Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday 12 August – Friday 23 August 2024

and

Monday 23 September – Thursday 26 September 2024

Virtual Hearing

Name of Registrant:	**Gerrard Archer**	
NMC PIN	11C0466E	
Part(s) of the register:	Registered Nurse sub part 1 Mental health nurse (level 1) – 16 April 2012	
Relevant Location:	Manchester	
Type of case:	Misconduct	
Panel members:	Mark Gower Vanessa Bailey Clare Taggart	(Chair, Lay member) (Registrant member) (Lay member)
Legal Assessor:	Trevor Jones	
Hearings Coordinator:	Catherine Blake (12 August 2024) Monsur Ali (13 – 23 August 2024, and 23 – 26 September 2024)	
Nursing and Midwifery Council:	Represented by Elin Morgan, Case Presenter (12 August – 20 August 2024) Rowena Wisniewska (23 September – 26 September 2024)	
Mr Archer:	Not present and not represented at the hearing	
Facts proved:	Charges 1, 2(b), 3(a), 4(a)ii), 5.	

Facts not proved:	Charges 2(a), 3(b), 4(a)i), 4(b)i, 4(b)ii)
Fitness to practise:	**Impaired**
Sanction:	**Strike-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 Archer was not in attendance and that the Notice of Hearing letter had been sent to Mr Archer's registered email address by secure email on 11 July 2024.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Archer's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In light of all of the information available, the panel was satisfied that Mr Archer 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 Archer

The panel next considered whether it should proceed in the absence of Mr Archer. It had regard to Rule 21 and heard the submissions of Ms Morgan who invited the panel to continue in the absence of Mr Archer.

Ms Morgan submitted that there was a public interest in the expeditious disposal of the case, which relates to allegations dating back to the end of 2020, there is also potential inconvenience to the witness who is due to attend.

Ms Morgan submitted that there had been no engagement by Mr Archer with the NMC in relation to today's proceedings. She further submitted that, while Mr Archer had previously engaged with the NMC, he has not communicated with the NMC since 23 June 2023 in which he expressed a desire to no longer be contacted in relation to these proceedings. Ms Morgan submitted that there has been no reason provided for Mr Archer's absence, and there was no reason to believe that an adjournment would secure Mr Archer's attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mr Archer. In reaching this decision, the panel has considered the submissions of Ms Morgan, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Archer;
- Mr Archer has not engaged with the NMC and has not responded to any of the letters sent to him about this hearing;
- Mr Archer has not provided the NMC with details of how he may be contacted other than his registered address;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A witness is scheduled to attend today to give live evidence;
- Not proceeding may inconvenience the witness, their employer and the clients who need their professional services;

- The charges relate to events that occurred in 2020;
- Further delay may have an adverse effect on the ability of witness to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Archer in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, Mr Archer has made no response to the allegations. Mr Archer will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Archer's decisions to absent himself from the hearing, waive his right 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 Archer. The panel will draw no adverse inference from Mr Archer's absence in its findings of fact.

Details of the charges (as amended)

That you, a registered nurse:

1) On 21 December 2020 left your shift without informing your line manager that you were unwell and unable to complete your shift.

2) Between 2 November 2020 and 21 December 2020 exercised inadequate patient care in that you failed to make contact with patients:
   a) As set out in Schedule 1;
   b) Generally.

3. Between 2 November 2020 and 21 December 2020 exercised inadequate patient care in that you failed to make contact with vulnerable patients under the Assertive Outreach Pathway in accordance with the requirements of the Pathway:
   a) As set out in Schedule 2;
   b) Generally.

4. Between 2 November 2020 and 21 December 2020 exercised inadequate record keeping in that you:
   a) failed to conduct and/or properly record ~~assessments~~ **activities**:
      i) As per Schedule 3;
      ii) Generally.
   b) failed to administer depot injections and/or properly record that you had administered depot injections:
      i) As per Schedule 4;
      ii) Generally.

5. Between 2 November 2020 and 21 December 2020 your conduct in respect of **charge 1 and/or** charge 2 and/or 3 and/or 4 amounted to a lack of integrity in that you failed to act in a timely fashion or at all to escalate the risk to patients under your care.

SCHEDULE 1

	Patient	Event
1.	A to O	Did not make contact with Patients A to O who required contact at least once every 4 weeks.
2.	T	Patient T required a visit whilst on home leave on 25 November 2020 and failed to action this.

3.	T	Patient T required a 72 hour follow up review and a 4-7 day follow up by 10 December 2020 and failed to action this.
4.	B1	Patient B1 required face to face contact to assess their mental health and failed to action this.

SCHEDULE 2

	Patient	Event
1.	U	Patient U required weekly contact and following a request at a zoning meeting on 3 November 2020 for contact to be made that week, failed to make contact until 9 November 2020 by telephone call.
2.	V	Patient V required weekly contact from 24 November 2020 to 18 December 2020, you failed to action this, making only 2 telephone calls.
3.	N	Patient N required contact at least once every 4 weeks, failed to make contact at all.

SCHEDULE 3

	Patient	Event
1.	W	Having agreed on 26 November 2020 to conduct an outpatient review with Patient W's consultant, failed to record whether this

		was actioned.
2.	W	Having agreed during a zoning meeting on 8 December 2020 to visit Patient W on 11 December 2020, failed to record whether this was actioned.
3.	W	Having agreed during a zoning discussion on 15 December 2020 to arrange a joint visit with Recovery Support to Patient W, failed to record whether this was actioned.
4.	W.	Having agreed during a zoning discussion on 17 December 2020 to cold call Patient W, failed to record whether this was actioned.
5.	Y	Patient Y required contact at least once every 4 weeks, failed to do so and/or record that you had done so.
6.	Z	Failed to escalate a request, on 12 November 2020 from a consultant psychiatrist for an informal admission, for a gatekeeping assessment and to escalate to the red zone in respect of Patient Z. You did contact the flow team to request a bed, but you failed to follow this up.
7.	A1	Patient A1 required a hand over of care to a mental health team in Scotland and close the referral, but you failed to action this.
8.	C1	Patient C1 required closer care following their discharge under the Mental Health Act 2020, but your clinical entries were not of the expected standard. **1. Clinical entries were not of the expected standard with full MSEs not recorded.**

		2. An incomplete care plan which required a follow up to address alcohol and substance misuse. **3. Failed to visit Patient C1 on a weekly basis as required under the Assertive Outreach Pathway.** ~~with full MSEs not recorded and an incomplete care plan which required a follow up to address alcohol and substance misuse and you failed to visit Patient C1 on a weekly basis as required under the Assertive Outreach Pathway.~~
9.	C1	Having agreed in zoning meetings on 26 November 2020 and 8 December 2020 to have contact with Patient C1, failed to record that these contacts took place.

SCHEDULE 4

	Patient	Event
1.	W	Having agreed during a zoning meeting on 24 November 2020 to re attempt administering Patient W’s depot injection on 26 November 2020, failed to record whether this was actioned.
2.	X	Having been required to administer Patient X’s depot injection on 5 November 2020, failed to do so until 6 November 2020.
3.	X	Having been required to administer Patient X’s depot injection on 19 November 2020, incorrectly recorded it as being due on 20 November 2020 which is when it was administered.

4.	Z1	Having been required to administer Patient Z1's depot injection on 9 November 2020, failed to do so until 12 November 2020.
5.	Z2	Having been required to administer Patient Z2's depot injection on 24 November 2020, failed to do so in accordance with the depot card on 30 December 2020.
6.	C1	Having been required to administer Patient C1's depot injection on 9 December 2020, failed to do so until 15 December 2020.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Morgan under Rule 31 to allow the written statement of Witness 2 into evidence. Witness 2 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend today due to being out of the country without stable access to the internet.

In the preparation of this hearing, the NMC had indicated to Mr Archer in the Case Management Form (CMF), that it was the NMC's intention for Witness 2 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 2, Mr Archer made the decision not to attend this hearing.

Ms Morgan submitted that Witness 2 never met Mr Archer and so has no reason to fabricate her statement. She further submitted that Witness 2's statement is premised on objective records from the time of the charges, and is not the sole and decisive evidence.

On this basis Ms Morgan advanced the argument that there was no lack of fairness to Mr Archer in allowing Witness 2's written statement into evidence.

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 gave careful consideration to the application to admit Witness 2's evidence. The panel noted that Witness 2's statement 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.

The panel considered whether Mr Archer would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 2 to that of allowing hearsay testimony into evidence.

The panel considered that as Mr Archer had been provided with a copy of Witness 2's statement and, as the panel had already determined that Mr Archer had voluntarily absented himself from these proceedings, he would not be in a position to cross-examine this witness in any case. The panel had regard to the submissions of Ms Morgan and noted that Witness 2's statement relies on objective facts to support the charges. The panel determined that there was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered whether the evidence was the sole and decisive evidence but also that the evidence may go to support Mr Archer.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Witness 2, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The charges against Mr Archer arose during his employment as a Registered Nurse with Service Care Solutions (SCS), which referred him to the Nursing and Midwifery Council (NMC) on 1 March 2021.

On 21 December 2020, by which time Mr Archer had been working for the CMHT for approximately eight weeks, he attended a virtual meeting at 10am. He then abandoned his work that day without telling anyone at the Bolton Community Mental Health Teams (CMHT) or the agency that employed him. Mr Archer's whereabouts were unknown to the CMHT staff throughout the working day and he did not respond to CMHT attempts to contact him. The team manager at the CMHT reviewed Mr Archer's patient notes to ascertain his whereabouts and found significant gaps in his record keeping relating to patients.

On 22 December 2020 Mr Archer's contract with Bolton CMHT was terminated.

Mr Archer provided a statement to the NMC in March 2021 but has otherwise engaged in only a limited way with the NMC investigation. In his statement, Mr Archer explained that he had previously worked with the Bolton North CMHT team but had accepted a temporary position with Bolton South CMHT due to travel constraints. He expressed regret for not contacting his manager on 21 December 2020 to inform them that he could not complete his shift on that day. He said that he attempted to contact Witness 1 without success, and acknowledged that he should have followed up with an email to explain his absence, which he attributed to mental fatigue.

Decision and reasons to amend the charges

The panel proposed the following three amendments to the charges:

1. Charge 5 should include Charge 1 within its scope.

2. Charge 4 - replace the term ~~assessment~~ with **activities.**
3. Schedule 3 item 8 - separate into three allegations.

The proposed inclusion of Charge 1 within the scope of Charge 5 reflects the fact that the allegations in Charge 1 raise questions about Mr Archer's integrity. The proposed amendments to Charge 4 and Schedule 3 have a practical purpose. In Charge 4 the word activities properly reflects the nature of the matters being considered. In Schedule 3 the panel considered that the separation of item 8 into three parts reflected the fact that it had three distinct elements that needed to be considered separately.

The panel bore in mind the overarching objective and Rule 28 of the NMC FTP Rules 2004. The panel invited representation from the NMC case presenter who was given time to consider the amendments and take necessary instructions. Having done so the NMC's position was that there was no objection to the proposed amendments forwarded by the panel and that these amendments could be made without injustice.

The panel was mindful that Mr Archer was not present and has largely disengaged with these proceedings and could not see a purpose in adjourning the proceedings to receive representation on this point from him. The panel concluded that the general public interest in proceeding to deal with this issue outweighed Mr Archer's interest and concluded that the charges could be amended without injustice.

The amendments are as follows:

'That you, a registered nurse:

Charge 4

Between 2 November 2020 and 21 December 2020 exercised inadequate record keeping in that you:

*a) failed to conduct and/or properly record ~~assessments~~ **activities**:*

i) As per Schedule 3;

ii) Generally.

b) failed to administer depot injections and/or properly record that you had administered depot injections:

i) As per Schedule 4;

ii) Generally.

Charge 5

Between 2 November 2020 and 21 December 2020 your conduct in respect of ***charge 1 and/or*** *charge 2 and/or charge 3 and/or charge 4 amounted to a lack of integrity in that you failed to act in a timely fashion or at all to escalate the risk to patients under your care.'*

Schedule 3, item 8

Schedule 3, Item 8 Patient C1 required closer care following their discharge under the Mental Health Act 2020, but your clinical entries were not of the expected standard.

1. ***Clinical entries were not of the expected standard with full MSEs not recorded.***
2. ***An incomplete care plan which required a follow up to address alcohol and substance misuse.***
3. ***Failed to visit Patient C1 on a weekly basis as required under the Assertive Outreach Pathway.***

~~*with full MSEs not recorded and an incomplete care plan which required a follow up to address alcohol and substance misuse and you failed to visit Patient C1 on a weekly basis as required under the Assertive Outreach Pathway.'*~~

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mr Archer. The panel noted that in Mr Archer's response dated 3 January 2023 to a letter from the NMC dated 8 December 2022 about the decision to send the case to the Case Examiners:

> *'I am accepting the regulatory concerns that both my record keeping and patient care were below the standards expected by the NMC of a practicing nurse, during my short time at this placement – On commencement of this placement I was allocated a caseload of patients.'*

The panel also noted that in the same response, which was on the Case Management Form that he returned to the NMC on 3 January 2023, Mr Archer indicated that he accepted the following two concerns:

> ***'Concern 1****: Poor record keeping – in that you failed to make records of vulnerable patients you assessed and administered depot injections to as part of your caseload.*
>
> ***Concern 2****: Poor patient care – in that you were diarised to make weekly contact with vulnerable service users under the Assertive Outreach Pathway however you failed to make contact at all.*'

The panel was clear that these were not admissions to the charges before it.

The panel also took into account that the NMC case presenter made the following request:

> *"If I could refer the panel now to the registrants response to the NMC letter dated the 3rd of January of 2023... I would ask that the panel take these admissions into account. Of course, Mr Archer is not directly admitting every element of the charge. In fairness to him, and I want to make it clear that he's not taking boxes to say that he admits every element of the charge, but what he is doing is offering a more general admission, showing that in my submission he knew that there were truths in the concerns had by the NMC."*

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 witness called on behalf of the NMC:

- Witness 1: Team Manager for Bolton Community Mental Health Teams at the time of the charges

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's consideration of whether to request further information.

The panel when considering the evidence was aware that, for example, it did not have complete patient records which may have assisted it in its deliberations. The panel considered carefully the NMC's overarching objective and whether it should request more documents from the NMC in line with Guidance in NMC DMA6, one section of which states: '*Further evidence: our overarching objective is the protection of the public. Because of this, the panel has a responsibility to obtain further evidence if they are*

concerned that there are gaps in the evidence which prevent them from properly performing their function.'

Following careful consideration of the large amount of evidence relating to the charges, the panel decided not to seek further disclosures. This was because the panel considered that the time needed to find and serve any such documents, assuming that they were indeed available and not subject to data protection restrictions, would be a disproportionate use of parties' time, and may not take the panel any further in its decision making.

The panel's approach to the schedules for Charges 2, 3 and 4

Charges 2, 3 and 4 required the panel to refer to four separate detailed schedules which set out allegations in relation to specific patients. The panel approached this task by considering each allegation in the schedule individually but with reference to the heading of the charge. Charges 2, 3 and 4 are also structured in a way that required the panel to consider whether all charges in the relevant schedule were made out in their entirety or whether the charge was made out generally.

In her opening submission, Ms Morgan explained the approach to be taken as follows:

> *"…you'll see from the charges that there is reference to different schedules and but the term generally is also used as an alternative. This means that if you are not satisfied that every element of the schedule is proven, you may still find the charge proven on the alternative approach..."*

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

Charge 1

On 21 December 2020 left your shift without informing your line manager that you were unwell and unable to complete your shift.

This charge is found proved.

The panel was satisfied that Mr Archer left the workplace on 21 December 2020 without informing his line manager that he was unwell and unable to complete his shift.

The panel was told by Witness 1, Mr Archer's line manager, that on 21 December 2020 she became concerned about Mr Archer's wellbeing when, having attended a virtual meeting at 10:00, he could not be located for the rest of the working day. The panel noted that at around 20:00 on 21 December 2020, Mr Archer sent an email to Witness 1, who had sought to locate him under the CMHT's Lone Working Policy (LWP), saying:

'Apologies for today, [PRIVATE]. Really sorry for causing an inconvenience. I won't be in now till next Tuesday, the 29th, [PRIVATE].'

As Mr Archer had been employed as an agency nurse since 2 November 2020, the panel was satisfied that he would have been aware of the importance of the CMHT's Lone Working Policy (LWP) and the need to report absence. Given the risks of operating in this environment where there are patients with critical mental health needs, who might also have drug and alcohol dependency, the welfare of autonomous staff working in the community mental health role is taken very seriously.

Witness 1 said in her statement that she was sufficiently concerned for Mr Archer and in accordance with the Greater Manchester NHS Foundation Trust – LWP, attended his home address on the evening of 21 December 2020 to check on his welfare.

Based on the evidence before it, the panel concluded that Mr Archer left the workplace without informing his employer and failed to follow the organisation's procedures for reporting absence from work, as evidenced by his previous actions. [PRIVATE]. Witness 1

also said in her written statement to the NMC dated 14 November 2022 that Mr Archer was advised of the correct procedure during his induction which commenced on the first day of his contract.

[PRIVATE]. The panel therefore concluded that Mr Archer’s failure to report on this occasion, was on the run up to the Christmas period, was a blatant disregard to his obligations and he knew of the likely impact on his colleagues by his absence.

In absenting himself from work after the morning team meeting the panel was concerned as to Mr Archer's integrity. He would be aware of the vulnerable state of many patients that would go unaddressed by the team and would be well aware of the need for the Team Manger to ensure his own safety when working as a CMHT member.

The panel therefore found this charge proved.

Charge 2)

Between 2 November 2020 and 21 December 2020 exercised inadequate patient care in that you failed to make contact with patients:

a) As set out in Schedule 1
b) Generally.

Charge 2(a) is found NOT proved.

Charge 2(b) is found proved.

With regards to Charge 2(a), the panel was informed by Witness 1 that a signing-in sheet is maintained daily, listing everyone scheduled to work, whether they are in the office, working from home, or out on assignment.

The panel concluded that while the signing-in sheet is intended to act as a useful reference of staff activities for the day but there were areas of incompleteness. The panel found inconsistencies, including where five people who were known to be attending a meeting about a specific patient not being recorded as in or out of the office on that day. The panel considered that this raises concerns about the overall accuracy and reliability of the signing-in sheet.

Schedule 1

1. **Patients A to O**

'Did not make contact with Patients A to O who required contact at least once every 4 weeks.'

The panel was told by Witness 1 that Mr Archer was allocated 30 patients when he started his temporary role on 4 November 2020. His role was described by Witness 1 as follows:

> *'He joined working for us through Service Care Solutions (SCS) as a band 6 community psychiatric nurse. His role involved care coordinating. I had reviewed Gerard's CV that was sent through to us by SCS and I felt he had adequate experience so we took him on and he was contracted to work until 8 January 2021… He was responsible for managing their mental health needs, assessing their mental state, administering depot medication, assessing risk, liaising with other agencies if patient is involved with other services, completing care plans and risk assessments.'*

In Charge 2, which cross references Schedule 1, it is alleged that between 4 November 2020 and 21 December 2020, Mr Archer did not make contact with Patients A to O who required contact at least once every 4 weeks.

The panel noted Mr Archer's comments as to his record keeping, *'I am accepting the regulatory concerns that both my record keeping and patient care were below the standards expected by the NMC of a practicing nurse during my short time at the placement.'*

Notwithstanding this, the panel considered the evidence relating to each of these patients separately, and in assessing these charges, it conducted a thorough check, cross-referencing multiple records in the process.

The panel was challenged to some extent by the lack of records for some patients, inconsistencies in the approach to record keeping within the team and the fact that some records, notably the multi-disciplinary team (MDT) sign in sheet and depot records, were incomplete. The panel also noted that there were anomalies with the PARIS records, such as the lack of clarity about whether the *'event name'* column was directly related to the patient shown in the patient column. The panel also noted that not all patient names were redacted or anonymised, making it difficult to establish whether any of the names listed related to otherwise anonymised patients and leading to a lack of clarity about whether Mr Archer had made contact with the patients in question.

Nevertheless, the panel gave careful consideration to the documents before it which included the PARIS records, the MDT sign-in sheet, patient notes, and depot records. In her oral evidence, Witness 1 assisted the panel with an explanation regarding the PARIS records in that they showed the access to patient records within the system by Mr Archer. The panel was also told that the sign-in sheets serve as a visual record of all MDT staff movements throughout the working day. The sign-in sheets play an important role in the operation of the lone working policy, in that they allow the team to account for all team members at the end of each working day. However, it was evident to the panel that they were not always completed or accurate.

Based on the evidence, the panel concluded that it was more likely than not that Mr Archer did not make contact with the following patients once every four weeks between 4

November and 21 December 2020: A, C, F, G, H, I, K, L, M, N and O. The panel did not have any records before it to support the view that Mr Archer had the required contact with these patients during the relevant period.

However, the panel concluded that Mr Archer was more likely than not to have had contact with the following patients: B, D, E and J.

Patient B

In reaching its decision with respect to Patient B, the panel noted that there is inconsistency between Witness 1's evidence and the hearsay evidence of Witness 2 as to whether contact took place. Additionally, there is a reference to a depot injection having been administered on 8 December 2020 which would have required Mr Archer's contact with the patient. Given these discrepancies and the fact that there is a record of a contact, the panel did not therefore find this charge proved with respect to Patient B.

Patient D

With respect to Patient D, Witness 1 stated that Mr Archer did not make contact with this patient *'any time'.* However*,* the PARIS records show a telephone call to SU (service user) on 9 November 2020. There are three entries within the PARIS records relating to Patient D and due to these inconsistencies in the evidence in relation to contact with this patient, the panel did not therefore find this charge proved with respect to Patient D.

Patient E

With respect to Patient E, Witness 1 stated that Mr Archer did not make contact with this patient *'any time'.* However, the panel found references to Patient E within the PARIS records for 4, 9, 17, 27 November 2020 and within the sign-in sheet for 16, 19, 23, 30 November and 1 December 2020. The panel considered that this evidence did not support the view that Mr Archer failed to make contact with Patient E. It considered it more likely

than not that Mr Archer made contact with this patient as required. The panel did not therefore find this charge proved with respect to Patient E.

Patient J

With respect to Patient J, Witness 1 said that Mr Archer did not make contact with Patient J at any time. The panel concluded that the evidence does not support this view.

This was because the sign-in sheets for 6 November and 4 December show that Mr Archer arranged to visit this patient on these dates. The panel recognised that this did not amount to evidence that the planned visits took place on these dates. However, based on PARIS records for this patient, the panel considered it more likely than not Mr Archer made contact with Patient J between 2 November and 21 December 2020. The panel also noted that 6 November 2020 fell within Mr Archer's supernumerary week, consequently he would not yet have full responsibility for patients at this time. The panel considered it possible that a colleague made an entry for this patient during the supernumerary week.

The panel did not therefore find this charge proved with respect to Patient J.

Schedule 1

2. **Patient T**

   'Patient T required a visit whilst on home leave on 25 November 2020 and failed to action this.'

With respect to the allegation that Mr Archer did not comply with a requirement to visit Patient T whilst on home leave on 25 November, the panel did not find this charge proved. There are detailed notes about Patient T's care in the weeks leading up and including 25 November, however, there is no reference within these notes to Mr Archer being required to visit Patient T whilst they were on home leave on 25 November 2020. This is the case

even though other visits that Mr Archer was required to carry out are referred to in these notes, including a visit on 23 November, which is also documented in the sign-in sheet and PARIS records.

The panel also noted that an entry in document JMS1, which outlines Mr Archer's '*caseload actions'* shows a record for a visit on 26 November and not 25 November. Furthermore, Witness 1's statement suggests that Mr Archer failed to visit Patient T on 18, 19, 23 and 26 November, but entries in the PARIS records and sign-in sheets indicate that he saw Patient T on 18 and 23 November 2020. The panel was concerned about these inconsistencies.

The panel also noted the high level of oversight of Patient T's care and day to day interactions, as documented in their detailed in-patient notes. It found no references to a missed visit, even though there are references to the patient discussing concerns about their future care in the community upon their discharge from the hospital.

The panel was not satisfied, on the evidence, that Mr Archer failed in this duty. The panel did not therefore find this charge proved with respect to Patient T.

Schedule 1

3. **Patient T**

   'Patient T required a 72 hour follow up review and a 4-7 day follow up by 10 December 2020 and failed to action this.'

There is a record of a home visit to Patient T on 4 December 2020, although it is unclear if Mr Archer conducted it given the patient progress notes only cover the period 17 – 26 November. The entry in the PARIS records for 4 December 2020 show '*Case notes – seen at home for 72hr follow up'.* The panel considered it more likely than not that there was a 72hr follow up given that these records relate to Mr Archer's activity on the PARIS

system and there is a reference in the sign-in sheet dated 3 December 2020 to indicate that a home visit was planned for this patient at 13:00 on that date. The panel consider the suggestion he did not visit within 72 hours is undermined by the additional reference to the visit on 3 December 2020.

In so far as the 4-7 day follow up, [PRIVATE]. The panel was aware from Witness 1's oral and written evidence that Mr Archer was off work from 9 December 2020, and was expected to follow up by 10 December, but [PRIVATE], he did not return until 15 December 2020, having sent an email on 14 December 2020 indicating he wanted to work from home. Given this timeline, the panel found it unlikely that Mr Archer would have been able to fulfil this obligation to complete the patient notes by 10 December 2020, [PRIVATE].

For these reasons, the panel did not therefore find this charge proved with respect to Patient T.

Schedule 1

4. **Patient B1**

'Patient B1 required face to face contact to assess their mental health and failed to action this.'

The panel considered the evidence of Witness 1 who stated in her statement that *'(Patient B1) only had three contacts by telephone with Gerard. He never met Patient B1 face to face to assess his mental state….The entries show that Gerard made contact with Patient B1 few times over the phone and met him at his home on 16 November regarding his drug addiction.'*

The panel considered that the evidence provided by Witness 1 contradicts itself as regards to Patient B1 in that she references three separate telephone contacts and that Mr

Archer never met Patient B1 face to face to conduct the mental health the assessment , whereas she also references a meeting at his home address on 16 November regarding his drug addiction. The panel took the view that this visit on 16 November formed part of the ongoing requirement to include the assessment of mental health. It concluded that there was face to face contact despite the limited documented records to show the outcome of any assessment. The panel noted the difficulties expressed by Witness 1 when engaging with this challenging client group (AOP patients) and they are not always easily accessed. Whilst Witness 1 said that ordinarily she would have expected a fuller record of this contact but she acknowledged that the level of engagement from the patient had a considerable bearing on how much information could be obtained and therefore recorded.

The panel also considered the PARIS access records which showed an Outpatients appointment took place at Barnett house on 26 November 2020. It considered this would have been an opportunity to assess Patients B1's mental state. Of note the team signing in sheet shows a another visit to Patient B1 was conducted by another team member on 16 November 2020. This was another opportunity for Patient B1's mental health to be assessed.

The panel did not therefore find this charge proved with respect to Patient B1.

Charge 2b)

> *'Between 2 November 2020 and 21 December 2020 exercised inadequate patient care in that you failed to make contact with patients:*
>
> *a)…*
>
> *b) Generally.'*

The panel adopted the approach set out by Ms Morgan when considering whether the charge was made out generally under Charge 2(b).

The panel determined that whilst not all charges within Charge 2 (a) were found proved, it considered the ordinary meaning of the word *"generally as shown in Charge 2 (b)"*. Taking account of its findings overall with regards to Charge 2 (a) and the sub-charges in Schedule 1 and an overview of the findings of the charges in 2(a) along with sub-charges in Schedule 1. The panel finds that NMC nonetheless has discharged the burden of proof. This is because, of the 17 patients referred to in Schedule 1, the panel concluded that Mr Archer failed to meet the requirements for contact in relation to 11 patients. The panel considered this to be sufficient to amount to a failure to make contact with the relevant patients generally.

Charge 2(b) is therefore found proved.

Charge 3

> *'Between 2 November 2020 and 21 December 2020 exercised inadequate patient care in that you failed to make contact with vulnerable patients under the Assertive Outreach Pathway in accordance with the requirements of the Pathway:*
> *a) As set out in Schedule 2;'*

When considering Charge 3, the panel bore in mind that, in her witness statement, Witness 1 described the Assertive Outreach Pathway (AOP) as follows:

> *'The AO is more for patients who need closer monitoring and need to be worked with more assertively by the care coordinator. This involves visiting patients at their homes without planned appointments. The patients could have Schizophrenia, diagnosis of psychosis or bipolar disorder. Patients are added on this pathway after a discussion with the MDT team on their current conditions.'*

> *'In summary an AO pathway patient is very difficult to engage and they are likely to be poorly compliant with the medication and the risk of noncompliance and the harm would be that they would relapse into a psychotic illness. This could present*

as them displaying aggression, violence, increased distress and they would experience delusional thoughts or perceptual disturbances. They are likely to have substance misuse issues which overall increases the risk of death or self-neglect.'

<u>Schedule 2</u>

1. **Patient U**

'Patient U required weekly contact and following a request at a zoning meeting on 3 November 2020 for contact to be made that week, failed to make contact until 9 November 2020 by telephone call.'

Witness 1 stated the following in her written statement:

'Gerard was asked to make contact with this patient on 3 November during a zoning meeting. He didn't actually complete contact with Patient U until 9 November by phone call.'

Witness 2 stated the following in her written statement:

'On Tuesday 03 November 2020 the note entered from the morning AO/zoning meeting was: "Had Depot 29/10. Needs contact this week." No evidence within clinical notes that the registrant made contact with Patient U between Tuesday 03 November 2020 and Sunday 08 November 2020.'

When assessing this charge, the panel noted that Mr Archer was on his supernumerary week at the material time and therefore not expected to carry full responsibility for his entire allocated patient list. The panel also noted that the patient progress notes for Patient U are limited to an entry by Mr Archer on 9 November 2020 relating to a telephone call. There is also an entry on the sign in sheets that refer to a cold call for Patient U on 4

November 2020, but no supplementary entry by Mr Archer showing that contact was made in that week as would be expected and requested in the zoning meeting.

The panel therefore find this charge proved with respect to Patient U.

<u>Schedule 2</u>

2. **Patient V**

> *'Patient V required weekly contact from 24 November 2020 to 18 December 2020, you failed to action this, making only 2 telephone calls.'*

The panel noted that two witnesses had reviewed the patient progress notes and found no evidence to indicate that contact had been made by Mr Archer between 24 November 2020 and 18 December 2020. Witness 2 referred to Mr Archer being present at seven zoning meetings, whereas there is reference in evidence to there being meetings on six separate dates. Witness 2's statement contains the following comment '*No evidence within clinical notes that registrant made contact with Patient V'.* The panel applied appropriate weight to the hearsay evidence of Witness 2 which corroborates Witness 1's evidence on this point which is as follows:

> *'We discussed Patient V during zoning meetings in the mornings. Gerard had said that he would make contact with Patient V from 24 November 2020 -18 December 2020 at least once a week. The clinical records for this patient showed that Gerard had not made contact. Only two telephone calls were made to this patient.'*

The panel reviewed all the evidence thoroughly and found no information in the sign-sheets, PARIS records, or any other source indicating that any contact was made during the week of 24 November 2020. The panel noted a single reference to a telephone call from housing, in the PARIS records on 1 December, however, the panel noted this was a call from housing and is not suggestive of contact with the patient. The second call refers

to a call to '*SU'* on 20 November 2020 which predates the period covered in the charge (24 November to 18 December 2020).

Based on the evidence, the panel concluded that Mr Archer did not discharge his duty in relation to the weekly contact for Patient V.

The panel, therefore, found this charge proved in respect of Patient V.

<u>Schedule 2</u>

3. **Patient N**

'Patient N required contact at least once every 4 weeks, failed to make contact at all.'

Witness 1 in her written statement stated that, *'**Patient N** and **Patient O** were also on the AO pathway however Gerard had not made any contact with these patients in four weeks.'*

The panel noted the requirement for contact to be made on a more regular basis and in any event at least once every four weeks as determined by the AOP policy.

The panel did not find any evidence before it to support the view that Mr Archer had made the required contact with Patient N during the relevant period.

The panel therefore found this charge proved in respect of Patient N.

Charge 3a

> ***'**Between 2 November 2020 and 21 December 2020 exercised inadequate patient care in that you failed to make contact with vulnerable patients under the Assertive Outreach Pathway in accordance with the requirements of the Pathway:*

a) As set out in Schedule 2;'

The panel found this charge proved in its entirety.

Charge 3b

'Between 2 November 2020 and 21 December 2020 exercised inadequate patient care in that you failed to make contact with vulnerable patients under the Assertive Outreach Pathway in accordance with the requirements of the Pathway:

a) …

b) Generally.'

Having found Charge 3(a) proved, the panel noted that there was no requirement to consider Charge 3(b).

Charge 4

Between 2 November 2020 and 21 December 2020 exercised inadequate record keeping in that you:

a) failed to conduct and/or properly record assessments:

i) As per Schedule 3;

<u>Schedule 3</u>

1. Patient W

'Having agreed on 26 November 2020 to conduct an outpatient review with Patient W's consultant, failed to record whether this was actioned.'

Although there is conflicting evidence about the date on which Mr Acher was asked to conduct an outpatient review with Patient W's consultant, the panel is satisfied that it was

around 24 November 2020. The panel did not find any evidence to support the view that Mr Archer made a record of his compliance with this request at any point from 24 November onwards.

The panel found this charge proved in respect of Patient W.

2. Patient W

'Having agreed during a zoning meeting on 8 December 2020 to visit Patient W on 11 December 2020, failed to record whether this was actioned.'

The panel noted that Patient W was on the Assertive Outreach Pathway (AOP). Witness 1 said in her oral evidence that tasks relating to AOP patients were likely to be reallocated if the member of staff responsible for that patient was absent from work. Witness 1 said that Mr Archer was absent from work from Wednesday 9 to Friday 11 December and was not back in work until Tuesday 15 December. The panel considered that, regardless of any agreement made on 8 December for Mr Archer to visit Patient W on 11 December, he was unable to carry out this duty to visit Patient W on this date because he was absent from work. Based on the oral evidence of Witness 1, the obligation to visit Patient W on 11 December 2020 would now fall to a colleague who would then be expected to create a record of any visit undertaken in Mr Archer's absence.

The panel found this charge not proved in respect of Patient W.

3. Patient W

'Having agreed during a zoning discussion on 15 December 2020 to arrange a joint visit with Recovery Support to Patient W, failed to record whether this was actioned.'

The panel took into account the evidence of Witness 2. In her written statement, she stated:

‘On 15 December 2020, during the morning zoning meeting, which the Registrant was present at, it is documented that the care coordinator would complete a joint visit on 15 December 2020 with Recovery Support to monitor the patient's mental state. No evidence within clinical notes that the registrant visited Patient W on 15 December 2020.’

The panel concluded that, following the zoning meeting, there was an expectation that Mr Archer would arranged a joint meeting with recovery support in relation to Patient W. The panel did not find any evidence to support the view that Mr Archer recorded whether this was actioned. The panel therefore considered it more likely than not that Mr Archer failed to record whether the joint visit to recovery support was arranged for Patient W.

The panel, therefore, determined that this charge is found proved in respect of Patient W.

4. Patient W

‘Having agreed during a zoning discussion on 17 December 2020 to cold call Patient W, failed to record whether this was actioned.’

Witness two in written evidence states the following:

‘On 17 December 2020, during the morning zoning meeting, which the Registrant was present at, it is documented that the care coordinator would complete a cold call visit on 17 December 2020. There is no other documentation on the patient's record to confirm that this cold call visit took place on 17 December 2020 by the registrant.’

The only other reference to Mr Archer’s obligation to cold call Patient W is provided by Witness 1 at JMS/1: *‘17 December 2020 – Zoning discussion – Gerrard reported he would cold call on 17 December 2020. No evidence this took place’.*

The panel were satisfied of the obligation upon Mr Archer to cold call Patient W in this regard and find no evidence to indicate that this was actioned or recorded by him.

The panel attributed appropriate weight to Witness 2's evidence, which corroborates the evidence of Witness 1 with respect to the question of whether Mr Archer was present at the zoning meeting and whether he was asked to cold call Patient W. The evidence supports the position that Mr Archer failed to record whether the cold call was actioned.

The panel, therefore, determined that this charge is found proved in respect of Patient W.

5. Patient Y

The charge is as follows:

> *'Patient Y required contact at least once every 4 weeks, failed to do so and/or record that you had done so.'*

The panel noted that Mr Archer accessed the PARIS records on 4 and 10 November 2020 and there is a reference to Patient Y on the sign-in sheet on 6 November 2020. However, the panel could not ascertain whether contact actually took place.

Furthermore, Witness 1 refers to a telephone call to the patient on 4 December 2020 which is consistent with the records on the PARIS records. In assessing the charge, the panel was of the view that it is conceivable that contact was made within the first four weeks of Mr Archer's employment. However, there are no records to indicate any such contact. He did not complete the second four weeks of his planned eight week employment contract. The panel determined there were no records of any contact up until 4 December when there should have been at least one recorded contact.

The panel, therefore, determined that this charge is found proved in respect of Patient Y.

6. Patient Z

The charge as set out in Schedule 3 is as follows:

> *'Failed to escalate a request, on 12 November 2020 from a consultant psychiatrist for an informal admission, for a gatekeeping assessment and to escalate to the red zone in respect of Patient Z. You did contact the flow team to request a bed, but you failed to follow this up.'*

This charge is found NOT proved.

The panel was of the view that this was a serious matter and there would have been an expectation on Mr Archer to escalate and/or to record the requirement following an online meeting with the Consultant Psychiatrist.

Evidence shows that Mr Archer took part in the call with the Consultant Psychiatrist on 12 November 2020. The panel does not have access to the patient notes for that day but noted that there is an entry from Mr Archer from 6 November 2020 as follows: '*CPN Discussed with his team leader and Consultant psychiatrist agreeable to see Patient Z for an OPA next week'*

The panel was challenged to some extent by the absence of records for the 12 November. In addition, the panel noted that Witness 1 said the following:

> *'He did contact the flow team to request a bed however didn't follow up anything else and the clinical records show this',*

However, Witness 2 said the following:

> '*The registrant attempted to telephone the bed hub on 12 November 2020, no answer from bed hub and registrant to try again later.'*

The panel noted that there is no reference by either witness to Mr Archer's absence [PRIVATE] on 13 November 2020 which is a day before the weekend. The panel considered that this raises doubts about whether Mr Archer could reasonably be expected to follow this up [PRIVATE].

Witness 1 was asked by the panel during her oral evidence, specifically on the point of this patient's care being handed over in these circumstances, she said that it was part of her role to look at these high risk cases and reallocate the tasks associated with any affected patients.

The panel was unable to rule out the possibility that a handover took place in Mr Archer's absence and noted in this respect the comments of Witness 1 about how important tasks such as this would be reallocated if a member of staff took sick leave. The panel considered it likely that responsibility shifted to another member of staff in Mr Archer's absence.

The panel, therefore, determined that this charge is not proved in respect of Patient Z

7. Patient A1

The charge as set out in Schedule 3 is as follows:

> *'Patient A1 required a hand over of care to a mental health team in Scotland and close the referral, but you failed to action this.'*

The panel noted that there was an entry in the PARIS records for Patient A1 on 17 November 2020 which stated the following: '*Care doc sent to Scotland'*.

The panel also noted that Witness 2's written evidence stated the following: *'It is recorded that on 17 November 2020, documentation was sent by the registrant via administration to*

CMHT in Kilmarnock. This included a care plan, risk assessment and last outpatient clinic letter.'

This evidence contradicts the evidence provided by Witness 1 who stated that no such handover took place.

Based on the evidence, the panel concluded that Mr Archer actioned the requirement to contact the health team in Scotland and closed the referral.

The panel, therefore, found that this charge is found not proved in respect of Patient A1.

8. Patient C1

The charge as set out in Schedule 3 is as follows:

> *'Patient C1 required closer care following their discharge under the Mental Health Act 2020, but your clinical entries were not of the expected standard with full MSEs not recorded and an incomplete care plan which required a follow up to address alcohol and substance misuse and you failed to visit Patient C1 on a weekly basis as required under the Assertive Outreach Pathway.'*

The panel identified three different elements to this charge. They are as follows:

1. Clinical entries were not of the expected standard with full MSEs not recorded.
2. An incomplete care plan which required a follow up to address alcohol and substance misuse.
3. Failed to visit Patient C1 on a weekly basis as required under the Assertive Outreach Pathway.

In relation to the first element of this charge, the panel noted the evidence of Mr Archer's clinical entries and the comments regarding expectations of what should be included. With respect to Mr Archer's record entries, Witness 1 stated:

> *'There is no evidence to show that the patient's mental state was fully assessed, there was no evidence that discussion had taken place with the patient around alcohol and substance misuse. I would have expected Gerard to conduct a mental state examination for Patient C1, talk about his appearance, explore his mood, his home environment, whether the patient was having delusional thoughts, document how the patient spoke to Gerard upon his review, whether he engaged well or if he was hostile towards Gerard. I would have also expected Gerard to explore the patient's understanding of his own mental health.'*

The panel considered that Mr Archer's clinical entries were not of the expected standard because he did not include a full mental state examination. This is demonstrated by the following extracts from the evidence bundle.

> *'Home visit to see Patient C1 at his home address. Patient C1 answered the door and the CPN discussed the new CC. Patient C1 appeared settled with no concerns noted. Patient C1 happy to have depot in 2/3 weeks time. CPN made sure Patient C1 had numbers for CMHT should he wish to contact same.'* This was recorded on 17 November 2020

> *'CPN attended Patient C1's flat to discuss his mental health. Patient C1 answered the door and appeared well with now signs of mental distress noted, good chat on the door step and CPN stated that they will attend next week and administer depot on time. Patient C1 happy with this plan, Patient C1 has the numbers to call should be require any support.'* This was recorded on 3 December 2020.

The panel concurred with the view that these entries do not meet the expected standard and found this part of the charge proved.

In relation to the second element of this charge, the panel was not provided with a copy of Patient C1's care plan and therefore could not assess whether this was incomplete, including whether alcohol and substance misuse needs had been assessed and acted upon.

The panel therefore found this element of the charge not proved.

Finally, the third element of this charge, which deals with the requirement for weekly visits under the AOP, the panel noted that in the document labelled Gerard Archer's Caseload Actions (JMS/1) the following is stated:

> *'Gerard stated that he will see patient again on the 26th or 27th November (weekly contact as per AO policy). This contact was not made by Gerard.'*

The panel found no evidence to indicate that Mr Archer had contact with Patient C1 in the week beginning 23 November 2020.

The panel therefore found this element of the charge proved.

The panel found elements one and three proved and therefore, found this charge in respect of Patient C1 partially proved.

9. Patient C1

The charge as set out in Schedule 3 is as follows:

> *'Having agreed in zoning meetings on 26 November 2020 and 8 December 2020 to have contact with Patient C1, failed to record that these contacts took place.'*

The panel first considered this charge in relation to 26 November 2020. Having already determined that there was no contact with Patient C1 in the week commencing 23 November 2020.

The panel found this charge proved in respect of 26 November 2020.

With respect to contact on 8 December 2020, Witness 2 stated in her written statement,

> *‘During the zoning meeting on 08 December 2020, which the registrant was present at, the following is documented: "T/C contact planned for 11.12.20" No contact was made by registrant until 16 December 2020.’*

This was also corroborated by Witness 1’s Exhibit JMS/1.

The panel determined from the evidence that whilst there was an arrangement to call this patient on 11 December 2020, Mr Archer was unable to fulfil this obligation due to [PRIVATE]. He did not return to the workplace until 15 December 2020 and the panel considered it reasonable therefore to conclude that he would not have been responsible for recording any contact that took place on 11 December 2020.

The panel, therefore, found this charge not proved in respect of 8 December 2020.

The panel, therefore, found this charge in respect of Patient C1 partially proved.

Charge 4a)(i)

> *‘Between 2 November 2020 and 21 December 2020 exercised inadequate record keeping in that you:*
>
> *a) failed to conduct and/or properly record assessments:*
>
> *i) As per Schedule 3*
>
> *ii) Generally;’*

The panel, in approaching 4(a), first considered all of the sub-charges in Schedule 3 which amounted to 12 individual findings across nine separate charges covering five patients, of which seven allegations were found proved.

Charge 4(a)(ii)

Having determined that not all charges set out in Schedule 3, the Schedule associated with Charge 4(a)(i), were found proved, the panel concluded that Charge 4(a)(i) was not made out in its entirety. In line with the approach set out by the NMC case presenter and adopted by the panel, the panel went onto consider Charge 4(a)(ii).

The panel approached Charge 4(a)(ii) using the ordinary meaning of the word *"generally".* Taking account of its findings overall with regards to Charge 4a) i) and Schedule 3 and an overview of the relevant materials before it, the panel finds that the NMC nonetheless had discharged the burden of proof. This is because seven of the 12 allegations relating to the five patients referred to in Schedule 3 were found proved. The panel considered that this amounted to a general failing to conduct and/or properly record activities.

The panel therefore found Charge 4(a)(ii) proved.

Charge 4b) i)

> Failed to administer depot injections and/or properly record that you had administered depot injections:
>
> i) As per Schedule 4;

<u>Schedule 4</u>

4. **Patient W**

'Having agreed during a zoning discussion on 15 December 2020 to arrange a joint visit with Recovery Support to Patient W, failed to record whether this was actioned.'

The panel noted that there is no evidence to suggest that Mr Archer arranged to see Patient W on 26 November 2020 as tasked in the zoning meeting on 24 November 2020 as per Exhibit JMS/1. The sign-in sheet of 26 November 2020 showed Mr Archer working that day and having scheduled appointments with two other patients.

The panel did not find any records to indicate that the depot injection was administered or recorded as administered on 26 November 2020 despite being required to do so as indicated in the evidence of Witnesses 1 and 2.

The panel was not able to determine whether the depot injection was administered because there was no evidence relating to a depot injection to Patient W on 26 November 2020. However, the panel concluded that Mr Archer did not properly record whether he had administered a depot injection for Patient W on that day.

The panel therefore found this charge proved in respect of Patient W.

5. Patient X

The charge as set out in Schedule 4 is as follows:

'*Having been required to administer Patient X's depot injection on 5 November 2020, failed to do so until 6 November 2020.'*

The panel accepted that the depot injection was required to be administered on 5 November 2020 and was not administered until 6 November 2020. The panel heard evidence from Witness 1 who stated that it was acceptable to administer the injection the following day. Additionally, the panel also heard that it was not a significant issue, that this

practice was a regular occurrence given that depot injections were not administered on weekends and at times this client group is difficult to access and/or engage.

The panel determined that administering the depot injection on 6 November 2020 was not unreasonable.

While the charge is factually established, when considering the overarching charge, the panel was informed by Witness 1 that administering the injection the next day was acceptable practice.

Therefore, this charge is found not proved in respect of Patient X.

6. Patient X

The charge as set out in Schedule 4 is as follows:

> *‘Having been required to administer Patient X’s depot injection on 19 November 2020, incorrectly recorded it as being due on 20 November 2020 which is when it was administered.’*

The panel, when considering this charge noted that the depot injection card for Patient X has an entry dated as being given on 6 November 2020 by Mr Archer. The next entry showing date ‘*due’* as 20 November 2020 and as administered on 20 November 2020 is signed by another person. Based on the evidence of Witness 1 the giving of this depot injection on 20 November 2020 would be correct because it is 14 days following the given date of the last depot injection. The entry on 20 November 2020 on Patient X’s depot record is signed by another person and there is no evidence to support the view that Mr Archer made that entry.

The panel, therefore, found this charge not proved in respect of Patient X.

4. Patient Z1

The charge as set out in Schedule 4 is as follows:

> *'Having been required to administer Patient Z1's depot injection on 9 November 2020, failed to do so until 12 November 2020.'*

The panel, in considering this charge bore in mind the evidence provided by Witness 1 about common and accepted practice relating to the completion of depot cards. Moreover, as found in 3X above, Witness 1, in evidence informed the panel that on the front of the prescription card for the depot indicates that the intervals at which the injections are given. Witness 1 also confirmed that staff do not administer the injections on weekends.

Exhibit JMS/13, the depot card for Patient Z1 indicates that paliperidone be administered monthly. The panel noted that Mr Archer's approach accords with the prescription.

The panel, therefore, found this charge not proved in respect of Patient Z1.

5. Patient Z2

The charge as set out in Schedule 4 is as follows:

> *'Having been required to administer Patient Z2's depot injection on 24 November 2020, failed to do so in accordance with the depot card on 30 December 2020.'*

This charge is found NOT proved.

In assessing the evidence the panel concluded that the reference to 30 December 2020 in the charge is incorrect. There is reference in the PARIS records that are provided in Exhibit JMS/19 for 30 November 2020 which are accessed by Mr Archer as well as a reference to a schedule meeting with Patient Z2 in the sign-in sheet with the word depot

besides it. Additionally, the PARIS records show an entry for 1 December 2020 for Patient Z2 *'seen at home F2F for depot'.*

Witness 1 made some reference to Patient Z2's depot card which the panel did not have sight of. As a result, the panel was unable to determine whether the date of 24 November 2020 in the charge was the correct specified due or given date. The panel accepted that a depot injection was administered on 30 November 2020 but was not able to determine whether this was administered late. Due to the lack of access to the depot card for Patient Z2 and the confusion created by the reference to multiple different dates within the charge, (30 December 2020 as Mr Archer had already been dismissed) and the evidence of Witness 1, the panel was not satisfied to the appropriate standard that Mr Archer failed to administer or record that he had administered the depot in accordance with the depot card.

The panel, therefore, found this charge not proved in respect of Patient Z2.

6. Patient C1

The charge as set out in Schedule 4 is as follows:

> *'Having been required to administer Patient C1's depot injection on 9 December 2020, failed to do so until 15 December 2020.'*

This charge is found NOT proved.

Witness 1 informed the panel that Mr Archer was absent from work between 9 to 11 December 2020. The panel noted that the depot injection was said to have been due on 9 December 2020 and that Patient C1 was an AOP patient. Given that Mr Archer was not working on 9 December 2020, he could not have administered the depot injection on this date. He did not return to the workplace until 15 December 2020 (12 and 13 December 2020 was the weekend) and therefore would not be responsible for administering or recording the depot injection which was due on 9 December 2020.

In reaching this conclusion, the panel noted the evidence of Witness 1 about how the task of administering Patient C1's depot injection is likely to have been reallocated to another member of staff in Mr Archer's absence. Furthermore, Witness 1's evidence appears to support the view that the task was reallocated.

Witness 1 states in Exhibit JMS/18:

> *'The depot was due on 9 December 2020, however, despite attempts by another member of staff, no contact with Patient C1 could be maintained.'*

This charge is therefore found not proved in respect of Patient C1.

Charge 4(b) i)

> *'Failed to administer depot injections and/or properly record that you had administered depot injections:*
>
> *i) As per Schedule 4;'*

The panel found five of the six charges within Schedule 4 not proved. As a consequence, Charge 4b) i) is found not proved.

Charge 4b) ii)

> *'Failed to administer depot injections and/or properly record that you had administered depot injections:*
>
> *i)…*
>
> *ii) Generally.'*

The panel found that Charge 4b) ii) is not proved.

Having carried out a thorough examination of all the evidence, which includes Mr Archer's admission to regulatory concerns in his letter dated 3 January 2023 with the appropriate weight applied to these admissions, the panel found only one of six charges from Schedule 4 proved. Even when considering the charges generally, the panel concluded that the burden of proof is not met.

The panel determined that this does not amount to a general failing with respect to this charge.

The panel therefore determined this charge is found not proved.

Charge 5)

> *'Between 2 November 2020 and 21 December 2020 your conduct in respect of charge 1 and/or charge 2 and/or charge 3 and/or charge 4 amounted to a lack of integrity in that you failed to act in a timely fashion or at all to escalate the risk to patients under your care.'*

This charge is found proved.

The panel concluded that Mr Archer's conduct in relation to Charges 1, 2, 3 and 4 amounted to a lack of integrity in that he failed to escalate the risk to patients under his care.

Mr Archer abandoned his work on 21 December 2022 without following the organisation's policy in relation to absence. In doing so, he diverted his colleagues' attention away from their work and towards establishing his whereabouts and the status of his patients, some of whom may have been placed at risk of harm. In addition he did not have the required contact with around half of his allocated patients including some who required a higher level of contact because they were under the AOP. He failed to keep accurate records of

his interactions with many of his patients, did not always update clinical records as required and did not record important details about patient care.

These failures go to the basis of team working and the skills required of practitioners working in CMHT. The team rely on one another to serve the interests of this challenging and at times vulnerable patient group. The panel noted that in Mr Archer's response to the NMC dated 3 January 2023, he said the following:

> *'I was aware of these issues from the start of the placement then continued to struggle to deal with them, upon reflection I should have raised the above issues immediately upon allocation of caseload.'*

> *'I am accepting the regulatory concerns that both my record keeping and patient care were below the standards expected by the NMC of a practicing nurse during my short time at the placement.'*

The panel did not find evidence to show that he alerted his line manager to the potential risks posed to patients under his care by his failings in relation to charges 1, 2, 3 and 4. The panel considered that this amounted to a lack of integrity in the sense that Mr Archer, an experienced professional with full knowledge of the needs of his patients, did not take steps to reduce risks that he had created by failing to contact patients and keep accurate records as required.

The panel, in applying the appropriate burden and standard of proof, finds 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 Archer's fitness to practise is currently impaired. There is no statutory definition of fitness

to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Archer'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 Wisniewska, on behalf of the NMC, 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 Wisniewska identified the specific, relevant standards where Mr Archer's actions amounted to misconduct. She submitted that Mr Archer's actions breached several key standards of the Code. She went through each charge and submitted the below in relation to misconduct.

Charge 1: Mr Archer left a shift early without informing his line manager, violating policies crucial in a mental health setting. This breached the Code's standards on dignity (paragraph 1), cooperation (paragraph 8), and safety (paragraph 19), placing patients at risk of harm.

Charge 2(b): Inadequate patient care also violated the standards for timely and appropriate care (paragraphs 1.2, 1.4, and 19.1).

Charge 3(a): Further inadequate care in specific cases was again a breach of the same provisions.

Charge 4(a)(ii): Failure to properly record or conduct activities violated record-keeping standards (paragraph 10), critical for accurate and safe patient care.

Charge 5: An integrity charge was raised, with Mr Archer violating the requirement to uphold professional standards (paragraph 20), demonstrating attitudinal failings and a lack of remorse, insight, or efforts to improve.

Ms Wisniewska submitted that these actions amount to serious professional misconduct, with a risk of repetition due to Mr Archer's lack of engagement or remediation. The panel is urged to view these breaches as significant, leading to impairment under the 2001 Order.

Submissions on impairment

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

Ms Wisniewska submitted that Mr Archer is unfit to practise without restriction, citing the test from Dame Janet Smith's Fifth Shipman Inquiry Report, confirmed *Grant*. She invited the panel to consider whether Mr Archer's past misconduct or lack of competence impairs his fitness to practise based on the following:

1. **Risk of Harm**: Mr Archer has previously placed patients at risk by failing to complete records, missing patient contact, failing to administer injections, and providing inadequate care. This misconduct poses an ongoing risk as no remediation has occurred, with a likelihood of recurrence.
2. **Dishonesty and Lack of Integrity**: Mr Archer demonstrated a lack of integrity by leaving shifts early and failing to escalate risks for vulnerable patients. This is a serious breach, even if distinct from dishonesty, and undermines professional expectations.
3. **Breach of Professional Standards**: He violated fundamental professional tenets by failing to ensure patient safety, communicate with colleagues, or escalate risks.
4. **Reputation**: The nature of his actions inevitably brings the profession into disrepute.

Ms Wisniewska submitted that all elements of the test are satisfied, with significant risk of repetition due to Mr Archer's attitudinal failings and lack of insight or remediation. She invited the panel to find that Mr Archer's fitness to practise is currently impaired.

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

Decision and reasons on misconduct

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

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

'Treat people as individuals and uphold their dignity
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

Act in the best interests of people at all times

Work cooperatively
To achieve this, you must:
8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

Keep clear and accurate records relevant to your practice
This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.
To achieve this, you must:
10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13.3 ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices
16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training
16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

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
19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.

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 and midwives to aspire to.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view with regard to seriousness that Mr Archer's misconduct related to his poor practice and indicated a dangerous approach to the safety of people receiving care. This persisted throughout his eight week contract and only came to a head when he absented himself from work leaving patients at risk and his colleagues concerned [PRIVATE].

The panel found that Mr Archer's misconduct would be regarded as deplorable by fellow practitioners and his actions fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

'The question that will help decide whether a professional's fitness to practise is impaired is:

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

Nurses occupy a position of privilege and trust in society and are expected to practise kindly, professionally and safely at all times. 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 unwarranted risk of harm, fundamental tenets of the profession were breached and the profession was brought into disrepute as a result of Mr Archer's misconduct. The panel has given detailed findings of facts above in reaching this conclusion in this respect.

In reaching this decision, the panel has borne in mind some specific concerns which it sets out in the non exhaustive list below:

- Abandoning his shift and failing to notify his employer of this fact
- Failing to prioritise patients' needs
- Failing to keep adequate records
- Failing to seek help despite recognising that he was struggling and unable to cope with his caseload throughout his eight week contract
- Failing to adhere to care plans including having the required contact with patients, some of whom were on AOP.

The panel has carefully considered the submissions made on behalf of the NMC concerning whether Mr Archer acted dishonestly. The panel noted that although Mr Archer had not been charged with this, it is very clearly in line with the findings of facts, that he acted without integrity. In this regard the panel particularly noted with concern that he took

a dangerous approach towards people receiving care. In this regard the panel particularly noted Mr Archer has stated he recognised his poor practice, but did not reach out to his manager for help and chose to continue with his poor practice until his last day of work when he absented himself placing his patients at risk and diverting time and resources of his manager who was obliged to seek him out to check on his wellbeing.

Mr Archer's misconduct cuts across all four themes of the Code which are as follows:

- prioritising people
- practising effectively
- preserving safety
- promoting professionalism and trust

It involves fundamental aspects of patient care expected of a nurse. The panel considered that Mr Archer had brought the nursing profession into disrepute through his misconduct.

As to whether Mr Archer is liable in the future to place patients at unwarranted risk of harm, bring the profession into disrepute, breach fundamental tenets of the profession or act without integrity, the panel finds that he presents such a risk.

The panel considered that insight is logically relevant to issues of remediation. It concluded that Mr Archer's insight is limited and there is risk of recurrence of misconduct.

Whereas Mr Archer admitted in correspondence with the NMC that he had been struggling with his workload at the material time, he has not addressed the reasons why he nevertheless continued to work in his role without seeking appropriate support from his line manager. It noted that in correspondence with the NMC dated 3 January 2023, he said that he was aware of these problems from the start of the placement and continued to struggle.

> *'I was aware of these issues from the start of the placement then continued to struggle to deal with them….'*

The panel concluded that Mr Archer's insight is limited and noted that when he was disengaging with the NMC and these proceedings, rather than accept fault he then began to blame others for his actions.

The panel noted that there is limited, if any, evidence of Mr Archer strengthening his practice or showing an understanding of the areas he needs to strengthen. This includes prioritising patients, escalating concerns, working within his capabilities, seeking support accordingly, and communicating with his patients about patient care, and any difficulties in relation to carrying out his role.

The panel concluded, with reference to its findings of fact, especially as to a lack of integrity, that the risk of repetition of misconduct is not highly unlikely.

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.

Taking this into account, the panel find that Mr Archer's fitness to practise is currently impaired and that such a finding is required for public protection. The panel finds that an informed member of the public would be shocked to find that Mr Archer was allowed to return to unrestricted practise at this time such that a finding of impairment in the public interest is required in this case.

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

Sanction

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

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

Submissions on sanction

Ms Wisniewska informed the panel that in the Notice of Hearing, dated 11 July 2024, the NMC had advised Mr Archer that it would seek the imposition of a striking-off order if it found Mr Archer's fitness to practise currently impaired.

Ms Wisniewska reminded the panel that it had found facts proved against Mr Archer who faced several charges, including leaving a shift early, inadequate patient care, poor record-keeping, failing to escalate patient risks, and a lack of integrity. These actions breached the fundamental principles of the Code.

Ms Wisniewska submitted that aggravating factors include the serious risk posed to vulnerable mental health patients, as well as concerns about Mr Archer's lack of insight, remorse, and engagement in addressing these failings, suggesting a risk of repeating the behaviour. She said the only mitigating factor is Mr Archer's prior clean practice record since registration in 2012, but Ms Wisniewska submitted that this does not detract from the gravity of the misconduct.

Ms Wisniewska opposed taking no further action, issuing a caution, or applying a conditions of practice order, as none would adequately protect the public or maintain confidence in the profession.

Ms Wisniewska further submitted that a suspension order would not be appropriate, due to Mr Archer's lack of honesty, integrity, and evidence of strengthened practice.

Ms Wisniewska submitted that a striking-off order is the most appropriate sanction, as the misconduct raises fundamental questions about Mr Archer's professionalism, and the public cannot be protected nor public confidence maintained unless Mr Archer is removed from the NMC Register. Ms Wisniewska concluded that this is the only sanction proportionate to the seriousness of the case.

Decision and reasons on sanction

Having found Mr Archer's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The extent of the risk created by Mr Archer's decision to abandon his shift on 21 December 2020 without alerting his colleagues.
- Nature and extent of the risk of harm to vulnerable patients caused by Mr Archer's inadequate record keeping.
- Limited insight in the sense that Mr Archer does not appear to appreciate or recognise the extent of his departure from the Code and expected professional standards required for safe practice, or the potential impact of his misconduct on patients, colleagues and public trust in the profession.
- There was a pattern of misconduct that breached all four themes of the Code over a continuous period of eight weeks
- Mr Archer's misconduct involved an abuse of his position of trust

The panel indicated that it would begin considering whether it could take into account the mitigating feature of Mr Archer’s length of practice, balanced against the limited period during which the misconduct occurred and the absence of any previous fitness to practise concerns, while reflecting on the NMC Guidance SAN-1.

> *‘For these reasons, panels should bear in mind there will usually be only limited circumstances where the concept of a 'previously unblemished career'[4] will be a relevant consideration when they are deciding which sanction is needed, or in giving their reasons.’*

Taking this into account, the panel decided that it could not consider this as a mitigating feature in this case.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Archer’s practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *‘the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.’* The panel considered that Mr Archer’s misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would neither be proportionate, protect the public, nor be in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Archer's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Moreover, the panel concluded that this order is not appropriate, as it necessitates that the registrant possess both the potential and willingness to respond positively to training, neither of which Mr Archer has demonstrated in the four years since the misconduct occurred. Furthermore, there are attitudinal concerns, as evidenced by his most recent correspondence with the NMC dated 23 June 2023, which are harder to remediate.

Furthermore, the panel concluded that the placing of conditions on Mr Archer's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. Taking into account the SG, the panel noted the following factors which it considers to make a suspension order inappropriate in this case.

- *This was not a single instance of misconduct and a lesser sanction is not sufficient;*
- *There is evidence of a harmful deep-seated attitudinal problem;*
- *The panel is not satisfied that Mr Archer has insight; and*
- *The panel considers that Mr Archer poses a significant risk of repeating the behaviour.*

The misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse.

The panel determined that the misconduct in this case is serious, where Mr Archer's practice indicates a dangerous attitude to the patients in a vulnerable group and while the imposition of a suspension order may afford some protection to patients for the period in

which it is in place, it would fail to maintain public confidence in the profession. This is particularly so, given that Mr Archer in his own admission was aware of the shortcomings in his practice and did nothing to raise any concerns, continuing regardless of the ongoing risks to patients under his care which only came to light after he left.

There is compelling evidence of an attitudinal problem, and Mr Archer presents a significant risk of repetition. Furthermore, Mr Archer has limited insight and has not demonstrated a willingness to remedy the concerns raised, nor has he taken any steps to strengthen his professional practice. Consequently, a suspension order would not adequately safeguard public confidence or uphold the required professional standards.

The panel also noted that the misconduct was not an isolated incident, having occurred over an eight week continuous period, and that it related to fundamental aspects of patient care and involved a significant risk of harm to patients and the public. Furthermore, having found Charges 2, 3 and 4, which were wide ranging and which affected a significant number of Mr Archer's patients, involved a lack of integrity as found proved in Charge 5 and therefore are more difficult to remedy. The panel noted that Mr Archer said in the correspondence with the NMC that he has left the profession and has no intention to return to practice. He has not provided evidence to show that he has taken steps to strengthen his practice and has not demonstrated insight into the gravity of his misconduct.

In light of the relevant NMC guidance, the panel considered that Mr Archer's conduct poses a clear danger to patients.

The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Archer's actions is fundamentally incompatible with him remaining on the register.

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

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

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

The panel concluded that Mr Archer’s actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the NMC Register. The panel was of the view that the findings in this particular case demonstrate that Mr Archer’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.

The panel has taken account of the Overarching Objective and has sought to balance the effect of any sanction with Mr Archer’s financially and professionally in determining sanction. Albeit, the panel has no information from Mr Archer as to the effect of such an order upon him, the panel determined that the public protection and public interest issues in this case outweighs his interest.

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 Mr Archer’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 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 decision will be confirmed to Mr Archer in writing.

Interim order

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

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

Submissions on interim order

The panel took account of the submissions made by Ms Wisniewska. She submitted that an interim suspension order for a period of 18 months should be made on the ground that it is necessary for the protection of the public and is otherwise in the public interest, in order to cover any appeal to be lodged and determined.

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 the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months. This order is for a period of 18 months in order to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.