Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 11 November 2024 – Friday, 15 November 2024
Monday, 18 November 2024 – Friday, 22 November 2024
Monday, 25 November 2024

Virtual Hearing

Name of Registrant:	**Sunjay Sungkur**	
NMC PIN	91I1454E	
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (19 September 1994)	
Relevant Location:	London	
Type of case:	Misconduct	
Panel members:	Shaun Donnellan Melanie Lumbers Rachel Barber	(Chair, Lay member) (Registrant member) (Lay member)
Legal Assessor:	Graeme Henderson	
Hearings Coordinator:	Eleanor Wills	
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter	
Mr Sungkur:	Present and represented by Thomas Buxton instructed by the Royal College of Nursing (RCN)	
Facts proved:	Charges 1a, 1b, 1c, 1d, 2, 3a, 3b, 4	
Facts not proved:	None	
Fitness to practise:	Impaired	
Sanction:	**Striking-off order**	
Interim order:	**Interim suspension order (18 months)**	

Decision and reasons on application to amend the charge

The panel, of its own volition, raised two discrepancies in the documentary evidence before it and the drafting of the charges. Firstly, there appeared to be an administrative error in relation to the drafting of charge 2. Charge 2 refers to *'your actions at 1c'*, when it appears to actually refer to your actions at charge 1d. Further, there appeared to be an administrative error in relation to the drafting of charge 3. Charge 3 refers to *'your conduct at charge 1b',* when it appears to actually refer to your conduct at charge 1c.

The proposed amendment in relation to charge 2 was to remove the reference to *'1c'* and instead insert *'1d'*. The proposed amendment in relation to charge 3 was to remove the reference to *'1b'* and instead insert *'1c'*.

> "That you being a registered nurse:
>
> 2. Your actions at ~~1c~~ **1d** above were dishonest in that you knew at the time of signing no medication had then been administered.
>
> 3. When challenged about your conduct at charge ~~1b~~ **1c**, above:
>
> …"

Mr Malik, on behalf of the Nursing and Midwifery Council (NMC), and Mr Buxton, on your behalf, both agreed that the proposed amendment would provide clarity and more accurately reflect the evidence.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice

would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charges as amended

That you being a registered nurse:

1. Adopted unsafe medication practices in that you:
    a) On unknown dates, on one or more occasions, pre-potted medication.
    b) On the 9 July 2018, left medication for Resident A unattended on a table without ensuring it was correctly administered;
    c) On the 23 August 2018, pre-potted medication for residents and placed this on a dressing trolley;
    d) On the 23 August 2018 pre-signed MAR charts prior to medication administration.

2. Your actions at 1d above were dishonest in that you knew at the time of signing no medication had then been administered.

3. When challenged about your conduct at charge 1c, above:
    (a) blocked the Regional Clinical Lead from taking a photograph,
    (b) took the trolley into the toilet and disposed of the medication.

4. Your actions at charge 3 above were dishonest in that you sought to conceal your unsafe medication practice.

And in the light of the above misconduct, your fitness to practise is impaired.

Background

On 31 May 2019, the NMC received a referral from Care UK raising concerns regarding your practice. You were an employee of Care UK and were employed as a Clinical Unit Manager at St Vincent Care Home (the Home) between 25 October 2013 and 11 March 2019.

It is alleged that on the 9 July 2018, you left Resident A's medication on a table and failed to ensure that the medication was taken.

It is alleged that on 23rd August 2018 you were seen wheeling a dressing trolley down the corridor of the Home which had pre-potted medication. Witness 1 was the Clinical Lead Nurse for the Home, and she stated that at the time, she asked what you were doing, and you stated that you were doing the evening drug round. Witness 1 then allegedly tried to take a picture of the trolley, but you blocked it. You apparently quickly went into the bathroom with the trolley and locked the door. It is alleged that you refused to come out when asked and Witness 1 could hear the water running and the toilet flushing. When you eventually came out of the bathroom there was allegedly no medication on the trolley. Witness 1 stated that she asked you what you had done with the medication, and you allegedly denied there being any medication on the trolley.

It is alleged that your conduct was dishonest in that you attempted to conceal the fact that you had pre-potted medication for the evening medication round. Witness 1 subsequently checked the Medication Administration Records (MAR) of the residents in the Home and found that you had allegedly signed all of the MAR charts to say that you had administered the medication, when you had not, as you had allegedly disposed of the pre-potted medication.

These allegations were investigated then re-investigated by Quality Development Manager, Witness 2, after you raised concerns about procedures, investigating officers

and confidentiality. You attended a disciplinary hearing on 27 February 2019 and were subsequently dismissed with effect from 11 March 2019 for gross misconduct. You appealed the decision, and an appeal meeting was held on 8 April 2019, however, the decision to dismiss was upheld.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Malik under Rule 31 to allow the hearsay testimony of Ms 1, Ms 2 and Ms 3 into evidence.

Mr Malik referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and invited the panel to consider the following principles:

> *'(i) whether the statements were 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 Appellant's career;*
> *(v) whether there was a good reason for the non-attendance of the witnesses;*
> *(vi) whether the Respondent had taken reasonable steps to secure their attendance; and*
> *(vii) the fact that the Appellant did not have prior notice that the witness statements were to be read.'*

Mr Malik submitted that despite numerous attempts, the NMC has not been able to obtain a signed, witness statement from Witness Ms 1, Ms 2 or Ms 3 as demonstrated by the following documents:

- Email from NMC to Ms 1 at Care UK, requesting confirmation of contact details dated 18 March 2024
- Email from NMC to Ms 1 dated 27 March 2024
- Letter from NMC to Ms 1's postal address dated 21 March 2024 and 3 April 2024
- Telephone calls attempts from NMC to Ms 1 dated 3 April 2024, 5 April 2024, 10 April 2024
- Tracing agent result for Ms 1 dated 9 April 2024
- Tracing agent result for Ms 2 dated 21 March 2024
- Note of the telephone call from NMC to Ms 3 dated 17 April 2024
- Email from Ms 3 to the NMC dated 24 April 2024

Mr Malik submitted that the hearsay evidence is highly relevant and was produced for the purpose of the internal investigations by Care UK.

In relation to the evidence of Ms 1, Mr Malik submitted that exhibit NB/1, is the Care UK serious incident report dated 28 August 2018, which pertains to the alleged incident on 23 August 2018 and supports charge 1c. Exhibit NB/2 is Ms 1's local statement dated 15 July 2018 which contains details about the alleged incident on 9 July 2018 which supports charge 1b.

In relation to the evidence of Ms 2, Mr Malik submitted that she witnessed the alleged incident on 9 July 2018 and provided her version of events in her email statement dated 16 July 2018, exhibit NB/7. Further exhibit NB/8 is the local investigation minutes of a meeting with Ms 2 dated 20 November 2019, which contains details about the alleged incident on 9 July 2018.

Mr Malik submitted that Witness 1 provided a NMC witness statement signed and dated 5 September 2019, and she will also be giving oral evidence. He submitted that on 23 August 2019 Witness 1 allegedly witnessed you pushing the dressing trolley down the corridor with the pre-potted medication. Witness 2 provided a NMC witness statement signed and dated 2 May 2024, and she will also be giving oral evidence. Mr Malik

submitted that Witness 2 reinvestigated the alleged incidents that took place on 23 August 2018 and 9 July 2018. Witness 2 provided the minutes of the investigation meeting dated 15 October 2018, in which you provided a response to the alleged incident that took place on 9 July 2018. Mr Malik therefore submitted that the evidence of Ms 1 and Ms 2 is not sole or decisive.

In relation the evidence of Ms 3, Mr Malik submitted that exhibit NB/10 is the Care UK disciplinary hearing meeting minutes dated 27 February 2019 and exhibit NB/11 is the Care UK appeal minutes dated 8 April 2019, in which you provide your version of events. Mr Malik therefore submitted that the evidence of Ms 3 is not sole or decisive.

Mr Malik submitted that there is no suggestion that Ms 1, Ms 2 or Ms 3 had any reason to fabricate their allegations or what they have witnessed. He submitted that the charges you are facing are serious including two charges of dishonesty. He submitted that the NMC has made reasonable efforts to obtain the witnesses' attendance. Mr Malik submitted that the evidence of Ms 1, Ms 2 and Ms 3 is relevant, and it is fair and in the public interest to admit these documents and statements into evidence.

Mr Buxton, on your behalf, accepted that the proposed hearsay evidence was relevant. However, he submitted that it would be unfair to introduce this evidence as it is the sole and decisive evidence in relation to charge 1b. Mr Buxton submitted that Ms 1 and Ms 2 are the only individuals who provide an account regarding the alleged incident on 9 July 2018. Mr Buxton submitted that you deny all charges and it would be unfair to admit hearsay evidence as you would not be provided the opportunity to explore and challenge the nature and content of the evidence.

Mr Buxton submitted that you were interviewed during the disciplinary meeting on 27 February 2019, at the time, you referred to the fact that you had had difficulties with management and had raised grievances in the past. Mr Buxton acknowledged that these allegations are serious involving charges of dishonesty. Mr Buxton acknowledged that the NMC has made efforts to get the witnesses to attend, however he invited the panel to

consider whether it deemed these efforts *'reasonable'*. Mr Buxton invited the panel to refuse the application to admit the hearsay given that it is sole and decisive evidence, and it would be unfair to admit it.

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 was also referred to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) at paragraph 45.

In considering whether to allow the hearsay evidence of Ms 1 the panel considered whether the evidence was relevant and whether it was corroborated by other accounts and documents.

The panel determined that exhibit NB/1 is relevant in that it is the Care UK serious incident report dated 28 August 2018, which pertains to the alleged incident on 23 August 2019. The panel also determined that it is not the sole or decisive evidence in relation to charge 1c and/or 1d.

In reaching this decision the panel noted that Witness 1 in her local statement provided her account of the alleged incident on 23 August 2018 in that she witnessed you pushing a trolley of pre-potted medication. Further Witness 1 in her NMC witness statement signed and dated 5 September 2019 exhibited her local statement and provided further details of her actions after the alleged incident, stating that *'the MAR charts were checked, and all the resident's medications had been signed off by [you] as "given"'.* The panel had regard to the fact that Witness 1 is due to give oral evidence. The panel took into account that Witness 2 in her NMC witness statement signed and dated 2 May 2024, stated that she reinvestigated the following allegations:

‘1. Serious breach of Care UK Medication policy on evening of 23 August 2018 at approximately 18.15h whereby it is alleged that you have:

a) Pre potted medications;
b) ….’

Further Witness 2 provided the minutes of the investigation meeting dated 15 October 2019, in which she interviewed you regarding the alleged incident on 23 August 2018 and you provided your account. The panel had regard to the fact that Witness 2 is due to give oral evidence.

The panel determined that exhibit NB/2 is relevant in that that it is Ms 1’s local statement dated 15 July 2018 in which she provided her account having witnessed the alleged incident on 9 July 2018. The panel also determined that it is not the sole or decisive evidence in relation to charge 1b.

In reaching this decision the panel took into account that Witness 2 in her NMC witness statement signed and dated 2 May 2024, stated that she reinvestigated the following allegations:

‘…

5. On the 9th July 2018 at lunchtime, you have allegedly failed to follow Care UK Medication Administration policy (and failed to follow NMC Code of Conduct), in that you have left medication for on her dining table where other residents living with dementia were walking around and could have taken the medication themselves. This allegation was investigated by…, Home Manager Cherry Orchard on 17th July 2018 however further clarification is required which will be undertaken as part of this investigation.’

Further Witness 2 provided the minutes of the investigation meeting dated 15 October 2019, in which she interviewed you regarding the alleged incident on 9 July 2018 and you provided your account. The panel had regard to the fact that Witness 2 is due to give oral evidence. The panel also considered that Witness 4, who is due to give live evidence, provided the notes of the investigation meeting with you dated 17 July 2019 in which you provided your account of the alleged incident on 9 July 2018.

In considering whether to allow the hearsay evidence of Ms 2 the panel considered whether the evidence was relevant and whether it was corroborated by other accounts and documents.

The panel took into account that Ms 2 claims to have witnessed the alleged incident on 9 July 2018 and provided her version of events in her email statement dated 16 July 2018, exhibit NB/7. Further exhibit NB/8 is the local investigation minutes of a meeting with Ms 2 dated 20 November 2019, which contains details about the alleged incident on 9 July 2018. The panel therefore determined that Ms 2's evidence is relevant in that it supports charge 1b. The panel also determined that Ms 2's evidence is not sole or decisive in relation to charge 1b.

In reaching this decision the panel took into account that Witness 2 in her NMC witness statement signed and dated 2 May 2024, stated that she reinvestigated the alleged incident on 9 July 2018. Further Witness 2 provided the minutes of the investigation meeting dated 15 October 2019, in which she interviewed you regarding the alleged incident on 9 July 2018 and you provided your account. The panel had regard to the fact that Witness 2 is due to give oral evidence. The panel also considered that Witness 4, who is due to give live evidence, provided the notes of the investigation meeting with you dated 17 July 2019 in which you provided your account of the alleged incident on 9 July 2018. The panel took into account that Ms 1 also corroborates Ms 2's account.

In considering whether to allow the hearsay evidence of Ms 3 the panel considered whether the evidence was relevant and whether it was corroborated by other accounts and documents.

The panel took into account that Ms 3 was a Human Resources (HR) manager, at the time, and she provided exhibit NB/10, the Care UK disciplinary hearing meeting minutes dated 27 February 2019 and exhibit NB/11, the Care UK appeal minutes dated 8 April 2019. The panel determined that the evidence is relevant in that the disciplinary hearing and appeal hearing pertain to the alleged incidents that took place on 9 July 2018 and 23 August 2023. The panel determined that Ms 3's evidence is not sole or decisive given that in both the disciplinary hearing and appeal hearing you provide your account of the alleged incidents, which supports your current position in that you dispute the allegations.

In these circumstances, the panel determined that the admission of the hearsay evidence of Ms 1, Ms 2 and Ms 3 is fair, as the evidence is relevant and not sole or decisive. The panel noted that you dispute the allegations. The panel took into account that whilst you have raised grievances, there is nothing on the documents before the panel, at this time, to demonstrate that there is evidence that there was reason for Ms 1, Ms 2 or Ms 3 to fabricate their accounts. The panel had regard to the serious nature of the allegations. The panel took into account the documents evidencing the attempts the NMC have made to get Ms 1, Ms 2 and Ms 3 to attend. The panel determined that the NMC has made reasonable attempts to get Ms 1, Ms 2 and Ms 3 to attend. The panel noted that no explanation has been given as to Ms 1 or Ms 2's nonattendance as they did not respond to the NMC's correspondence. However, Ms 3 did provide a response to the NMC in an email dated 24 April 2024 stating that she would not attend as she could provide no further explanation or clarification regarding the allegations. The panel therefore determined that it is *'fair and relevant'* to admit the hearsay evidence of Ms 1, Ms 2 and Ms 3.

Decision and reasons on facts

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

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

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

- Witness 1: Regional Clinical Lead Nurse employed by Care UK, working at the Home, at the relevant time
- Witness 2: Quality Development Manager employed by Care UK, at the relevant time
- Witness 3: Carer employed by Empire Employment Limited, working at the Home, at the relevant time
- Witness 4: Team leader practitioner/trainer employed by Care UK, working at the Home, at the relevant time

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. In relation to the charges of dishonesty the legal assessor referred the panel to the case of *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords Club)* [2017] UKSC 67:

> *'What was the defendant's actual state of knowledge or belief as to the facts; and was his conduct, in light of that state of mind, dishonest by the standards of ordinary decent people?'*

In considering the evidence before it, the panel were invited by Mr Buxton to have regard to the contextual circumstances of the case.

The panel had sight of a selection of grievances you submitted to the Home, as well as your supplementary handwritten notes regarding these alleged concerns/grievances. These grievances included clinical issues such as pre-assessment, staffing levels and staff competencies. These appeared to have been formally investigated and addressed, resulting in some changes to practice. The changes to practice included home managers counter-signing all pre-assessments. Information was also provided regarding the newly implemented dependency tool which determines staff ratio. The panel noted you appeared to disagree with many of the investigation outcomes.

The panel took into account that you also raised concerns around staff qualifications and experience. The panel noted that the investigation into your grievances showed that a robust recruitment process was in place.

The panel took into consideration that you raised a formal grievance in relation to Ms 2's poor practice on 9 July 2018, the date on which it is alleged that Ms 2 witnessed you leaving medication for Resident A unattended on a table without ensuring it was correctly administered. The panel noted that you raised a further complaint at 19:30 to the Human Resources manager specifically in relation to Witness 1's alleged harassment, on 23 August 2018, the date on which it is alleged that Witness 1 witnessed you undertaking the evening drug's round having pre-potted medication and pre-signed MAR charts.

The panel took into account your formal grievance raised on 18 July 2018 where you stated you were victimised and intimidated as you were a whistle blower; with allegations from you further linked to your race, colour and gender. The panel saw or heard no evidence to support this. It bore in mind that Witness 3 had never met you prior to the alleged incident on 23 August 2018. As part of the investigation within the Home, Witness 1 described your professional working relationship as one of working infrequently with you, as she had other care homes she was responsible for. She said, *'we have been in contact minimally, never directly except when I did his medic administration assessment*'.

The panel took into account the Care Quality Commission (CQC) report of the Home, dated November 2018, which stated that there was an issue regarding staffing at the Home. The panel accepted evidence from witnesses that there was an issue with staffing, in that there was a high turnover of management, at the relevant time. The panel took into account that it does not have before it any evidence that these grievances or concerns were upheld in relation to the allegations of harassment or discrimination nor the allegations regarding Ms 2 or Witness 1. The panel took into account that it has heard no evidence from any of the witnesses that there was any reason to fabricate any of the evidence.

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

Charge 1a

> "That you, a registered nurse, adopted unsafe medication practices in that you:
>
> a) On unknown dates, on one or more occasions, pre-potted medication.

This charge is found proved.

In reaching this decision, the panel first considered whether pre-potting medication is unsafe medication practice. The panel determined that pre-potting medication puts residents at risk of harm in that there is an increased risk of medication being incorrectly administered or not being administered at all. The panel therefore determined that pre-potting medication is unsafe medication practice. The panel noted that you also accepted that this practice is unsafe.

The panel next considered whether you on unknown dates, on one or more occasions, pre-potted medication. The panel took into consideration Witness 4's account provided in her oral evidence, her telephone conversation with the NMC on 11 December 2019 and her NMC witness statement signed and dated 8 May 2024. Witness 4 stated in oral evidence that she worked the same shift as you three times a week and part of her role was to observe what was happening in the Home and provide support and training to staff. She stated she saw you preparing medication at least once a week and that she had observed you pre-potting medication on several occasions leading up to the alleged incident on 23 August 2018.

The panel had regard to the communication log of a phone call from the NMC to Witness 4 dated 11 December 2019 in which Witness 4 stated:

> *'I had concerns about him pre-potting medication. It was something that was becoming common practice for him. Most mornings, I would see him pre potting the medication in the nursing room and then put it on a trolley. However, I was not present when he was doing the medication round so I do not know (sic) he administered the medication. I raised my suspicions about this to the managers and asked them to do a check floor at breakfast time so they could see him, but he was very clever and no one caught him.'*

The panel took into account Witness 4's NMC witness statement signed and dated 8 May 2024, in which she stated:

‘I frequently saw him removing medication from the blister packs for one resident, placing it in a pot, then putting the pot to the side. Sometimes he would place a bit of paper in a pot, which I assumed to detail the name of the resident the medication was for. This is called pre-potting. He would then repeat the process for several other residents, before taking all the pots out on a dressing trolley to give to the residents. I saw him do this in the medication room, nursing office, and I think the dining room.’

The panel noted that Witness 4 did not raise this with you, at the relevant time. The panel had regard to Witness 4’s NMC witness statement signed and dated 8 May 2024 in which she stated:

‘I never raised my concerns about his practice with [him] directly because he was my senior. He would have belittled me, asking if I was a nurse, which he had said to me in the past when I had questioned him about something. I did however raise it with [Ms 1].’

The panel took into consideration that you have consistently denied this allegation and have stated that Witness 4 could never have seen you preparing medication, as she was not allowed in the nurse’s office or medication room.

The panel determined that, on the balance of probabilities, Witness 4 did have the opportunity to observe you preparing medication. The panel concluded that Witness 4’s account was clear and consistent. The panel determined that there was no evidence before it to indicate that there was any reason for Witness 4 to fabricate her evidence.

The panel questioned Witness 4, during her oral evidence, in relation to her comments regarding how you challenged her, she agreed that the concept of being challenged was healthy and constructive in the workplace but took issue with the tone and manner of your comments. She further went on to say that you were really passionate and were liked by some people in the workplace. The panel concluded that Witness 4 was credible and

reliable. Although Mr Buxton was critical of the fact that Witness 4 was unable to supply dates and times the panel did not consider this affected her reliability as a witness. It accepted her evidence that she dealt with this issue by reporting to management.

The panel therefore decided that, on the balance of probabilities, it preferred Witness 4's account.

The panel therefore found charge 1a proved.

Charge 1b

> "That you, a registered nurse, adopted unsafe medication practices in that you:
>
> …
>
> b) On the 9 July 2018, left medication for Resident A unattended on a table without ensuring it was correctly administered;

This charge is found proved.

In reaching this decision, the panel first considered whether leaving medication unattended, without ensuring it is correctly administered is unsafe medication practice. The panel determined that leaving medication unattended puts residents at risk of harm in that there is an increased risk that the medication is taken by another resident, who is not the intended recipient, or harm is caused by incorrect ingestion of the medication, or the medication is not administered at all. The panel therefore determined that leaving medication unattended, without ensuring it is correctly administered is unsafe medication practice.

The panel next considered whether you, on 9 July 2018, left medication for Resident A unattended on a table.

The panel took into account the hearsay evidence of Ms 2. In an email dated 16 July 2018 she stated that:

> *'medication was left unattended in front of [Resident A] to whom it was intended to be given and another resident was sitting across [Resident A] at the same table... Due to the risk …, I removed the medication.'*

The panel took into account that Witness 2 interviewed Ms 2 regarding the alleged incident on 9 July 20218 and the minutes of this investigation meeting dated 20 November 2019 have been provided. The panel had specific regard to the following excerpt of the investigation minutes:

> *' [Witness 2]: Do you remember anything around medications?*
> *[Ms 2]: [Mr Sungkur] left some medications on the table for a resident*
> *…*
> *[Witness 2]: What happened?*
> *[Ms 2]: I took them away.'*

The panel had regard to Ms 1's local statement dated 15 July 2018 which contains details about the alleged incident on 9 July 2018 which is consistent with Ms 2's account in that she stated:

> *'During the service he came into the dining room with a medication pot containing a tablet for Resident A. He put the pot on the dining table in front of Resident A and walked away. He did not wait to make sure Resident A had taken her tablet which was for her Parkinson's condition or risk assessed the dining area noting that residents living with dementia were walking around and could have picked the medication up themselves.'*
> *…*
> *He did not return [Ms 2] picked up the tablet from the table.'*

The panel took into consideration that you have consistently insisted that you handed the pot of medication to Resident A, in keeping with her wishes and her care plan.

The panel in considering which account it preferred, on the balance of probabilities, determined that Ms 2's account provided in her email statement dated 16 July 2018 and the investigation meeting minutes dated 20 November 2019 was clear and consistent. The panel noted that Ms 2's account is hearsay but that it is consistent with the account given by Witness 2 and Ms 1 and therefore decided to attach significant weight to Ms 2's account. The panel was of the view that there was no evidence before it to support that Ms 2 had any reason to fabricate her evidence. The panel therefore determined that it preferred the account of Ms 2 in that you did leave medication for Resident A unattended on a table.

The panel next considered whether you, on 9 July 2018, did not ensure the medication for Resident A was correctly administered.

The panel had regard to the care plans of Resident A. The panel took into account the Care UK's Medication management policy issued April 2018, specifically section 5.3 and 5.4. The panel took into account that you stated in oral evidence and in the investigation meeting with Witness 2, on 15 October 2018 that you did administer the medication in line with Resident A's wishes and her care plan, in that *'she likes to take her medication in a pot in her hand and she will remove the medication from the pot with her hand and will take it by herself'*.

However, you accepted that you left Resident A unattended whilst she was in possession of the medication. You explained to the panel that you knew Resident A well. You told the panel that she would only take her medication with water that had been poured freshly from a tap. Whilst you had given her the medication you accepted in your oral evidence that you turned your back to go and get some water for Resident A, but stated it was only for a moment (up to a minute). You stated that when you turned around the medication was gone and that you were unaware who took it. The panel took into account that you

accepted in oral evidence that you did not follow the correct procedure in that you should have brought water to Resident A with the medication at the same time.

The panel therefore determined that charge 1b, is found proved.

Charge 1c and 1d

> "That you, a registered nurse, adopted unsafe medication practices in that you:
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> …
>
> c) On the 23 August 2018, pre-potted medication for residents and placed this on a dressing trolley.
>
> d) On the 23 August 2018 pre-signed MAR charts prior to medication administration."

These charges are found proved.

In reaching this decision, the panel had regard to its previous finding that pre-potting medication is unsafe medication practice. The panel also determined that pre-signing MAR charts prior to medication administration is unsafe medication practice in that it can result in inaccurate or false records which puts patients at risk of harm of being administered incorrect medication or failing to be administered medication at all.

The panel considered whether on the 23 August 2018 you pre-potted medication for residents and placed this on a dressing trolley. The panel noted that it is accepted by both the NMC and you that on 23 August 2018 you were pushing a dressing trolley which had medication pots and a jug of water on it.

The panel took into account Witness 1's account provided in her local statement dated 23 August 2018, NMC witness statement signed and dated 5 September 2019 and her oral evidence. Witness 1 stated that she noted you pushing a dressing trolley with pots of

medication and no MAR charts. She stated she asked you what you were doing, and you responded, at the time, that you were doing the evening drug round. Witness 1 stated that she then asked you why you had potted the medication and were using the dressing trolley instead of the medication trolley and the MAR charts. She stated that you responded, *'What do you mean I am doing the evening drug round.'* Witness 1 stated that whilst she was questioning you, you quickly pushed the trolley to the nurse's office.

The panel had regard to the Care UK Serious incident report dated 28 August 2018 provided by Ms 1, in which it was stated:

> *'At approximate 18:15pm, on 23/08/18, [Witness 1] witnesses [Mr Sungkur] … pushing the trolley used to carry wound dressings down the corridor by room 26 with medication pre potted containing liquid and tablet medications. There were no MAR charts on the trolley.*
>
> *[Witness 1] asked [Mr Sungkur] what he was doing; [he] replied that he was doing the evening drug round.'*

The panel took into consideration that you have consistently denied this allegation and stated in oral evidence and in the investigation meeting with Witness 2, on 15 October 2018, that you have never pre-potted medication. You stated that, at the relevant time, you had cleared medication left in a resident's room, who had been discharged, and were heading to the nurse's office. In your reflective piece dated 8 August 2022, you stated *'As I was doing medication the (sic) round, I came to notice the non-medication trolley in [room] 26.'*

You accepted that you were pushing a dressing trolley when you were seen by Witness 1. Your position was that the resident who occupied room 26 had been provided with their own carers. You stated when it was time for this resident to leave a new prescription was ordered and the drugs, she had been supplied with for use in the Home, had been left

behind. The drugs that had been left behind were not kept where other drugs were but were kept in a drawer in room 26.

As a result, it was your position that you were pushing a trolley which contained medication pots, a jug of water and creams. In your more recent accounts, you also stated that the dressing trolley contained drugs (paracetamol), inhalers and Ensure supplementary drink. The panel also noted that in your disciplinary hearing dated 27 February you provide a different timeline of events.

The panel in considering which account it preferred, on the balance of probabilities, determined that Witness 1's account provided in her local statement, NMC witness statement signed and dated 5 September 2019, and her oral evidence was clear and consistent. The panel considered that your explanation of being seen pushing a dressing trolley which contained drugs, jugs of water and medication pots was inherently unlikely. It was improbable that, having administered medication, the person doing so would have left behind the pots. It is also unlikely that the Resident's drugs would be left in the room following discharge. On 27 February 2019 you said, at a disciplinary hearing, that you interrupted a drug round to deal with the mess in the room. You had no reason to go into that room whilst on your drug round. If a room had been left in a mess it would have been tidied by an assistant whilst changing the bedding.

Further the evidence of Witness 1 was corroborated by the Care UK Serious incident report dated 28 August 2018. The panel was of the view that there was no evidence before it to support that Witness 1 had any reason to fabricate her evidence. The panel therefore determined that on the balance of probabilities, it preferred the account of Witness 1.

The panel therefore found charge 1c proved.

The panel next considered whether on the 23 August 2018 you pre-signed MAR charts prior to medication administration. The panel noted that it is accepted by both parties that

the MAR charts for the residents were not on the dressing trolley, they were in the nurse's office, at the relevant time.

The panel took into account the Care UK's Medication management policy issued April 2018, specifically section 5.3 and 5.4. The panel noted that a resident must be administered medication before their MAR chart can be signed as "*given*" in case of refusal or if the medication is not taken due to unavailability of the resident or the medication.

The panel took into account that the correct procedure for medication administration was evidenced by witnesses, you and the Care UK's Medication management policy. The panel noted that it is clear that the MAR charts are taken with the nurse during a medication round and signed after the resident receives their medication. Witness 1 confirmed you were aware of this policy in light of the fact she assessed your medicine competency and successfully signed you off as competent on 23 July 2018.

The panel took into consideration that Witness 1 stated in her NMC witness statement signed and dated 5 September 2019:

> *'The first thing that caught my attention when I saw [Mr Sungkur] on the corridor was that he was transporting the medication not in a medication trolley with the Mar charts, but on a dressing trolley with no MAR charts.*
>
> *…*
>
> *Following the incident, I immediately call the Home Manager, [Ms 1] and informed her about what had happened. The MAR charts were checked and all the resident's medications had been signed off by [Mr Sungkur] as "given".'*

The panel took into consideration Witness 1's email to the NMC dated 22 November 2022 in which she confirmed she witnessed the incident then checked all medications were

signed as administered. Witness 1 stated *"he had signed as administered for all medication due at tea time but he clearly had medicine pots with medication on the trolley before he went into the toilet and when he came out the pots were empty".*

The panel had regard to the Care UK Serious incident report dated 28 August 2018 provided by Ms 1, in which it was stated:

> *'All the MAR charts have been signed as medication administered by [Mr Sungkur], I am unable to confirm if the MAR charts were signed prior to medication being administered or after [Mr Sungkur] came out of the toilet whilst [Witness 1] was …escorting [Mr Sungkur] out of the home.'*

The panel had regard to your oral evidence and your account provided during the investigation meeting with Witness 2, on 15 October 2018, in which you stated that during your interaction with Witness 1 in the corridor you went to the nurse's office, and she pushed past you to check the MAR charts. You stated Witness 1 opened the MAR charts and briefly checked them.

The panel in considering which account it preferred, on the balance of probabilities, determined that Witness 1's account provided in her local statement, NMC witness statement signed and dated 5 September 2019, and her oral evidence was clear and consistent. Further it was corroborated by the Care UK Serious incident report dated 28 August 2018. The panel also noted that it had made a finding that there was no evidence before it to support that Witness 1 had any reason to fabricate her evidence. The panel therefore determined that it preferred the account of Witness 1 in that there were no MAR charts on the trolley, and when she checked the MAR charts they were signed as *'given'*. Having taken into account that you stated, Witness 1 checked the MAR charts during your interaction in the nurse's office on 23 August 2018, the panel determined that it was more likely than not that you pre-signed the MAR charts prior to administering the medication. In reaching this decision the panel took into account that it has found charge 1c proved.

The panel therefore found charge 1d proved.

Charge 2

> "Your actions at 1d above were dishonest in that you knew at the time of signing no medication had then been administered."

This charge is found proved.

In considering this charge the panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords Club)* [2017] UKSC 67. The panel also took into account the NMC guidance titled *'Making decisions on dishonesty charges and the professional duty of candour',* reference *'DMA-8',* last updated 27 February 2024, which states that when making decisions on charges involving dishonesty panels need to consider:

- *'what the nurse, midwife or nursing associate knew or believed about what they were doing, the background circumstances, and any expectations of them at the time*
- *whether the panel considers that the nurse, midwife or nursing associate's actions were dishonest, or*
- *whether there is evidence of alternative explanations, and which is more likely.'*

The panel took into account that it had found charge 1d proved in that you pre-signed MAR charts prior to administering medication. The panel took into consideration that it had found charge 1c proved and accepted the account of Witness 1, in that she caught you undertaking an evening drug round having pre-potted medication, whilst also not in possession of the MAR charts. The panel determined that you knowingly falsified patient records by signing the MAR charts as *"given"*, when you had not yet administered the medication to residents. In doing so you were attempting to create an inaccurate impression that you had administered medication to residents when you had not.

The panel determined that your conduct would be deemed dishonest by the standards of *'ordinary decent people'.* The panel took into consideration the working environment of the Home in that you were short staffed. The panel had regard to your conduct after being caught by Witness 1, in that you rushed and pushed the trolley to the Nurse's office, where the MAR charts were at the relevant time. The panel determined that you were attempting to conceal the fact that you were administering medication having pre-signed MAR charts. The panel concluded that your conduct at charge 1d was dishonest in that you knowingly signed resident's MAR charts as "given" when you had not administered the medication, in order to take an administrative shortcut. The panel determined that there was no evidence of an alternative explanation for your conduct at charge 1d.

The panel therefore found charge 2 proved.

Charge 3

"When challenged about your conduct at charge 1c, above:

(a) blocked the Regional Clinical Lead from taking a photograph,

(b) took the trolley into the toilet and disposed of the medication."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's account provided in her local statement dated 23 August 2018, NMC witness statement signed and dated 5 September 2019 and her oral evidence. Witness 1 stated that whilst she was questioning you, you quickly pushed the trolley to the nurse's office. She tried to take a photograph of the trolley but that you prevented her from doing so by blocking the trolley with your body. Witness 1 stated whilst you were trying to push the trolley into the nurse's office, the jug of water on the trolley fell and spilt. She stated that you then moved the trolley out of the nurse's office, and she was behind you attempting to take a photo. Witness 1 stated that you then went into the toilet with the dressing trolley and locked the door. She stated she knocked on the door and asked you to open it. Witness 1 stated that whilst you were in the

toilet she could hear the flushing of the toilet and water running. She stated when you exited the toilet, there was no longer medication on the trolley and when she asked you what you did with the medication in the pots, you stated there was no medication.

The panel had regard to the Care UK Serious incident report dated 28 August 2018 provided by Ms 1 in which it is stated that:

> *'Whilst [Witness 1] was asking [Mr Sungkur] he rushed and pushed the trolley in the nurse's office…. [Witness 1] went to take a photo of the trolley and the pre potted medication, [Mr Sungkur] saw that [Witness 1] was going to take a photograph of the trolley and pre-dispensed medication and positioned him-self in front of her and the trolley so she was not able to take the photo as evidence. [Mr Sungkur] then went on to push the trolley into the nurse's station when the jug of water on top of the trolley fell and split over the floor and trolley.*
>
> *[Mr Sungkur] then continued to push the (sic) out of the nurse's office and pushed it into the communal toilet and locked himself inside. The medication was still in pots on the trolley at this point.*
>
> *[Witness 1] knocked on the toilet door asking [Mr Sungkur] to come out which he refused shouting at her. [Witness 1] heard the toilet flush whilst ...(sic) was inside.*
>
> *When [Mr Sungkur] finally came out of the toilet, [Witness 1] noticed that the pots were empty.'*

The panel had regard to Witness 3's account provided in her NMC witness statement signed and dated 24 April 2024 and her oral evidence. Witness 3 stated in her NMC witness statement that:

> *'…I heard raised voices in the corridor. There was a male voice, which I believed to be [Mr Sungkur]…He sounded very angry. This continued for a few minutes. The*

next thing I heard was [Witness 1] shouting "open the door! Why are you locking yourself in?" I then dipped out of the patient's room to see what was happening. [Mr Sungkur] sounded so angry that I thought the two of them were going to get into a physical fight and I was concerned about [Witness 1].

[Witness 1] continued to bang on the door and shout for [Mr Sungkur] to open it. I could see it was the toilet door. A few minutes later [Mr Sungkur] cam out of the toilet with the trolley. From memory, I could not see anything on the trolley at that point.'

The panel noted that Witness 3 previously stated during a local investigation meeting on 5 September 2018 that she did not know if you came out of the toilet with the medication trolley. However, the panel heard consistent evidence that it was a dressing trolley not a medication trolley that was involved in the incident that day. The panel noted Witness 3 during her investigation meeting on 5 September 2018, appeared fearful in that she did not immediately respond to the questions asked to her and only provided a response when she was assured that she would be protected. In an investigation meeting on 5 November 2018, Witness 3 stated she saw you come out of the toilet with the dressing trolley.

The panel determined that there was no evidence before it to suggest that there is any reason for Witness 3 to fabricate her evidence. The panel noted that both yourself and Witness 3 stated that you did not know one another, and this was the first time Witness 3 had worked on your unit. The panel had regard to the fact that Witness 3 during her oral evidence was consistent and clear that she has seen you leave the toilet with a dressing trolley.

The panel noted that you accepted that Witness 1 was trying to take a photograph of the trolley. The panel took into account that you stated in oral evidence, that you were trying to go to the nurse's office, to get the MAR charts, when Witness 1 pushed you aside so she could access the MAR charts herself. You stated that Witness 1 then pushed the trolley

aggressively towards you. You stated your finger was injured in the process and a jug of water spilt on the trolley, the floor and you. You stated that you then went into the toilet to attend to your injury and to change your upper clothing, and you denied that you took the dressing trolley in with you. You accepted that Witness 1 was banging on the toilet door and that there were raised voices. The panel noted some inconsistencies in your accounts, provided in the investigation meeting with Witness 2 on 15 October 2018, your oral evidence and your response to the regulatory concerns dated 8 August 2022, in relation to the order of events, your injured hand and the spilt jug of water.

The panel in considering which account it preferred, on the balance of probabilities, determined that Witness 1's account provided in her local statement, NMC witness statement signed and dated 5 September 2019, and her oral evidence was clear and consistent. Further it was corroborated by the Care UK Serious incident report dated 28 August 2018 provided by Ms 1 and the evidence of Witness 3. The panel also noted that it had made a finding that there was no evidence before it to support that Witness 1 had any reason to fabricate her evidence. The panel therefore determined that it preferred the account of Witness 1 in that you did block her from taking a picture of the dressing trolley. You did enter the toilet with the dressing trolley, containing pre-potted medication, and whilst you were in the toilet Witness 1 heard the toilet flushing and running water, and when you exited the toilet there was no longer any medication on the trolley. The panel therefore concluded that it was more likely than not that you disposed of the medication in the toilet.

Accordingly, the panel determined that on the balance of probabilities charge 3a and 3b are found proved.

Charge 4

> "Your actions at charge 3 above were dishonest in that you sought to conceal your unsafe medication practice."

This charge is found proved.

In considering this charge the panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords Club)* [2017] UKSC 67. The panel also took into account the NMC guidance titled *'Making decisions on dishonesty charges and the professional duty of candour',* reference *'DMA-8',* last updated 27 February 2024.

In reaching this decision, the panel took into account its previous finding that pre-potting medication is unsafe medication practice.

The panel took into account that it had found charge 3 proved in that you did block Witness 1 from taking a photograph of the dressing trolley and you did take the trolley into the toilet to dispose of the pre-potted medication. The panel determined that you knowingly blocked Witness 1 from taking a photograph; in doing so you were attempting to conceal the fact that you had pre-potted medication. Further you intentionally disposed of the pre-potted medication in the toilet so that you could conceal the fact that you had pre-potted medication.

The panel determined that your conduct would be deemed dishonest by the standards of *'ordinary decent people'.* The panel took into consideration the working environment of the Home in that you were short staffed. The panel had regard to your conduct after being caught by Witness 1, in that you quickly pushed the trolley to the nurse's office, blocked her from taking a photograph of the trolley and then locked yourself in the bathroom with the trolley. The panel determined that you were attempting to conceal the fact that you had pre-potted medication. The panel concluded that your conduct at charge 3 was dishonest in that you intentionally attempted to conceal your unsafe medication practice. The panel determined that there was no evidence of an alternative explanation for your conduct at charge 3.

The panel therefore found charge 4 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 ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

Mr Malik invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code).

Mr Malik identified the specific, relevant standards where your actions amounted to misconduct. Mr Malik submitted that your actions fell seriously short of the standards expected of a Registered Nurse in that you adopted unsafe medications practice by pre-

potting medication, leaving medication unattended and pre-signing MAR charts prior to medication administration. Mr Malik submitted that your failings are directly linked to your clinical practice. He submitted that you put residents at risk of harm as unsafe medications practice results in increased risk of medications being administered to residents incorrectly. Mr Malik submitted that you have been found to have acted dishonestly on two occasions. He submitted that honesty and integrity are fundamental tenets of the nursing profession.

Mr Malik therefore submitted that the charges found proved are serious and amount to misconduct.

Mr Buxton acknowledged that the findings of the panel are serious. He conceded that the charges relating to your unsafe medication practice and dishonesty would amount to misconduct with the exception of charge 1b.

Mr Buxton submitted that charge 1b would not amount to misconduct as it was act of omission or mere negligence rather than an egregious breach of professional standards. Mr Buxton referred the panel to the Investigation report dated 11 February 2019 provided by Witness 2. Mr Buxton submitted that, *'it was unlikely that residents living with dementia were walking around and would have been able to pick up medication which was placed next to AM in a medicine pot'.*

Mr Buxton submitted that Resident A was well known to you, and you had administered mediation to her over a period of 2 years. Mr Buxton submitted that you strive to provide person centred care and therefore administered the medication in keeping with Resident A's wishes, at the time. Mr Buxton acknowledged that you did turn your back to Resident A in order to get her water. However, Mr Buxton submitted that no harm was caused as the medication was removed by Ms 2.

Mr Buxton submitted that although you neglected to strictly adhere to the medication administration protocol/guidance your actions, at charge 1b, do not amount to misconduct.

Submissions on impairment

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

Mr Malik submitted that all four limbs of '*Grant'* test are engaged. He submitted that the charges found proved are serious especially in light of the two findings of dishonesty. He submitted that your actions put patients at risk of unwarranted harm due to you undertaking unsafe medications practice. Mr Malik submitted that you breached fundamental tenets of the nursing profession and brought it into disrepute.

Mr Malik submitted that dishonesty is inherently difficult to remediate and is indicative of behavioural/attitudinal issues. Mr Malik submitted that your failings are directly linked to your clinical practice. Mr Malik submitted that you have demonstrated a lack of insight and have failed to address the regulatory concerns identified. Mr Malik therefore submitted that there remains a high risk of repetition.

Mr Malik therefore submitted that a finding of impairment is required in order to protect the public given the risk of repetition and subsequent risk of harm.

Furthermore, Mr Malik submitted that a finding of impairment is required in order to address the public interest. He submitted that Registered Nurses hold a position of trust, and the public expects Registered Nurses to conduct themselves with honesty and integrity. Mr Malik submitted that the public's trust and confidence would be severely undermined given that you have been found to have breached your duty of candour. Additionally, a finding of impairment is required in order to uphold the standards of conduct expected of a Registered Nurse.

Mr Buxton submitted that a finding of impairment is not required on the ground of public protection. Mr Buxton submitted that these events occurred over 6 years ago and informed the panel that you have been employed for the last three years by Excelcare with no further concerns raised regarding the areas of regulatory concern. Mr Buxton referred the panel to the testimonials provided in support of your practice.

Mr Buxton referred the panel to the training certificates you have provided. He submitted that you have strengthened your practice and addressed the areas of regulatory concern.

Mr Buxton referred the panel to your reflective pieces dated 23 August 2019, 23 August 2020, 23 August 2021, 8 August 2022, 23 August 2022, 20 December 2022, 23 August 2023 and 23 August 2024. Mr Buxton submitted that you have acknowledged and demonstrated an understanding of the importance of safe medication administration and management. Mr Buxton informed the panel that your medication competency is tested annually by your new employer. Mr Buxton submitted that you have acknowledged and addressed the importance of honesty and integrity in healthcare. Mr Buxton submitted that you seek to provide person-centred care, and the safety of residents is at the forefront of your mind.

Mr Buxton submitted that the risk of repetition is low given that you have strengthened your practice, demonstrated insight and addressed the areas of regulatory concern. Mr Buxton therefore submitted that a finding of impairment is not required on the ground of public protection.

Mr Buxton conceded that a finding of impairment may be required on the ground of public interest given the findings of dishonesty, in order to declare and uphold the standards of conduct expected of a Registered Nurse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000]

1 A.C. 311, *Mallon v General Medical Council* [2007] ScotCS CSIH_17, *Biswas v General Medical Council* [2003] EWHC 2342, *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Sawati v General Medical Council* [2022] EWHC 283 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that 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:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***4 Act in the best interests of people at all times***
> *To achieve this, you must:*
> *4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*
> *4.2 make sure that you get properly informed consent and document it before carrying out any action*
>
> ***8 Work co-operatively***
> *To achieve this, you must:*
> *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:

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

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

To achieve this, you must:

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

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.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct and that there requires to be a significant falling short of the standards expected before it could find misconduct.

The panel considered whether each charge amounted to misconduct.

Charge 1a and 1c

The panel determined that your actions at charge 1a and 1c amounted to misconduct. In reaching this decision the panel took into account that pre-potting medication is unsafe medication practice and presents a risk of harm to residents, as previously identified. The panel also noted that you agreed that pre-potting medication was unsafe medication practice. The panel took into account that correct medication administration and management is a fundamental tenet of the nursing profession. The panel noted that your actions at charge 1a and 1c were deliberate and directly linked to your clinical practice. The panel therefore determined your actions, at charge 1a and 1c, fell significantly short of the standards expected of a Registered Nurse and amounted to misconduct

Charge 1b

The panel determined that your actions at charge 1b amounted to misconduct. In reaching this decision the panel took into account that leaving medication unattended and not ensuring it is correctly administered is unsafe medication practice and presents a risk of harm to residents, as previously identified. The panel also noted that leaving Resident A unattended with the tablet posed a risk to her and also the risk of not knowing whether she had successfully taken her medication. The panel had regard to the fact that it heard evidence that at least one other resident was in close proximity to Resident A and other residents may have also been in the same room. The panel took into account that correct medication administration and management is a fundamental tenet of the nursing profession. The panel noted that your actions were directly linked to your clinical practice.

The panel therefore determined your actions at charge 1b, fell significantly short of the standards expected of a Registered Nurse and amounted to misconduct.

Charge 1d

The panel determined that your actions at charge 1d amounted to misconduct. In reaching this decision the panel took into account that pre-signing MAR charts prior to medication being administered is unsafe medication practice and presents a risk of harm to residents, as previously identified. The panel had regard to the fact that MAR charts are legal documents. The panel took into account that accurate record keeping is a fundamental tenet of the nursing profession. The panel noted that your actions at charge 1d were deliberate, in order to conceal your unsafe medication practice and were directly linked to your clinical practice. The panel therefore determined your actions, at charge 1d, fell significantly short of the standards expected of a Registered Nurse and amounted to misconduct

Charge 2 and 4

The panel determined that your actions at charge 2 and 4 amounted to misconduct. In reaching this decision the panel took into account that Registered Nurses have a duty of candour. Additionally, honesty and integrity are fundamental tenets of the nursing profession. The panel noted that your actions at charge 2 and 4 were deliberate and directly linked to your clinical practice in that you were attempting to conceal your unsafe medication practice. The panel therefore determined your actions, at charge 2 and 4, fell significantly short of the standards expected of a Registered Nurse and amounted to misconduct.

Charge 3a and 3b

The panel determined that your actions at charge 3a and 3b amounted to misconduct. In reaching this decision the panel took into account that your actions at charge 3a and 3b,

intended to conceal your unsafe medication practice and prevent a colleague's attempt at gathering evidence to make a formal disclosure of your poor clinical practice. Your actions were also demeaning and disrespectful towards your colleagues. The panel noted that honesty and integrity are fundamental tenets of the nursing profession. Further your actions in disposing the medication resulted in confusion as to whether residents had or had not been administered their medication as prescribed, resulting in a risk of harm to residents. The panel took into account that correct medication administration and management is a fundamental tenet of the nursing profession and a requirement of the Medication Management Policy of the Home, in addition to the Code. The panel noted that your actions at charge 3a and 3b were deliberate and directly linked to your clinical practice. The panel therefore determined your actions, at charge 3a and 3b, fell significantly short of the standards expected of a Registered Nurse and amounted to misconduct.

The panel found that your actions 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.

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

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

In this regard the panel considered the test of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 76, she said:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel determined that all four limbs of the '*Grant'* test were engaged. The panel found that patients were put at risk of harm, as previously identified, as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Further it determined that you had in the past acted dishonestly.

In considering whether you are liable in the future to repeat this behaviour, the panel first considered whether the misconduct in this case is capable of being addressed. The panel took into account that your misconduct in relation to unsafe medication practice is capable of being addressed through retraining. However, the panel noted that your misconduct in

relation to your dishonesty is inherently more difficult to remediate. The panel also noted that your conduct is suggestive of attitudinal concerns which is more difficult to address. The panel took into consideration that you acted dishonestly in order to conceal your unsafe medication practice. Further you sought to blame colleagues in order to conceal your unsafe medication practice, linking the dishonesty directly to your clinical practice.

The panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice.

The panel noted that you have undertaken some training to address the areas of regulatory concern. The panel noted that some of the training certificates you provided, although demonstrating your continuing professional development, they do not address the areas of regulatory concern. The panel also took into consideration that some of the training certificates you provided are mandatory training modules. The panel noted that you have not undertaken further training in areas relating to the regulatory concerns.

Further the panel was mindful that on 23 July 2018 you were signed off as having successfully passed your medication knowledge competency assessment having achieved 100% and yet some of the charges involving unsafe medication practice occurred one month later, on 23 August 2018. The panel was of the view that you appear to understand the policies and procedure of medication administration and management in theory, but you chose to ignore theses policies and procedures and take an administrative shortcut. The panel noted that this is suggestive of attitudinal issues. The panel determined that you have yet to sufficiently demonstrate that you would implement this knowledge in your clinical practice.

The panel was not satisfied you have strengthened your practice to sufficiently address the regulatory concerns, specifically in relation to medication administration and management, record keeping and duty of candour.

The panel took into account that you stated that it has been six years since the concerns were raised, you have been practising for the last three years as a Registered Nurse with Excelcare, and no further concerns have been raised regarding the areas of regulatory concern. The panel considered the 15 testimonials provided by you.

The panel took into account that of the 15 testimonials provided, 11 were generic in content and contained the following statement:

> *'To Whom it may concern,*
>
> *This testimonial is to certify that [your name was hand written here] has embraced the ATLAS system of medication management by using the electronic administration chart (EMAR) where medications are administered in a timely manner.*
>
> *I have witnessed him administering medication to residents on many occasions safely and competently according to policy and procedures.*
>
> *He also reflects and learns from any incidents that arise.'*

The panel noted that these 11 testimonials were signed and dated either 22 September 2024 (four testimonials), 28 September 2024 (four testimonials), 29 September 2024 (one testimonials) or 7 October 2024 (two testimonials).

The panel found these testimonials to be somewhat nebulous, they appeared to attest to your understanding and application of a system of medicines administration and to the fact that you have *"safely and competently"* administered medication on *"many occasions".* However no further evidence of this was provided. The testimonials also stated that you *"reflect and learn from incidents that arise"* but no further information was provided as to whether this is reflecting and learning on incidents concerning this system or a wider

interpretation. The panel noted that none of these 11 testimonials spoke to the dishonesty charges found proved.

The panel therefore gave limited weight to these 11 testimonials.

The panel took into account that of the 15 testimonials provided, three testimonials were bespoke. The first testimonial dated 13 July 2022 appeared to speak of your work and character at unknown periods between 1990 and 2004, the letter contained no suggestion that the author knew the details and background of the charges you faced during this hearing.

The second testimonial, dated 7 August 2022, concerned the author's knowledge of your working practice between 2015 and 2018 and whilst the author conceded to knowing you faced four charges, there was no mention of the dishonesty charges.

The final bespoke testimonial, dated 8 August 2022, is from another former colleague who speaks to his working relationship with you between 2010 and 2013, this person stated that he has '*seen allegations made'* against you, but is silent on what these allegations were or are.

In relation to these three testimonials the panel determined to give them little weight as they were largely historical and did not address the charges or regulatory concerns.

The last testimonial provided by you was a document entitled *"Team appreciation day"* and was a corporate *'thank you'* to staff from the CEO and COO, it was undated, does not specifically mention you, nor the charges proved. The panel therefore gave this no weight as a testimonial.

The panel noted that you have provided reflective pieces and have given oral evidence. The panel took this into account when considering whether you have demonstrated insight to sufficiently address the regulatory concerns, including dishonesty.

The panel recognised your right to reject/dispute the allegations. The panel noted that in the reflective pieces you have provided, you have demonstrated an understanding of the importance of correct medication administration and management and acting with honesty and integrity. Further you have demonstrated an understanding of the impact of, failing to act with honesty and integrity and unsafe medication practice, on residents, colleagues and the wider public. However, the panel was not satisfied that you have demonstrated sufficient insight in relation to the attitudinal concerns identified, how you would mitigate these concerns, nor how you would handle a similar situation differently in the future.

The panel therefore determined that there is a risk of repetition given that you have not sufficiently addressed the areas of regulatory concern nor demonstrated sufficient insight in relation to the attitudinal concerns identified. In reaching this decision the panel took into account that you disputed all charges and challenged the evidence of witnesses. The panel appreciated that it was unrealistic to expect you to express remorse and address the findings of the panel in the short time between the handing down of the decision and reasons on facts and submissions on impairment. However, there was a gap between your theoretical appreciation of how serious the charges were and your practical means of addressing the charges.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection given the risk of repetition and subsequent risk of harm identified.

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

The panel determined that a finding of impairment on public interest grounds is required as the public's trust and confidence in the profession would be severely undermined if a

finding of impairment was not made in this case given the nature of the charges including two counts of dishonesty. The panel concluded that a finding of impairment was required in order to uphold the standards of conduct expected of a Registered Nurse.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

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

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

Submissions on sanction

Mr Malik informed the panel that in the Notice of Hearing, dated 30 September 2024, the NMC had advised you that it would seek the imposition of a striking off order if it found your fitness to practise currently impaired.

Mr Malik submitted that the following aggravating features are present in this case:

- Dishonesty directly linked to clinical practice
- Sustained dishonest conduct
- Attitudinal concerns
- Limited remediation, insight and remorse

Mr Malik submitted that there are no mitigating features present in this case.

Mr Malik submitted that, in relation to the panel imposing no action or a caution, neither would be proportionate or appropriate given the serious nature of the charges found proved including two findings of dishonesty. Further neither outcome would sufficiently protect the public nor address the public interest concerns identified.

Mr Malik referred the panel to NMC Guidance *'conditions of practice order'*, reference '*SAN-3c'* last updated 28 January 2020. Mr Malik submitted that there is evidence that residents were put at risk of harm. He submitted that you have demonstrated a pattern of sustained dishonest behaviour linked to your clinical practice. Further you sought to blame colleagues to conceal your unsafe medication practise. Mr Malik submitted that you have undertaken some training but the training you have undertaken does not address the areas of regulatory concern. Mr Malik referred to the panel's previous finding that it was not satisfied that you have sufficiently strengthened your practice or demonstrated sufficient insight in relation to the attitudinal concerns identified. Mr Malik submitted in the absence of sufficient evidence of insight, strengthening of practice and remediation there is a significant risk of repetition. Mr Malik submitted that a conditions of practice order would not be appropriate given the nature of the concerns in that you have been found to have been dishonest on two occasions and attitudinal issues have been identified. Mr Malik submitted that there are no workable conditions that could be formulated to address the regulatory concerns identified and sufficiently protect the public and address the public interest.

Mr Malik referred the panel to NMC Guidance *'suspension order'*, reference '*SAN-3d'* last updated 12 October 2018. Mr Malik submitted that your actions are fundamentally incompatible with remaining on register. He submitted that the charges found proved are very serious including deep-seated attitudinal concerns. Mr Malik submitted that this was not a one-off instance of misconduct. He submitted that your insight is very limited and there is a significant risk of repetition. Mr Malik therefore submitted that a suspension order is not appropriate nor proportionate as it would not adequately address the public interest concerns identified.

Mr Malik referred the panel to NMC Guidance *'striking-off order'*, reference '*SAN-3e'* last updated 30 August 2024. Mr Malik submitted that the nature and seriousness of the charges found proved calls into question your integrity and professionalism. He submitted that the public's trust and confidence in profession can only maintained with a striking-off order. He submitted that your actions are significant departures from the standards expected of Registered Nurse and are fundamentally incompatible with remaining on register. Mr Malik therefore invited the panel to impose a striking-off order as the only appropriate and proportionate order in this case.

Mr Buxton submitted that striking-off would be disproportionate. He highlighted that the purpose of imposing a sanction is not to punish a registrant for past wrongdoing but to impose the least restrictive sanction which sufficiently protects the public and addresses the public interest concerns identified.

Mr Buxton submitted that you have engaged with NMC proceedings. He submitted that you are an experienced nurse and that this is the first time you have been referred to the NMC in respect of medication administration and management and dishonesty. Mr Buxton invited the panel to consider the contextual environment in which the charges found proved occurred. Mr Buxton submitted that it has been six years since these incidents have occurred and there have been no further concerns raised regarding your practice. Mr Buxton informed the panel that [PRIVATE]. Mr Buxton submitted that you would be negatively impacted financially if your practice was restricted.

Mr Buxton submitted in relation to your dishonest conduct that it was an isolated instance, and you did not benefit personally. Mr Buxton submitted that you have undertaken training and have been observed having correctly and competently administered and managed medication. Mr Buxton submitted that you have demonstrated insight and have stated that you will learn and act differently. Mr Buxton submitted that you can practise kindly, safely and professionally and that you have provided evidence to support this assertion. Mr Buxton referred the panel to the evidence you have provided of your continued training and professional development, testimonials and reflection. Mr Buxton emphasised that there has been no repetition of the regulatory concerns since the charges occurred.

Mr Buxton invited the panel to impose a conditions of practice order as the appropriate and proportionate order. Mr Buxton submitted that a conditions of practice order could be formulated which would sufficiently address the clinical concerns which are the substance of this case. However, Mr Buxton acknowledged that two findings of dishonesty have been made against you and submitted that a period of supervised practice would ensure improved standards of behaviour and would bring any indiscretion to the immediate attention of the regulator.

Mr Buxton submitted that if the panel is not minded to impose a conditions of practice order, then he invited it to consider a suspension order which would sufficiently protect the public by temporarily removing you from practice and would send a message to the wider public ensuring that confidence and trust is maintained in the profession and the regulator.

Mr Buxton submitted that a striking-off order would be wholly disproportionate and unduly punitive, for the reasons previously outlined.

Decision and reasons on sanction

Having heard submissions from Mr Malik and Mr Buxton the panel then went on to consider which sanction to impose having regard to the SG. It started by considering aggravating and mitigating features.

The panel considered the following features to be aggravating:

- The nature of your defence, which sought to discredit others in order to conceal your unsafe medication practice
- Abuse of position of trust
- Dishonesty directly linked to clinical practice
- Limited remediation, insight and remorse
- Conduct which put patients and colleagues at risk of suffering harm

The panel considered that there were no mitigating features present in this case. However, the panel had regard to its previous finding, in relation to the contextual circumstances in which the regulatory concerns arose, in that there were staffing issues at the relevant time in the Home.

In considering which sanction to impose the panel first determined the seriousness of the charges found proved.

The panel had regard to the NMC guidance *'Considering sanctions for serious cases'*, reference *'SAN-2'* last updated 27 February 2024. The panel determined that you deliberately '*breached your professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care'*. The panel took into consideration that it had made a finding that you acted dishonestly by intentionally attempting to conceal your unsafe medication practice including pre-potting medication and pre-signing MAR charts prior to medication administration. The panel determined that your actions in concealing your unsafe medication practice put vulnerable residents at direct risk of harm, as previously identified. The panel noted that you deliberately misused your power by taking administrative shortcuts in your medication administration and

management and record keeping. The panel concluded that your dishonest conduct was premeditated and directly linked to your clinical practice.

The panel had regard to the NMC guidance *'Serious concerns which are more difficult to put right'*, reference *'FTP-3a'* last updated 27 February 2024. The panel determined that you breached your *'professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague …who wants to raise a concern, … or otherwise contributing to a culture which suppresses openness about the safety of care'.* In reaching this decision the panel noted that it had made a finding that you physically obstructed a colleague from obtaining evidence of your unsafe medication practice. Further you sought to blame colleagues in order to conceal your unsafe medication practice.

The panel therefore determined that the dishonesty charges found proved are at the higher end of the spectrum of seriousness.

Having considered the nature and seriousness of the charges the panel next determined what, if any, was the appropriate sanction to impose.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate

in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG in that conditions may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

- *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 there are no practical or workable conditions that could be formulated, given the serious nature of the charges in this case, including two findings of dishonesty. The panel noted that it has made two findings of dishonesty and previously identified attitudinal concerns, it concluded that these are issues which are inherently more difficult to remediate and address through retraining. The panel took into account that it has determined that you, in the six years since the concerns arose, have not yet demonstrated sufficient insight, strengthening of practice or remediation to address the regulatory concerns identified and therefore there is a risk of repetition of this behaviour and subsequently a real risk of harm to residents, colleagues and the wider public.

The panel therefore concluded that the placing of conditions on your registration would not be appropriate nor proportionate. The panel determined that a conditions of practice order

would not be sufficient to protect the public and address the public interest concerns identified given the nature and seriousness of the charges found proved.

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

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

The panel noted that the serious breaches of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register. The panel determined that there is evidence of harmful deep-seated attitudinal problems. The panel took into account that there is no evidence before it of repetition of this behaviour since the incident. However, the panel noted that this does not diminish the seriousness of the charges found proved. Further the panel was not satisfied that you have demonstrated sufficient insight, strengthening of practice or remediation to address the areas of regulatory concern. The panel therefore determined that you pose a significant risk of repeating this behaviour.

In this particular case, the panel determined that a suspension order would not be an appropriate or proportionate sanction. The panel took into account that a suspension order would prevent you from practicing and therefore it would adequately protect the public for a limited period of time. However, a suspension order would not sufficiently address the public interest concerns identified given the nature and seriousness of this case.

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

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

The panel concluded that your actions were too serious for any other sanction to be appropriate and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were very serious and indicative of deep-seated attitudinal issues. The panel determined to allow you to continue practising would severely undermine the public's trust and confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Malik and Mr Buxton.

Mr Malik invited the panel to impose an 18-month suspension order in order to adequately protect the public and sufficiently address the public interest concerns identified, during any period of appeal.

Mr Buxton submitted that you have been working since the charges occurred. He invited the panel to consider allowing you to continue to work during the 28-day appeal period, so that you can put your affairs in order.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim

suspension order for a period of 18 months in order to adequately protect the public and sufficiently address the public interest concerns identified, during the period of any appeal.

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

That concludes this determination.