Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday 14 November 2024 – Friday 22 November 2024,
Wednesday 27 November 2024

Virtual Hearing

Name of Mr Tamarra:	**Dick Tamarra**
NMC PIN	05I0864O
Part(s) of the register:	Registered Nurse – Adult Nursing (September 2005)
Relevant Location:	Worcestershire
Type of case:	Misconduct
Panel members:	Dave Lancaster (Chair, Lay member) Karen Naya (Lay member) Sarah Jane Freeman (Registrant member)
Legal Assessor:	Jeremy Barnett (14 & 15 November 2024) Robin Hay (18 November – 22 November 2024, 27 November 2024)
Hearings Coordinator:	Emma Norbury-Perrott
Nursing and Midwifery Council:	Represented by Uzma Khan, Case Presenter
Mr Tamarra:	Not Present and unrepresented
Facts proved:	Charges 1, 2b, 2c, 4, 5, 6, 7, 8, 9, 10
Facts not proved:	Charges 2a, 2d, 3
Fitness to practise:	Impaired
Sanction:	**Striking-off order**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Tamarra was not in attendance and that the Notice of Hearing letter had been sent to his registered email address by secure email on 7 October 2024.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other matters, information about Mr Tamarra's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence. The panel had also seen an email from Mr Tamarra acknowledging he was aware of the proceedings.

In the light of all the information available, the panel was satisfied that Mr Tamarra has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Tamarra

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

Ms Khan referred the panel to an email sent by Mr Tamarra to his NMC case officer on 13 November 2024. It states:

'I'm happy for the panel to proceed without me. Many thanks.'

The panel accepted the advice of the legal assessor.

The panel was aware that its power to proceed in the absence of Mr Tamarra is discretionary and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Mr Tamarra. In reaching this decision, the panel has considered the submissions of Ms Khan, the correspondence from Mr Tamarra, and the advice of the legal assessor. It had regard to the overall interests of justice and fairness to all parties. It had in mind that:

- Mr Tamarra has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Seven witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2022 and 2023, and further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

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

he has made no response to the allegations. In conversations with the NMC case officer, he stated he would be submitting written evidence in response to the allegations, but despite multiple attempts by the NMC to obtain this, he has not done so. He will be unable to challenge the evidence relied upon by the NMC, nor will he be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Tamarra's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge (as amended)

That you, a registered nurse, whilst working as an agency nurse at the Worcester Royal Hospital:

On 16 April 2023 on the Surgical Assessment Unit

1. In relation to Patient A

    a. did not administer intravenous Pabrinex.
    b. recorded on the medication administration chart that you had administered Pabrinex, when you had not.
    c. signed the medication administration chart in the name of an unknown person to indicate that person had witnessed the administration of Pabrinex, when they had not.
    d. did not complete the fluid balance charts despite stating you had done so.
    e. inaccurately assessed their national early warning score (NEWS).
    f. did not follow Colleague A's instructions to continue observations.

2. In relation to Patient B

a. did not administer
    i. Allopurinol,
    ii. Atorvastatin,
    iii. Ferrous Fumarate and
    iv. Amlodipine
b. did not administer intravenous Flucloxacillin
c. left one or more of the medications listed at 2a(i) to (iv) unsecured on the bedside table.
d. recorded on the medication administration chart that you had administered, those listed at 2a (i) to (iv) when you had not.

3. In relation to Patient C

    a. did not administer
        i. Perindopril,
        ii. Lansoprazole and
        iii. Ferrous Fumarate Bisoprolol
    b. recorded on the medication administration chart that you had administered those listed at 3a(i) to (iii) when you had not.

4. In relation to Patient E did not administer intravenous Gentamycin.

5. Acted in a manner that was:
    i. inappropriate and/or
    ii. unprofessional and/or
    iii. rude, in that you

a. walked off when Colleague A was speaking with you
b. tutted at Colleague A stating '*well I don't agree with you'* or words to that effect.
c. continually sought to interrupt Colleague A who was administering a blood transfusion when she asked you to wait.
d. stood tapping your foot and said '*will you hurry'*, or words to that effect
e. interrupted Colleague B who was giving information to colleague A
f. called a patient A '*stupid*' or words to that effect.

6. On or around 14 January 2023 on [PRIVATE] in relation to Patient E

    a. incorrectly administered intravenous Levofloxacin 500mg via a syringe
    b. failed to ensure the intravenous Levofloxacin 500mg was checked by a second checker.

c. signed the medication administration chart in the name of an unknown person to indicate that person had witnessed the administration of Levofloxacin when they had not.
d. did not wear a face mask.

On the [PRIVATE] ward on 7 December 2022

7. You were rude to Patient F, stating they had too many opiates.

8. Failed to provide adequate care to Patient G, in that you failed to escalate a NEWS score of 5.

9. Your actions in charges 1b, 2d, 3b and 6c were dishonest as you intended to deceive others into believing you had administered medication to Patients A, B, C and E when you had not.

10. Your actions in charges 1c and 6c were dishonest in that you intended to deceive others into believing that the medication for Patients A and E had been properly witnessed when it had not.

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

Decision and reasons on application to amend the charge

Ms Khan made an application to amend the wording of charge 5.c. The proposed amendment was to correct a typographical error. She submitted that the proposed amendment would provide clarity and more accurately reflect the evidence.

Proposed amendment:

5. Acted in a manner that was:
*c. continually sought to ~~interpret~~ **interrupt** Colleague A who was administering a blood transfusion when she asked you to wait.*

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel determined that such an amendment, as applied for, was in the interest of justice. It was satisfied that there would be no prejudice to Mr Tamarra 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.

Decision and reasons on application for hearing to be held in private

Ms Khan made an application under Rule 19 that this case be held partly in private on the basis that proper exploration of the case involves matters concerning [PRIVATE].

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session as and when such issues are raised in order to be able to properly explore the case [PRIVATE].

Decision and reasons on application to admit hearsay evidence

Ms Khan made an application under Rule 31 to allow the hearsay evidence of Patient A, Patient E, and Patient F, contained within several witness statements admitted into evidence. Her submission was that the evidence is highly relevant and though not provided during the course of the NMC's investigation, was produced for the purpose of the internal investigations. While the patients are not appearing before NMC, the evidence was submitted through witnesses who have given evidence. The hearsay evidence is contained within the witness statements of Witness 1, 5, 2 and 4, which has been accepted.

In the preparation of this hearing, the NMC had indicated to Mr Tamarra in the Case Management Form (CMF), dated 7 October 2024, that it was the NMC's intention to adduce the hearsay material. Despite knowledge of the nature of the evidence to be given, Mr Tamarra made the decision not to attend this hearing. On this basis Ms Khan submitted that there was no lack of fairness to Mr Tamarra in allowing the hearsay into evidence.

The panel accepted the advice of the legal assessor.

The Patient hearsay is contained within the witnesses statements which had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by her.

Mr Tamarra had been provided with a copy of the evidence bundle. This included the witness statements and, as the panel had already determined that he had voluntarily absented himself, and was unrepresented, he would not be in a position to cross-examine in relation to this hearsay evidence.

The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of the witnesses and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel determined that it would be fair and relevant to admit the hearsay evidence. It would however give appropriate weight to this evidence once it had heard and evaluated all the evidence before it.

Background

The background to this case is as follows:

On 24 April 2023 the NMC received a referral from [PRIVATE] Trust (the Trust) in relation to Mr Tamarra. At the time of the concerns raised, Mr Tamarra was working as a registered nurse at the Trust.

The referral raised concerns about Mr Tamarra's:

- Medicines management;
- Record keeping;
- Unprofessional communication with patients and staff; and
- Dishonesty.

Decision and reasons on facts

In reaching its decision the panel had regard to all the evidence and the documentation before it, together with the submissions of Ms Khan, and the reflective statements of Mr Tamarra. It accepted the advice of the legal assessor. The panel is aware that the burden of proof rests upon the NMC and the facts must be proved on the balance of probabilities.

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

- Witness 1: Nurse in charge of the Surgical assessment unit at the time of the events.

- Witness 2: Student Nurse on placement in the Surgical assessment unit.

- Witness 3: Registered Nurse Associate working at the surgical assessment unit.
- Witness 4: Ward Manager for [PRIVATE] general surgical ward.
- Witness 5: Ward Manager at [PRIVATE] ward
- Witness 6: Registered Nurse (Bank) working in the surgical assessment unit.
- Witness 7: Junior Sister working in the surgical assessment unit.

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

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

Charge 1a, 1b, and 1c.

"On 16 April 2023 on the Surgical Assessment Unit

1. In relation to Patient A

    a. did not administer intravenous Pabrinex.
    b. recorded on the medication administration chart that you had administered Pabrinex, when you had not.
    c. signed the medication administration chart in the name of an unknown person to indicate that person had witnessed the administration of Parbinex, when they had not.

Charges 1a, 1b, and 1c are found proved.

In reaching this decision, the panel took into account oral and written evidence from Witnesses 1, 3, 7, 6, Patient A's drug chart, a contemporaneous DATIX entry submitted by Witness 1, and the medication management policy.

Mr Tamarra was responsible for overseeing all care of Patient A on the day of the incident. The panel had sight of the medication management policy for the ward, which they were told was readily accessible for staff on the ward. As an intravenous drug, the administration of Pabrinex to Patient A required a second registered nurse to check the medication, witness administration and then countersign the patient's medication chart.

Witness 1's evidence was that Mr Tamarra left the ward at around lunchtime [PRIVATE]. Patient A complained to staff that he had not received his medication (Pabrinex). On investigation, Witness 1 found that the medication was still in the Omnicell medication dispenser on the ward, and in the light of this, it is highly unlikely that the medication was administered. Taking into account that the patient also stated he did not receive his medication, the panel was satisfied that these factors were a strong indicator that the medication had not been given. It heard from Witness 1 that Patient A had full capacity, and there was nothing to indicate that he was confused.

The panel had sight of Patient A's drug chart. The initials 'RT' were entered for the medication administration, suggesting that Mr Tamarra had put his initials to it. A countersignature is also present relating to the medication administration for Patient A. However, the panel heard corroborative evidence from Witnesses 1, 3, 6, and 7, each stating that they did not countersign the drug chart with Mr Tamarra. Further, no registered nurses on the ward who would have been able to countersign, recognised the countersignature.

Witness 1 said that an extensive investigation had been undertaken regarding the countersignature on Patient A's drug chart. The panel also had regard to Witness 1's statement, which describes questioning Mr Tamarra about who countersigned the medication with him for Patient A:

‘I asked who the other signature was and explained that I had checked with the other colleagues on the Ward and no one confirmed that it was theirs. Mr Tamarra responded "well it was one of you", or words to that effect.’

Several witnesses said that in their opinion as registered nurses, it was unlikely that an unknown member of staff from another department would countersign for medication administration for a patient, because they would not have received a handover for the patient and would not have a complete clinical picture of the patient’s needs and requirements.

In a subsequent telephone call to the ward, Mr Tamarra maintained that he had administered the Pabrinex, despite the contrary evidence which the panel found more compelling.

Therefore, the panel find these charges proved.

Charge 1d, 1e, and 1f

“On 16 April 2023 on the Surgical Assessment Unit

1. In relation to Patient A

    d. did not complete the fluid balance charts despite stating you had done so.
    e. inaccurately assessed their national early warning score (NEWS).
    f. did not follow Colleague A’s instructions to continue observations.”

Charges 1d, 1e, and 1f are found proved.

In reaching this decision, the panel took into account oral and written evidence from Witnesses 1, 3, 7, 6, Patient A’s NEWS chart, Patient A’s fluid balance chart, and a contemporaneous DATIX entry submitted by Witness 1.

The panel heard evidence from Witness 1 in regard to Mr Tamarra being responsible for completing Patient A's fluid balance chart. Witness 1 described how Mr Tamarra, as a registered Nurse, was expected to comply with the requirement to complete the fluid balance chart which had been explained to him at the patient handover at the start of his shift.

At lunchtime that day, Mr Tamarra left the ward [PRIVATE]. Witness 1 told the panel that she asked him if Patient A's fluid balance chart had been completed, which he confirmed. Witness 1 took over the care of Mr Tamarra's patients when he left the ward, and she observed that the fluid balance chart had in fact not been completed by Mr Tamarra.

The panel had regard to Patient A's fluid balance chart and they observed that Mr Tamarra had not completed the required documentation, even though he told Witness 1 that he had completed it. The panel found that Mr Tamarra did not complete the fluid balance chart.

Witness 1 described the concerns which she raised regarding Mr Tamarra having inaccurately recorded Patient A's NEWS score. Further, not following instructions from a senior nurse to continue hourly observations, in the light of the raised NEWS score and the patient being visibly unwell.

The panel had regard to Patient A's NEWS chart and requirements for action in response to NEWS scores. It heard that a score of above 3 requires hourly observations, and escalation to medical staff. The NEWS chart documents that at 10:51 the observations were completed by another member of staff and the score was 8. However, when Mr Tamarra completes the observations at 12:11 he documents a score of 4. The following set of observations completed by another member of staff resulted in a score of 6. Witness 1 said that in her professional opinion, although not impossible, it is unlikely that a NEWS score would drop from 8, to 4, in a short period of time given that the patient was visibly unwell earlier that day.

The panel therefore finds charge 1e proved.

Witness 1 described to the panel that Patient A required hourly observations due to the consistent raised NEWS score. Witness 1 gave instructions to Mr Tamarra that hourly observations were to be completed in line with NEWS chart policy. Further, Mr Tamarra did not accept her instructions.

The panel had regard to Witness 1's written statement:

> *"When I spoke to Mr Tamarra about Patient A and asked him to continue the observations as they had been so unwell, he just walked off. This was not an appropriate response. I expected him to explain why he disagreed with me or why he did not want to do it, but he just walked off."*

The panel therefore finds charge 1f proved.

Charge 2a.

"On 16 April 2023 on the Surgical Assessment Unit

2. In relation to Patient B

    a. did not administer
        i. Allopurinol,
        ii. Atorvastatin,
        iii. Ferrous Fumarate and
        iv. Amlodipine

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence from Witness 1, and Patient B's drug chart. Witness 1 said that Patient B reported that she had not received her medication:

'When Mr Tamarra had left the Ward on 16 April 2023, Patient B complained to me when I went to review all the patients, that they had not been given their medication. I went to bed 20 where the patient was and all of the patient's prescribed medication was left out on the bedside table.'

Witness 1 explained that Mr Tamarra had access to the key for the patient's locker, where prescription medications brought in from home must be kept. The nurse overseeing the care of the patient is then responsible for administering these medications at appropriate times in line with the prescription details. The patient cannot access the key to the locker, only registered staff members can hold the key. Witness 1 stated that unidentified medication had been left on the bedside cabinet, which she observed when Patient B told her that he had not received his medication.

The drug charts indicate that there were several days and times when Mr Tamarra was not on duty and drugs are marked as declined or self-administered by the patient.

These drugs were the patient's own supply and therefore, although they should be securely stored, there is no stock checking process as there would be with hospital dispensed drugs.

Further, there was no evidence to corroborate the hearsay evidence relative to Patient B. The panel therefore could not be satisfied that there was sufficient evidence that the medication had not been administered.

The panel therefore found that this charge is not proved.

Charge 2b

b. did not administer intravenous Flucloxacillin

This charge is found proved.

In reaching this decision, the panel took into account the evidence given by Witness 1, and Patient B's drug charts. Witness 1's evidence was:

> *'From the charts at AH/09, it can also be seen that Mr Tamarra had not given Patient B his prescribed IV antibiotic of flucloxacillin. This was the antibiotic of choice for wound infections and the 12:00 dose was given by myself and another nurse once Mr Tamarra had left the Ward. The dose was actually given at 2:00pm so the dose was not late. The issue was that it was not handed over that the dose had not been given and therefore the dose could have been missed after Mr Tamarra had left the Ward. Mr Tamarra had been asked when he left if all medications had been given and he stated that they had.'*

Although this was a hospital dispensed drug, there was no documentary or other evidence to indicate that it had been administered by Mr Tamarra. Therefore this charge is found proved.

Charge 2c

c. left one or more of the medications listed at 2a(i) to (iv) unsecured on the bedside table.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's evidence describing finding medication unsecured on the bedside table of Patient B:

> *"I went to bed 20 where the patient was and all of the patient's prescribed medication was left out on the bedside table."*

This panel heard that this medication should be stored within a locked cupboard which the patient could not access. Mr Tamarra was responsible for medication security and administration for this patient.

The panel therefore finds this charge proved.

Charge 2d

d. recorded on the medication administration chart that you had administered, those listed at 2a (i) to (iv) when you had not."

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's evidence, and Patient B's drug chart.

Mr Tamarra was the nurse in charge of Patient B's care on this shift. Patient B's drug chart does not contain signatures for the administration of medications. However, numbers are entered which reference the reason for non-administration. In this instance, Witness 1 explained the 'numbers' found on Patient B's drug chart relate to a patient declining medication, and also self-administration of medication. Further, Witness 1 explained that there was no self-administration policy on the ward. These codes appear consistently over several days and times, and the use of the self-administration code was not limited to the date when Mr Tamarra was on duty.

The panel therefore finds that this charge is found not proved.

Charge 3a and 3b

"On 16 April 2023 on the Surgical Assessment Unit

3. In relation to Patient C

a. did not administer
   i. Perindopril,
   ii. Lansoprazole and
   iii. Ferrous Fumarate Bisoprolol

b. recorded on the medication administration chart that you had administered those listed at 3a(i) to (iii) when you had not."

Charge 3a and 3b are found NOT proved.

In reaching this decision, the panel took into account evidence of Patient C's Drug chart, and the evidence of Witness 1. In her written statement, Witness 1 said:

> *'When Mr Tamarra had left the Ward, I went around to check drug charts and talk to the patients. Patient C was in bed 21 next to Patient B. Patient C told me that they had not had their morning medication.'*

On Patient C's drug charts, the initials 'RT' appear in the corresponding boxes indicating that all three drugs were administered on the morning in question, and then signed for. As the nurse in charge of Patient C's care, Mr Tamarra was responsible for administering the medication. Witness 1 was unable to speak with Mr Tamarra as when she became aware of the allegation, he had already left the ward.

There was no corroborating evidence before the panel to support the hearsay evidence of Patient C.

Therefore the panel finds this charge is not proved.

Charge 4

"On 16 April 2023 on the Surgical Assessment Unit

4. In relation to Patient E did not administer intravenous Gentamycin."

This charge is found proved.

In reaching this decision, the panel took into account evidence of Witness 1, Patient E's nursing care documentation, and a contemporaneous DATIX entry detailing the incident in question. Mr Tamarra was responsible for overseeing all care of Patient E. Gentamycin requires administration via Intravenous route, and therefore a second registered nurse must check the medication, witness administration and then countersign the medication chart.

Witness 1 said that Mr Tamarra left the ward at around lunchtime that day [PRIVATE]. Prior to him leaving the ward, he said to Witness 1 that he had administered the medication at the designated time as per the patient's prescribed medication plan. After taking over care of Mr Tamarra's patients for the remainder of the day shift, Witness 1 observed that the administration of Gentamycin by Mr Tamarra was not recorded on the patients medication chart. Upon further investigation, she found that the medication was still in the Omnicell medication dispenser.

The panel was satisfied that the medication had not been given as it was still in the Omnicell. Further, the documentation relating to Patient E showed that the Gentamycin was administered later that afternoon by Witness 1.

Therefore, the panel find this charge proved.

Charge 5

"On 16 April 2023 on the Surgical Assessment Unit

5. Acted in a manner that was:
   i. inappropriate and/or
   ii. unprofessional and/or
   iii. rude, in that you

   a. walked off when Colleague A was speaking with you
   b. tutted at Colleague A stating '*well I don't agree with you'* or words to that effect.

c. continually sought to interrupt Colleague A who was administering a blood transfusion when she asked you to wait.
d. stood tapping your foot and said '*will you hurry'*, or words to that effect
e. interrupted Colleague B who was giving information to colleague A
f. called a patient A '*stupid*' or words to that effect."

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 4, a contemporaneous DATIX submitted after the incident by Witness 1, and Mr Tamarra's reflective statement.

The panel heard evidence from Witness 1 in respect of charges 5a and 5b, that this conduct occurred when she was giving him instructions in his duties of patient care. Charges 5c and 5d relate to [PRIVATE] his eagerness to leave his shift. Witness 1 was conducting a blood transfusion at the time and she said that he interrupted her repeatedly and said "*will you hurry?"* or words to that effect. She asked him to wait until she had completed the procedure before speaking with her.

Subsequently, while a health care assistant was updating witness 1, Mr Tamarra kept interrupting as he wished to hand over his patients prior to leaving. Witness 1 said:

> *'[Colleague B] was giving me information on another patient's urine output and Mr Tamarra interrupted and said he wanted to handover his patients. I said "will you just give me one second so [Colleague B] can just finish giving me this information". Mr Tamarra tutted at me again.'*

In evidence, Witness 1 said that Mr Tamarra had left the ward at lunchtime [PRIVATE]. She said:

‘After I had finished administering some medication to a patient, I was called to the telephone. At the end of the line was Mr Tamarra. He first apologised if I thought he was being rude.’

Witness 1 said that Mr Tamarra telephoned her that afternoon to apologise if she felt he had been rude but he was under pressure as [PRIVATE].

‘I then asked Mr Tamarra about Patient A and if he could confirm a question about his medication. I said that he had signed for Patient A's pabrinex, but the patient was stating he had not had it. Mr Tamarra responded by saying "well what does he know he's stupid", or words to that effect’

Although Mr Tamarra might have been under pressure [PRIVATE], this does not detract from the fact that the panel found his conduct to be unprofessional, inappropriate, rude, and likely to compromise patient safety.

Therefore, the panel find this charge proved.

Charge 6a

“6. On or around 14 January 2023 on [PRIVATE] in relation to Patient E

a. incorrectly administered intravenous Levofloxacin 500mg via a syringe”

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5, and the documentation evidence relative to Patient E.

Witness 5’s evidence was that Mr Tamarra was in charge of Patient E’s care on the date in question. Witness 5 described how Patient E was to receive intravenous Levofloxacin

which was Mr Tamarra's responsibility to administer. Patient E had raised concerns regarding Mr Tamarra, with the nurse in charge on the ward:

> *'They had raised concerns that their Intravenous Antibiotics ("IVAB") had been administered through a syringe, when they were used to it being administered via a bag. The patient stated they had questioned Mr Tamarra as to whether it was the correct drug and Patient E was unsatisfied with the answer they were given.'*

Witness 5 said that Levofloxacin is received from pharmacy in a premade bag which is to be administered as an intravenous infusion over 30-60 minutes. Further, that if a nurse is unsure regarding the correct administration method of a drug, a copy of the medicines management policy is available on the ward, and nurses can also refer to Medusa via the hospital intranet, which offers guidance on IV drug preparation and administration. Also:

> *'Mr Tamarra could have liaised with the ward pharmacist for advice or refer to the "BNF". The BNF is a book that is updated every 6 months with every drug included, what it was used for, how to administer, how to prepare it and the potential side effects.'*

She said that Levofloxacin can cause irritation to veins due to its potency and administering this via bolus is incorrect and unsafe. She also said that there would be instructions for administration on the bag or on the packaging. It should be clear to a registered nurse that administration via a syringe would be impractical and improper due to the volume involved.

Therefore the panel found this charge proved.

Charge 6b and 6c

> "b. failed to ensure the intravenous Levofloxacin 500mg was checked by

a second checker.

c. signed the medication administration chart in the name of an unknown person to indicate that person had witnessed the administration of Levofloxacin when they had not."

Charges 6b and 6c are found proved.

In reaching this decision, the panel took into account the evidence of Witness 5, her contemporaneous DATIX incident report, Patient E's drug chart, and Mr Tamarra's reflective statement.

Intravenous drug administration requires a second registered nurse to check the medication, witness administration and then countersign the patient's medication chart.

Patient E's drug chart showed the initials 'RT' indicating that Mr Tamarra had administered Levofloxacin. There is also a countersignature relating to this.

Witness 5's evidence was:

> '*When I reviewed the drug chart for Patient E from 14 January 2023, I could only recognise Mr Tamarra's signature. The counter-signature did not appear to be any of my staff's signatures. I knew the staff that were working that day and I knew their signatures.'*

Also she described how Mr Tamarra had obtained the counter signature in question:

> '*he claimed that he could not find a nurse on [PRIVATE] Ward for a counter-signature so he went to another ward after preparing the drug to get a signature from a nurse on another ward. This was a very unusual claim and does not normally happen. I spoke to the nurses that were working on the other ward at the time and they all denied signing for this medication or being asked to sign it by Mr Tamarra.'*

Mr Tamarra, in his reflective statement said:

> *'I went to the treatment room placed the prescribed IVABS on a tray and waiting for another nurse to check my IVABS, while I was standing at the door I saw this female nurse and asked her to check my IVABS in which she agreed, while she was checking my IVABS I've also asked her if she works in [PRIVATE] and she said "no I worked on a different ward but I can check your IVABS" before she left the ward I asked her if I could administer this IVABS through Bolus and she said "Yes and slow push.".'*

Patient E also made a formal complaint to the hospital regarding Mr Tamarra's failure to listen to her concerns regarding the method of medication administration he had chosen which was not in line with that of others.

The panel accepted that it would be highly unusual to ask a passing nurse who did not work on the ward to assist in anything other than an emergency. Moreover, there were several registered nurses working on the ward to act as second checker. The panel therefore found Mr Tamarra's account to be implausible.

As a consequence, the panel finds this charge proved.

Charge 6d

"d. did not wear a face mask."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5, her contemporaneous DATIX incident report, a copy of the infection prevention control ward policy, and Mr Tamarra's reflective statement.

Witness 5 said that Patient E had made a formal complaint regarding the care provided at the hospital, including that by Mr Tamarra.

Patient E complained that Mr Tamarra was seated at the end of the bed, but not wearing a face mask. Witness 5 stated that face masks were to be worn at all times, and that infection prevention control is imperative on the ward, due to the complex nature of immunocompromised patients being cared for.

Mr Tamarra submitted a reflective statement in response to Witness 5 raising concerns about his practice with the agency he was contracted to. The panel noted that Mr Tamarra stated in his reflective piece:

> *'In regards with face mask, I myself as a clinician always emphasise the importance of wearing them. Especially in your rendering nursing care, in order to protect the patients and myself from airborne diseases such as COVID 19. I would just like to sincerely apologise with all the miscommunications to everyone and ill consider these incidents as a learning curve and hoping not to happen again in the future.'*

In his reflective statement, Mr Tamarra talks in general terms about the importance of face masks but without actually addressing the specific complaint made. He did not deny that he had failed to wear a mask.

Therefore, the panel finds this charge proved.

Charge 7

> "On the [PRIVATE] ward on 7 December 2022
>
> 7. You were rude to Patient F, stating they had too many opiates."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4 and Witness 2, describing how Patient F was visibly distressed and crying after the alleged interaction with Mr Tamarra. It would be appropriate for an agency nurse, unfamiliar with the patient, to query the medication routine. However, the nurse should refer to the medical and nursing records and consult with nursing staff who were more familiar with the patient, prior to discussing it with the patient. Any such conversation with the patient should be compassionate.

Mr Tamarra says in his reflective statement dated 31 January 2023 which refers to the incident:

> *'With my experience as a nurse its also my job to impart some health teaching, I only suggested to my patient saying "Please reconsider avoiding too many opiates" in which she understood and thanked me.'*

The panel found this to be unlikely in the light of the degree of distress demonstrated by the patient, and described by Witnesses 4 and 2.

Mr Tamarra acknowledged in this reflective piece that he might have been thought to have been rude in his approach to questioning Patient F's medication requirements. He did apologise to Patient F after the medication round, but only when prompted by Witness 4.

In the above circumstances, the panel find this charge proved.

Charge 8

> "On the [PRIVATE] ward on 7 December 2022
>
> 8. Failed to provide adequate care to Patient G, in that you failed to escalate a NEWS score of 5."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and Witness 4, and Mr Tamarra's reflective statement on this incident. They corroborated each other in their accounts of the incident. The panel heard that all staff were expected to understand the NEWS documentation and escalation policy, and where to obtain NEWS charts if required. Agency nurses were briefed as part of their induction relating to this. This was not Mr Tamarra's first shift on the ward.

An increase in the patient's NEWS score indicates a deterioration in the patient's condition, which at a certain level triggers a need for a change of intervention and escalation to medical staff. The NEWS documentation clearly states trigger points and the actions required.

Patient G's NEWS documentation does not record any escalation to medical staff by Mr Tamarra. Witness 2 also stated that when he became aware of the non-escalation, he spoke to medical staff on the ward who confirmed they had not been made aware that Patient G required a medical review based on a high NEWS score.

Witness 2 said that a healthcare assistant made him aware that she had taken a NEWS observation of 5 requiring escalation, and had reported this to the responsible nurse, Mr Tamarra. Rather than accepting the observations, he chose to repeat them, stating in his reflection that the patient looked well and that she said she was feeling fine. He then stated the NEWS score that he found was 2, and that he recorded it on his handover sheet rather than the observation record, which he could not then find. It is a requirement that handover sheets are placed in the confidential waste at the end of the shift, after any content had been entered into the records.

Witness 4 confirmed that new observation charts were readily available and accessible to all staff working on the ward, and it would have been an expectation to start a new chart if the existing chart could not be located.

Subsequent observations taken by other staff showed a trend more in line with observations not taken by Mr Tamarra, and ultimately resulted in the patient requiring transfer to a critical care team.

In the light of the above evidence, the panel concluded that Mr Tamarra did not escalate the high NEWS score to medical staff as was his responsibility as the registered nurse overseeing Patient G's care.

Therefore, the panel found this charge proved.

Charge 9

> "On the [PRIVATE] ward on 7 December 2022
>
> 9. Your actions in charges 1b, 2d, 3b and 6c were dishonest as you intended to deceive others into believing you had administered medication to Patients A, B, C and E when you had not."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 5, a contemporaneous DATIX report submitted by Witness 5, and Patient E's drug chart, and Patient A's drug chart.

In regard to this charge the panel has now considered only their findings under 1b and 6c.

The panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 which sets out the test for dishonesty. The panel decided that Mr Tamarra has acted in a deliberate way in order to mislead professional colleagues, and patients, in regard to completion of medication administration. He did so by signing the records when he had not administered the medication, and by creating a countersignature suggesting

that it had been administered, checked, and witnessed. These events could not have occurred in error.

The panel also determined that, from an objective point of view, Mr Tamarra's conduct was dishonest by the professional standards set out within the NMC code, and by the standard of ordinary, decent people.

Therefore, the panel found this charge proved.

Charge 10

> "On the [PRIVATE] ward on 7 December 2022
>
> 10. Your actions in charges 1c and 6c were dishonest in that you intended to deceive others into believing that the medication for Patients A and E had been properly witnessed when it had not."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 1, 7, 3, 6, 4 and 2. The panel had regard to Patient A and Patient E's drug charts. The panel heard that Mr Tamarra was responsible for administering the medication to patient A and E on this day. When administering intravenous drugs, a second registered nurse is required to check the medication, witness administration and then countersign the patient's medication chart.

The drug charts for Patient A, and Patient E record the initials 'RT'. A countersignature is also present relating to the medication administration for both patients. There was evidence from all registered nurses on duty on the shift in question, stating that they did not countersign the drug chart with Mr Tamarra, nor were they asked to do so, and they did not recognise the countersignature.

Witness 1's evidence was that she asked Mr Tamarra who countersigned the drug chart:

‘I asked who the other signature was and explained that I had checked with the other colleagues on the Ward and no one confirmed that it was theirs. Mr Tamarra responded "well it was one of you", or words to that effect.’

The evidence of several witnesses who worked on the wards involved said that it was unlikely that an unknown member of staff from another department would countersign for medication for a patient, particularly because they would not have received a handover for the patient and would not have a complete clinical picture of the patient’s needs and requirements.

The panel has therefore concluded that this was a calculated attempt by Mr Tamarra to cover up his failure to administer the medications in line with the Trust Medicines Management Policy.

The panel also determined that, from an objective point of view, Mr Tamarra’s conduct was dishonest by the professional standards set out within the NMC code, and by the standard of ordinary, decent people.

Therefore, the panel found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Tamarra’s fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a Mr Tamarra’s ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

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

Ms Khan identified the specific, relevant standards where Mr Tamarra's actions amounted to misconduct, namely: 1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 2.3, 2.4, 10.3, 13.1, 13.2, 13.3, 18.1, 18.2, 18.3, 19.1, 20.1, 20.2, 20.3

Ms Khan referred to the panel's decision on facts and submitted that there has been cogent and credible evidence before the panel to demonstrate that the charges proven could amount to a finding of misconduct. She highlighted that Mr Tamarra repeatedly falsified documentation, incorrectly administered medication without following guidelines, failed to escalate the care of patients with a deterioration of health, and intentionally

misled colleagues. He also failed to correctly document the administration of medications, and his conduct towards colleagues and patients was proved to be rude and inappropriate for that of a registered nurse.

Ms Khan submitted that Mr Tamarra has fundamentally breached the NMC code, proving a lack of integrity and responsibility for patient safety. Further, she submitted that Mr Tamarra acted in deliberate, dishonest and misleading manner when creating a countersignature for drug administration. This conduct did not occur in error and the panel should find that this amounts to serious misconduct.

Ms Khan submitted that the charges found proved amount to a finding of misconduct.

Submissions on impairment

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

Ms Khan submitted that Mr Tamarra's misconduct is not easily remediable due to the dishonesty found proved, reflecting deep seated attitudinal issues. She referred to the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Khan submitted that Mr Tamarra's reflective statements were self-serving and attempted to shift blame to those around him, showing a lack of professional accountability and integrity. Further, she stated that Mr Tamarra failed to acknowledge and accept that his actions had jeopardised patient safety and wellbeing. She stated that dishonesty profoundly undermines public confidence in the nursing profession and it is the NMC's duty to reassure the public that this kind of misconduct will not be tolerated.

Ms Khan submitted that the misconduct happened on several occasions over an extended period of time, and Mr Tamarra continued to engage in this behaviour even though investigations were ongoing in relation to his professional conduct.

Ms Khan concluded that Mr Tamarra engaged in serious misconduct, while breaching fundamental professional standards. He has demonstrated no significant insight or remorse for his misconduct, which determines that there is significant risk of repetition, and that Mr Tamarra's Fitness to Practise should be deemed impaired in order to protect the public, and uphold public confidence in the nursing profession in order to mark a profound unacceptability of conduct.

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

In reaching its decision, the panel had regard to the evidence before it, Mr Tamarra's reflective statements, and Ms Khan's submissions.

Decision and reasons on misconduct

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

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

> ***'1 Treat people as individuals and uphold their dignity***
> ***To achieve this, you must:***

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

2 Listen to people and respond to their preferences and concerns
To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.2 recognise and respect the contribution that people can make to their own health and wellbeing
2.6 recognise when people are anxious or in distress and respond compassionately and politely

8 Work co-operatively
To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

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

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

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

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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**:*

18.4 take all steps to keep medicines stored securely

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

20 Uphold the reputation of your profession at all times
***To achieve this, you must**:*

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

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

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

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

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

Although Mr Tamarra's failings did not directly cause harm to patients, with the exception of one patient who required an escalation of care to a specialist team, any inaccuracy of recordings and treatments must represent potential risk of harm to patients. Patient records and documentation are important to patients, as well as nurses and medical staff to provide a full and accurate clinical picture.

The panel found that Mr Tamarra's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct, and by undermining public confidence in the profession, the public may be less inclined to access healthcare services. The panel found that all the charges found proved were serious and would be regarded as deplorable by fellow practitioners.

Decision and reasons on impairment

The panel next considered whether as a result of the misconduct, Mr Tamarra's fitness to practise is currently impaired.

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

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

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

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

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

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

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

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

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

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

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

The panel finds that patients were put at risk and were caused physical and emotional harm as a result of Mr Tamarra’s misconduct. Furthermore, his misconduct was such that he was in breach of fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel concluded that all three limbs of *Grant* apply given the wide ranging concerns, and the dishonesty involved.

Regarding insight, the panel determined that Mr Tamarra has not demonstrated an understanding of how his actions put patients at a risk of harm, nor why his conduct was inappropriate and unprofessional and impacts negatively on the reputation of the profession.

In his reflective pieces, where Mr Tamarra addresses some of the complaints made about his practice and incivility towards patients and colleagues, he attempts to shift blame to those around him and includes partial denials.

These reflective statements are wholly inadequate; they demonstrate a significant lack of accountability and of insight or real intention to remedy his misconduct. Indeed, as a result, the panel has determined that this indicates deep seated attitudinal issues.

The panel saw no significant evidence before it in determining whether or not Mr Tamarra has taken steps to strengthen his practice.

As a consequence, the panel has concluded that there is a serious risk of repetition of misconduct of this nature.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

An informed member of the public would be concerned about Mr Tamarra's conduct and public confidence in the profession, and also the confidence of colleagues, would be undermined if a finding of impairment were not made. The panel therefore finds Mr Tamarra's fitness to practice also to be impaired on public interest grounds.

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

Sanction

The panel has decided to make a striking-off order. The effect of this order is that the NMC register will show that Mr Tamarra has been struck-off the register.

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

Submissions on sanction

Ms Khan provided the following written submissions on sanction:

> *'This submission is made in connection with the proceedings brought before the Fitness to Practise Committee of the Nursing and Midwifery Council in relation to Dick Tamarra. Based on the evidence of serious misconduct and impairment, it is submitted that the appropriate sanction in this case is a striking-off order.*
>
> ***Striking-Off Order:***
>
> 1. ***Seriousness of Misconduct:***
>
> - *Mr. Tamarra's actions demonstrate a pattern of serious misconduct, including falsification of medical records, failure to adhere to clinical guidelines, and unprofessional behaviour. These actions have directly compromised patient safety and trust in the nursing profession.*
>
> 2. ***Dishonesty and Lack of Integrity:***

- *The evidence shows that Mr. Tamarra falsified documentation related to medication administration and failed to obtain valid countersignatures. This dishonesty is a fundamental breach of the trust placed in healthcare professionals and is incompatible with continued registration.*

3. ***Risk to Patient Safety:***

- *Mr. Tamarra's failure to accurately monitor and escalate patient conditions, as well as his improper handling of medications, posed significant risks to patient safety. The potential for harm in these instances is substantial and cannot be overlooked.*

4. ***Unprofessional Behaviour:***

- *Mr. Tamarra's rude and dismissive behaviour towards colleagues and patients undermines the professional standards expected of a registered nurse. Such behaviour is unacceptable and erodes the confidence that patients and the public have in the nursing profession.*

5. ***Lack of Remorse and Insight:***

- *Throughout the incidents, Mr. Tamarra has shown a lack of remorse and insight into the seriousness of his actions. His unwillingness to acknowledge his mistakes and take responsibility further supports the need for the most severe sanction.*

Discounting Other Sanctions:

6. ***No Order*** *No further action (SAN-3a) – the panel has the discretion to take no further action however, given the serious nature of these concerns, relating to clinical errors, poor record keeping, dishonesty in covering up a failure to follow policy designed to keep patients safe, and failing to work collaboratively with colleagues, are all suggestive that such a sanction would be incompatible to provide sufficient protection to the public and is not otherwise in the public interest.*

7. ***Caution Order:***

- *A caution order is not appropriate in this case due to the severity and repeated nature of the misconduct. A caution would not adequately protect the public or maintain confidence in the nursing profession.*

8. ***Conditions of Practice Order:***

- *Such an order may ordinarily have dealt appropriately with the clinical concerns that have arisen in this case, however given the dishonesty and the attitudinal concerns found which are indicative of being deep seated in nature, such an order cannot be used to address these concerns as it would be impossible to formulate, workable conditions for these concerns. Such a sanction would not adequately protect the public and is unlikely to be in the public interest.*

- *Given the fundamental issues of dishonesty and lack of integrity and attitudinal concerns which are indicative of being deep seated in nature, such an order cannot be used as it would be impossible to formulate, workable conditions for these concerns. Such a sanction would not adequately protect the public and is unlikely to be in the public interest. Conditions of practice would not be sufficient to address the risks posed by Mr. Tamarra. His actions indicate a deep-seated disregard for professional standards that cannot be remedied through retraining or supervision.*

9. ***Suspension Order:***

- *a committee would be required to consider if such an order would sufficiently protect patients, the public confidence in the professions and look at the conduct. This referral deals with incidents that are clinical in nature that could have resulted in significant harm to the patients in question. Colleagues were also put at risk because they could not trust the registrant's documentation. The concerns raised are repetitive and despite reflections provided there is a lack of insight on the registrant's part and no learning.*

- *The risk of repetition increases the risk to the public, patients and colleagues. The dishonesty is a sign of deep-seated attitudinal concerns which are incompatible with continued registration. Such an order would be insufficient to adequately protect the public from the underlying issues of dishonesty and unprofessional behaviour and would not otherwise be in the public interest. While a suspension order would temporarily remove Mr. Tamarra from practice the risk to patient safety and the breach of trust are so significant that a suspension would not be an adequate response.*

Conclusion:

10. *The clinical concerns are serious and a failure to give medication or to give such medication in the incorrect manner, put patients at a real risk of significant harm. Colleagues are also at risk when then they cannot trust the records which a nurse has written, which could lead to delays in patient care. The registrant's attitude towards colleagues and patients does not prompt collaborative and safe working practices, which in turn puts patients a significant risk of harm. Acting in a manner that is dishonest by falsely recording a signature on medical records is suggestive of deep-seated attitudinal concerns which are wholly incompatible with continued registration.*

11. *In light of the serious and repeated nature of Mr. Tamarra's misconduct, his dishonesty, the risk to patient safety, and his lack of remorse and insight, it is submitted that the only appropriate sanction is a striking-off order. This sanction is necessary to protect the public, maintain confidence in the nursing profession, and uphold the standards of professional conduct expected of registered nurses.*

12. *The FTPC is urged to consider the gravity of the evidence and the need to ensure that such behaviour is not tolerated within the nursing profession. A striking-off order is the only sanction that adequately addresses the seriousness of Mr. Tamarra's actions and serves to protect the public and the integrity of the profession.'*

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

Decision and reasons on sanction

Having found Mr Tamarra's fitness to practise currently impaired, the panel determined 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 regard to the NMC sanction guidance (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Lack of insight into failings
- A pattern of misconduct over a period of time in multiple locations
- Wide ranging incidents
- Lack of integrity
- Lack of remorse
- Conduct which put patients at risk of suffering harm.
- Deep seated attitudinal issues
- Repeatedly dishonest conduct

The panel found there to be the following mitigating features

- [PRIVATE]

However, the panel determined that this does not mitigate the wide ranging pattern of misconduct and dishonesty across several locations and dates.

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. Misconduct of this nature demands a sanction.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the misconduct, and the public protection issues identified, an order that does not restrict Mr Tamarra's practice would not be appropriate. 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.'* Mr Tamarra's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

> *'Conditions may be appropriate when some or all of the following factors are apparent:*
>
> - *No evidence of harmful deep-seated personality or attitudinal problems;*
> - *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
> - *No evidence of general incompetence;*
> - *Potential and willingness to respond positively to retraining;*
> - *……*
> - *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
> - *The conditions will protect patients during the period they are in force; and*

- *Conditions can be created that can be monitored and assessed.'*

Although some of the concerns identified could be addressed through retraining, dishonest conduct and the attitudinal concerns identified are more difficult to remedy. The panel therefore determined that given the seriousness of the misconduct, the attitudinal concerns and Mr Tamarra's lack of sufficient insight into the severity and impact of his actions, there were no relevant, proportionate, workable and measurable conditions that could be formulated. Accordingly, a conditions of practice order would not address the risk of repetition, which poses a risk of harm to patients' safety and to the public. Consequently, the panel decided that a conditions of practice order would not protect the public, would not reflect the seriousness of Mr Tamarra's misconduct, or be in the public interest.

The panel then considered 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 determined that the charges did not reflect a single incident of misconduct, and it was not persuaded that Mr Tamarra's insight was sufficient to convince it that he did not pose a significant risk of repeating behaviour. The panel determined his dishonesty to be attitudinal in nature and therefore difficult to remedy.

The panel has determined that Mr Tamarra's misconduct, particularly his dishonesty and conduct in falsifying patient documentation, and putting patients directly at harm, amounted to a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. Mr Tamarra has failed to demonstrate sufficient insight into the severity and impact of his misconduct on colleagues, patients and the wider public. This misconduct and dishonesty is a serious breach of the fundamental tenets of the nursing profession which has brought the nursing profession into disrepute.

The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Mr Tamarra's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel has found that Mr Tamarra's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. Further, members of the public would be concerned if he were allowed to continue in practice.

Balancing all these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Tamarra's actions in bringing the profession into

disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient as a sanction.

This order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Mr Tamarra in writing.

Interim order

As the strike-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Tamarra's own interests until the strike-off order takes effect.

Submissions on interim order

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

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim suspension 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, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow for any appeal to be resolved, not to impose an interim suspension order would be inconsistent with the panel's earlier decision.

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

That concludes this determination.