impaired. The panel determined that this order is necessary to protect the public, mark the seriousness of the misconduct, maintain public confidence in the profession, and send to the public and the profession, a clear message about the standard of behaviour required of a registered nurse. The panel concluded that only a period of twelve-month suspension would be sufficient to uphold public confidence given the seriousness of your dishonest conduct involving attempted coercion of junior staff.

Finally, the panel wishes to emphasise that it seriously considered making a striking-off order but concluded that it would be disproportionate, at this time, in the particular circumstances of this case.

The panel noted the hardship a suspension order will inevitably cause you, however, this is outweighed by the public interest in this case.

The panel decided that a review of this order should be held before the end of the period of the suspension order.

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

Any future panel reviewing this case may be assisted by:

- A reflective statement, using a model such as the Gibbs model of reflection, demonstrating sufficient insight into the severity and impact of your misconduct, with particular regard to your dishonesty.

- Any updated references or testimonials attesting to your capability to perform your duties, in whatever role, professionally in any paid or unpaid work, following this hearing.

- Evidence of up-to-date relevant training courses undertaken in the areas of concern including in upholding professionalism at work.

- A supporting statement from your line manager or supervisor commenting on your general attitude and interaction with colleagues and how you manage difficult situations at work.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Brahimi. He submitted that given the panel's decision on sanction, an interim suspension order for a period of 18 months is necessary in order to protect the public and otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective.

Mr Morrison stated that he did not oppose the application.

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

Decision and reasons on interim order

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 was therefore satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest.

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 in order to protect the public and because it is also in the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

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

That concludes this determination.