Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 10 February 2025 – Tuesday 25 February 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Wezi Wilma Msanide**
NMC PIN	14C0813E
Part(s) of the register:	Nurses – Sub part 1 RNMH: Mental health nurse – level 1 (05 May 2014)
Relevant Location:	Surrey
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, lay member) Vanessa Bailey (Registrant member) Oluremi Alabi (Lay member)
Legal Assessor:	William Hoskins
Hearings Coordinator:	Khatra Ibrahim (10 February 2025) Hazel Ahmet (11-25 February 2025)
Nursing and Midwifery Council:	Represented by Dr Marcia Persaud, Case Presenter
Miss Msanide	Present and represented by Gerard McGettigan
Facts proved by admission:	1a, 1b, 1c, 2, 4, 5, 6a, 6b, 7, 8, 9a, 9b, 10
Facts found proved:	3, 11, 12(1.1), 12(1.2), 13a, 13b, 13c, 13d, 13e, 13g(i)
Facts with no case to answer:	12(1.3), 12(1.4), 13f, 13g(ii)

Fitness to practise:	**Impaired**
Sanction:	**Striking-Off Order**
Interim order:	**Interim Suspension Order (18 months)**

Details of Charges:

That you, a registered nurse

1. On 22 December 2022 did not record on the drug charts for Patients A -F
   a. the medication administered,
   b. your signature,
   c. the next appointment date

2. On or around 22 December 2022 did not complete the electronic records for Patients A-F.

3. On or around 22 December 2022 failed to visit Patient G when requested to do so.

4. Breached condition 6 of the Interim Conditions of Practice Order ('ICOPO') imposed on 31 January 2023 by an Investigating Committee of the NMC, in that you did not disclose to the NMC details of anywhere you were working within 7 days and/or the employer contact details

5. Your actions in charge 4 above were dishonest in that you attempted to conceal from the NMC the details of your employer.

6. Between 31 January 2023 and 20 September 2023 breached condition 8 of the Interim Conditions of Practice Order ('ICOPO') imposed on 31 January 2023 by an Investigating Committee of the NMC, in that you,

   a. did not disclose to NHS Professionals that you were subject to an Interim Conditions of Practice order
   b. did not provide NHS Professionals with a copy of the conditions

7. Your actions in charge 6 above were dishonest in that you attempted to conceal from NHS Professionals that regulatory restrictions had been placed on your practice.

8. Breached undertaking 1b which took effect on 20 September 2023, by not sending your NMC case officer your employers contact details.

9. Breached undertakings 3a and 3b which took effect on 20 September 2023, in that you did not give a copy of these undertakings to

a. any organisation or person you work for,
b. any agency you applied to or are registered with for work.

10. Breached undertaking 6 which took effect on 20 September 2023 in that you worked for an agency at more than one setting.

11. On 16 November 2021 had a verbal altercation with an unknown Patient and/or threatened to section them.

12. On one or more occasions on the dates listed in schedule 1, cancelled or failed to attend a booked shift.

13. On one or more occasions failed to uphold the standards of the profession in that you,

    a. were repeatedly late for work.
    b. were rude to colleagues.
    c. used derogatory language when communicating colleagues about patients and/or their families.
    d. refused Patient H leave.
    e. did not attend clinical meetings when required to do so.

f. did not attend booked shifts.
g. did not work cooperatively with colleagues in that you,
   (i) did not follow instructions during the medication round; and/or
   (ii) did not assist with medical incidents.

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

Schedule 1

1. 15.06.23
2. 07.07.22
3. 16.07.22
4. 24.10.22

Decision and reasons on application to amend the charge

The panel, of its volition, amended the wording to charges 4 and 13g (ii).

The panel was of the view that such an amendment was in the interest of justice. The amendments did not change the nature or details of the allegation. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being made. It was therefore appropriate to make the amendment, as applied for, to ensure clarity and accuracy.

The proposed amendments were to correct typographical errors. The panel determined that the proposed amendment would provide clarity and more accurately reflect the evidence.

'That you, a registered nurse:

4. *Breached condition 6 of the Interim Conditions of Practice Order ('ICOPO') imposed on 31 January 2023 by an Investigating Committee of the NMC, in that you did not ~~disclosure~~ **disclose** to the NMC details of anywhere you were working within 7 days and/or the employer contact details*

13. *On one or more occasions failed to uphold the standards of the profession in that you,*

    a. *were repeatedly late for work.*
    b. *were rude to colleagues.*
    c. *used derogatory language when communicating with patients and/or their families.*
    d. *refused Patient H leave.*
    e. *did not attend clinical meetings when required to do so.*
    f. *did not attend booked shifts.*
    g. *did not work cooperatively with colleagues in that you,*
        i. *did not follow instructions during the medication round; and/or*
        ii. *did ~~to~~ **not** assist with medical incidents.*

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

Mr McGettigan and Dr Persaud did not oppose the panel's decision and confirmed the proposed amendments would not cause you any injustice or prejudice and were merely typographical errors.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Dr Persaud, on behalf of the NMC, under Rule 31 to allow parts of the written statements and exhibits of Witnesses 4, 5, 6, 7 and 8 into evidence. The parts related to hearsay evidence in relation to complaints made about the registrant's conduct at work.

Dr Persaud referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and submitted that this case set out the principles to be applied in considering this application.

Dr Persaud identified the various parts of the evidence which were objected to as hearsay and invited the panel to allow them into evidence.

Mr McGettigan referred the panel to the NMC's guidance DMA-6 on evidence which states:

> *'Evidence* may *be unfair where it cannot be challenged.'*

Mr McGettigan submitted that hearsay statements usually carry less weight than oral evidence, due to the inability to test them. He submitted that hearsay evidence may also be inadmissible where no weight could be given to it in the circumstances of the case, even if there was other evidence that could 'corroborate' (or support) it. He referred the panel to the case of *Thorneycroft v NMC* 2014 EWHC 1565 (para 45):

- *'1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness* before *admitting the evidence.*
- *1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.*

- *1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.*
- *1.4.* ***Where such evidence is the sole or decisive evidence in relation to the charges****,* ***the decision whether or not to admit it requires the Panel to make a careful assessment****, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence.* ***The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.'***

Mr McGettigan submitted that the hearsay evidence before the panel is the sole or decisive evidence in relation to the factual accuracy of the allegations made in charges 11-15. He submitted that the evidence relating to these charges is entirely grounded in hearsay. He also submitted that following Thorneycroft and the aforementioned guidance, the evidence leans towards non-admissibility, and requires careful assessment, including considering what other evidence needs to be called, and the potential consequence of admitting the evidence.

Mr McGettigan further submitted that there is no other evidence to be called with respect to those charges. The consequence is that evidence which is impossible or at least very difficult to challenge, regarding incidents that happened long ago, so that you cannot recall them, would be held against you, and may be used to find charges proved. He submitted that there remains an issue of fairness, and that the panel may not be satisfied as to whether the evidence is demonstrably reliable, and that there is no way of testing its reliability.

Mr McGettigan submitted that in view of the anonymity of some of the sources which include patients, who's state of health is unknown. The evidence cannot be demonstrably relied on, and therefore, there is no way for you to test its reliability. He submitted that the witnesses who are due to give oral evidence can only speak on what they can recall, and

there is insufficient detail available for you to appropriately address the allegations put to you, as you cannot recall the existence of most of them. He further submitted that you have disputed some of the charges put to you, due to not being able to remember the incidents. He submitted that it is impossible for you to properly and specifically dispute evidence that is non-specific, and that this would be unfair to your case.

Mr McGettigan submitted that if the panel are not with him, he submitted that the panel should, if it wishes to do so, attach no weight to the evidence before it.

Witness 5's evidence

Mr McGettigan submitted that in regard to Witness 1's statement, they were made aware of the concerns from an anonymised source, and they could not provide a name, and could not remember the name of the receptionist on duty. He submitted that in relation to the following paragraphs and their related charges, they the sole and decisive evidence and are not reliable and cannot be challenged:

- *Paragraph 10 – Charge 13b*
- *Paragraph 11 – Charge 13c*
- *Paragraph 12 – Charge 13a*
- *Paragraph 13 – Charge 13d*
- *Paragraph 15 – Charge 13g*

Mr McGettigan submitted that the only other evidence available for these charges from Witness 5 is Exhibit EC1, where they state: '*…members of staff here had various concerns…'*, but there remains the issue of no names being specified. He submitted that this is the sole and decisive evidence for these charges, that they are not reliable and cannot be tested or challenged.

Witness 6

Mr McGettigan submitted that in regard to Witness 6, he drew the panel's attention to paragraphs 10, 11, 12, 15 and 25. He submitted that the witness statement appears to be based on reports from others, including Person 1, and there is no statement from Person 1 in relation to this incident. He submitted that this is the sole and decisive evidence for charge 13e, and that it is not demonstrably reliable and cannot be challenged.

Mr McGettigan submitted that in relation to paragraph 16 of Witness 6's statement, this paragraph does not relate to any charge put to you. He submitted that it is unfair to adduce, given that it has not been brought to you as a charge. He submitted that again, this section appears to be based on reports from others, and that it is not demonstrably reliable and cannot be tested.

Mr McGettigan submitted that other evidence contained within this witness' statement should also be considered as hearsay:

- An email from Person 2, dated 18 August 2021 – this person is not present at these proceedings to give oral evidence;
- An email from Witness 6, which lists concerns relating to your practice, but these concerns were raised by anonymous sources, who are not able to give evidence attesting to their recollection; and
- An email from Witness 6, which lists concerns relating to your practice, but these concerns were raised by anonymous sources, who are not able to give evidence attesting to their recollection.

Witness 7's evidence

Mr McGettigan referred the panel to paragraphs 10, 11, 12, 15 and 16 and submitted that these paragraphs are the sole and decisive evidence for charge 11. He submitted that they are clearly not demonstrably reliable and cannot be challenged. He submitted that Witness 7 states that they think they heard the concerns from another colleague but cannot be sure. He submitted that Witness 7 confirmed that they have a vague

recollection of the events, but then states they cannot recall who informed them, but that it may have been a consultant. He submitted that the witness admitted that they do not know who the patient is and could not provide details. He further submitted that in paragraph 15, Witness 7 states:

> '*If* [you] *had threatened the patient with a section…'*

Mr McGettigan submitted that based on this statement, it is clear that Witness 7 cannot categorically say that you did threaten the patient, and that paragraph 16 suggests that it was the patient who had mentioned sectioning.

Mr McGettigan submitted that the only other evidence available regarding this witness is a complaint form submitted to NHSP, which is where elements of the witness statement arise from. He submitted that suggests that an unnamed patient told Witness 7, and that there appears to be a nurse and patient response, which is not accepted to be accurately recorded. He submitted that this is clearly unreliable and untestable.

Mr McGettigan referred the panel to an statement produced by Witness 4 and provided by a witness to the events, who apparently made a contemporaneous report, but who has not been produced as a witness. He further submitted that the statement is inaccurate, as there is no mention of threatening the patient with sectioning, and as a result, there is no one who can be challenged, given the hearsay nature of the evidence. He submitted that this exhibit should excluded.

Mr McGettigan referred the panel to paragraphs 20 and 26 of Witness 7's statement, and submitted that this relates to charge 12. He submitted that this is the sole or decisive evidence, and is clearly not demonstrably reliable, and cannot be challenged. He submitted that Witness 7 states that he believes an unnamed colleague told them, and as the unnamed colleague is not present to give evidence, they are unable to say how many your shifts were cancelled on short notice. He submitted that this evidence is unfair and should be excluded.

Mr McGettigan submitted that the only other evidence produced by Witness 7 confirms in its content that it is hearsay, as it is stated '*according to ward team…'* He submitted that it is unclear who is in that team and submitted that therefore the evidence should be excluded.

Witness 8's evidence

Mr McGettigan referred the panel to Witness 8's statement and submitted that in relation to charge 12, regarding the incidents on 7 July 2022, that it is not demonstrably reliable and therefore cannot be challenged. He submitted that the information was learnt from an unnamed person, and that Witness 8 cannot recall who this person was, and if it was Person 3, they are not here to confirm this. He further submitted that the member of staff is not documented anywhere and that it would be unfair to adduce this evidence.

Mr McGettigan submitted that the only other evidence available are the emails contained in exhibits provided by Witness 8, and this confirms that Witness 8 was the person who made the complaint, which is not contained within the evidence. He stated that this is essentially hearsay, as it is not clear how close the shift was to starting, and who relayed the information to Witness 8. He submitted that this would be unfair to you to adduce into evidence and should therefore be excluded.

Witness 4's evidence

Mr McGettigan referred the panel to Witness 4's exhibits and submitted that the statement confirms the following:

- Paragraph 3 – They never met you;
- Paragraph 6 – That all and any feedback is received by Trusts to NHS Professionals (NHSP), is sent out to relevant agencies to resolve directly with the

Trust. NHSP do not have any details as to how feedback is managed, and there is no real input;

- Paragraph 10 – It is clear that Witness 8 has produced the complaint documents via the Trust's system, and includes a summary, which states:

> *'If you would like to obtain further information regarding them, please contact the agencies directly.'*

- It is clear the aforementioned action was not carried out; and
- Paragraph 12 – Reiterates the hearsay nature of Witness 8's statements.

Mr McGettigan submitted that this evidence cannot be challenged and would be unfair to you and your case to adduce into evidence. He submitted that this evidence should be excluded.

Mr McGettigan submitted that in regard to Witness 8's second statement, Witness 8 confirms they never met you. He submitted that Witness 8 makes reference to Witness 5 stating that they had already dealt with an email regarding *'members of staff had concerns…',* but that it is not clear who the members of staff were. He referred the panel to the evidence provided by Witness 4 and submitted that Witness 6 had also dealt with concerns raised: *'we have following concerns…'*, but that they confirm in their statement that it was others who had concerns, and not them. He further submitted that Witness 8 had also confirmed in their statement that although they had dealt with an event where '*staff called her…'*, Witness 8 confirmed that it was not direct knowledge, and therefore is hearsay.

Mr McGettigan submitted that, also within the evidence provided by Witness 1, Person 5 is mentioned, and that it is unclear as to who this anonymised source is. He submitted that in relation to charge 12 (3), this is the sole evidence for this charge, and there is no further information, and that therefore it is not reliable and cannot be tested.

Mr McGettigan referred the panel to the exhibit provided Witness 1, and submitted that there is no author attached to this statement, and that it is the sole evidence for charge 13g (ii), and that it relates to the alleged medical incidents. He submitted that in regard to this charge, it is clearly unreliable and cannot be challenged.

Mr McGettigan submitted that in relation to this exhibit, it is unclear as to who Person 6 is, as there is no details nor is there a statement available. He submitted that this statement relates to charges 12 and/or 13f, and that it is decisive and unreliable.

Mr McGettigan submitted that in regard to a further exhibit provided by Witness 4, the evidence is a collation of information received from anonymous sources and cannot go towards the evidence. He submitted that this exhibit has multiple hearsay accounts within it, which is unnecessary and unfair to your case, and that it should be excluded from the evidence before the panel.

Mr McGettigan submitted that a fourth exhibit provided by Witness 4 is not clear, in that it is unknown who sent the letter to you, which alleges what anonymous sources told the author. He stated that although the contents of the letter are not relevant to the charges brought against you, this is unfair. He also submitted that in relation to two additional exhibits provided by this witness, the contents relate to charges 13 a, b, c, d and g(i); and 12 (3), respectively. He submitted that the evidence is not demonstrably reliable and therefore cannot be challenged.

Mr McGettigan submitted that in relation to another exhibit produced by Witness 4, the author is Person 7, who is not present at these proceedings, did not provide a witness statement, and therefore cannot be challenged on the evidence presented. He submitted that this is decisive evidence in relation to charge 11 and is inconsistent with the account in the complaint form and with Witness 7’s statement. He further submitted that there is no mention of a threat to section the patient, and that Person 7 cannot be challenged on the inconsistencies. He also stated that you dispute this version of events, and that it is

unfairly prejudicial, as you cannot challenge the evidence. He submitted that it would be unfair to admit this exhibit 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 was referred to the approach recommended in *'Thorneycroft'.*

The panel also considered the NMC'S guidance on *'Evidence',* DMA-6, which is derived from the principles set out in *Thorneycroft.* It further considered which parts of the evidence to admit as hearsay.

In general terms, the panel noted that Mr McGettigan sought to exclude the evidence of witnesses who, as part of their normal employment role, received complaints relating to your conduct at work. These witnesses recorded and collated the complaints they had received and, in many cases, completed a complaint form which was then transmitted to the agency through which you had been engaged. In some cases, there were also email exchanges in relation to the complaints in which you participated. The panel did not consider it to be unfair to admit evidence of these complaints as the witnesses who received them were due to give oral evidence and could be cross examined about the circumstances in which the complaints were made, or the emails were written. They produced contemporaneous documentation in relation to those complaints and could be challenged about that documentation.

Witness 5

The panel had regard to Witness 5's statement, in particular paragraphs 10, 11, 12, 13 and 15. It considered that these paragraphs were supported by contemporaneous documentation.

Witness 5 prepared this documentation as part of her role as Ward Manager. She can be challenged about this and the circumstances in which complaints were made to her and the panel can attach appropriate weight to her evidence in due course.

The panel determined that Witness 5's statement including paragraphs 10, 11, 12, 13 and 15, as well and the related exhibit will be admitted as hearsay, and they can be questioned during their live evidence.

The panel therefore decided to admit this evidence.

Witness 6

The panel had regard to Witness 6's statement and in particular, paragraphs 10, 11, 12, 15, 16 and 25 together with the exhibits that relate to those paragraphs. The panel noted that the emails which relate to these paragraphs were contemporaneous. It did not consider it unfair to you to admit these emails. Indeed, you had participated in this email correspondence. Witness 6's evidence in relation to this aspect can be challenged by you and the panel can attach appropriate weight to this evidence in due course.

The panel determined that it would be admitted as hearsay in relation to the exhibit produced by Witness 6and paragraphs 10, 11, 12, 15, 16 and 25, and they can be questioned during their live evidence.

In relation to paragraph 16, relating to further evidence provided by Witness 6, the panel had regard to an email dated 19 August 2021 sent at 3:43:41pm, [PRIVATE]. The panel decided to exclude this email as it has no bearing upon the charges which you face.

Witness 7

The panel had regard to the witness statement (paragraphs 10, 11, 12, 15 and 16), as well as the evidence of Witness 7, which detail a complaint made to Witness 7. The panel

determined that Witness 7 can be cross-examined about the circumstances in which this complaint was made and noted also that there is some further evidence in relation to this complaint in the form of a written statement from a care assistant who allegedly witnessed the episode in question. The panel determined that Witness 7 can be cross examined about the circumstances in which this complaint was made to him and the panel can in due course, attach appropriate weight to his evidence.

The same principles apply to the complaint form completed by Witness 7 and sent to the agency through which you were engaged. The panel determined that it would be admitted as hearsay and paragraphs 10, 11, 12, 15, 16 and they can be questioned during their live evidence.

Witness 8

The panel took into consideration paragraphs 10, 11, 12 and 13. It noted that these paragraphs are supported by contemporaneous documentation. The panel determined that the witness can be cross-examined and challenged in relation to this evidence and the panel can decide what weight to attach to it.

The panel noted that Mr McGettigan did not pursue any issue with the evidence provided by Witness 2 which consisted of a record of shifts worked.

In relation to a further exhibit provided by Witness 2, which relates to a number of complaint forms submitted, and refers to an allegation about the wearing of false nails on the ward. It does not form part of the charges, and the panel decided to exclude it as irrelevant.

Other parts of Witness 2’s evidence can be admitted as they amount to contemporaneous documentation prepared by Witness 4 and she will be giving evidence before the panel and can be cross examined about that documentation.

The panel concluded that complaint forms which were either anonymous or prepared by individuals who were not due to give oral evidence before the panel should be excluded. Accordingly, a number of complaint forms were excluded: and those which were anonymous were excluded. The panel decided that these forms were not capable of any effective challenge, and it would be unfair to admit them in the absence of a witness who had knowledge of these circumstances in which the forms came to be completed.

Further evidence provided by Witness 4, appeared to consist of summaries of various matters which had been set out in complaint forms which the panel had already seen. Applying the principles which the panel has applied throughout this exercise, subsequently, the same complaint numbers will be excluded. These are to be excluded as these witnesses will not be giving evidence and the circumstances in which they made these forms cannot be effectively challenged.

In relation to letters from *'NHS professionals'*, the panel decided to exclude the letters of provided as evidence by Witness 4 dated 10 June 2021 and 29 November 2023. These letters referred to discussions with you and the authors of the letters were not due to give oral evidence. The nature and effect of these discussions, as set out in the letters, could not therefore be effectively challenged by you.

On the other hand, an entirely formal letter from NHS Professional, dated 24 August 2021 can be admitted as there is no reference to any particular discussion with you.

The panel also noted the further evidence, in relation to completing an NMC reflective practice form, in a written report.

Decision and reasons on application to amend the charge

The panel heard the application made by Dr Persaud, to amend charge 13c. This application was made under Rule 28(1) and Rule 28(2) of the *Nursing and Midwifery Rules.*

The proposed amendment was to include further wording into charge 13c. Dr Persaud submitted that this change would provide clarity and more accurately reflect the detail, evidence and seriousness of this charge.

The original written form of charge 13c reads as follows:

13. On one or more occasions failed to uphold the standards of the profession in that you,

c. used derogatory language when communicating with patients and/or their families.

Consequently, the proposed amended charge would read as follows:

13. On one or more occasions failed to uphold the standards of the profession in that you,

c. used derogatory language when communicating with ***colleagues about*** *patients and/or their families.*

Dr Persaud submitted that the NMC have reviewed the evidence and charge 13c, and noted that the amendment of this charge, as stated above, would better reflect the evidence provided by Witness 5.

The panel heard from submissions from Mr McGettigan, who stated that this application is opposed. He submitted that, having regard to the merits of the case, and the fairness of proceedings, the proposed amendment cannot be made without unfairness. He submitted that the evidence referred to by Dr Persaud, which relates to this charge, was made by Witness 5 and was merely hearsay. He further highlighted that Witness 5 had not provided any detail, particulars, names or details, which would support charge 13c further. Mr McGettigan submitted that Witness 5 could not remember the source of the complaint form, which relates to this charge. Witness 5 further was unable to argue or respond to

your denial of this charge, as she was not there to have heard or experienced you stating the alleged derogatory term.

Mr McGettigan submitted that the NMC have had this case for a *'long enough time' and* have had the opportunity to have amended this charge at an earlier time.

Consequently, Mr McGettigan submitted that the questioning he undertook with Witness 5, was undertaken with the original form of charge 13c in the *'back of'* his mind. He submitted that the evidence cannot be remedied, and consequently, the amendment cannot be made without injustice. He therefore submitted that the application to amend this charge is opposed.

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

The panel was of the view that such an amendment was in the interest of justice.

The panel determined discussed the merits of this case. It determined that it has evidence before it that a derogatory comment has been made but highlighted that this was challenged by Mr McGettigan, and at this stage, the panel is not making a determination on how reliable Witness 5's evidence is.

The panel determined that it is the duty of this fitness to practice committee to acknowledge and consider the alleged derogatory comment.

The panel was satisfied that there would be no prejudice to you, and no injustice would be caused to either party by the proposed amendment being allowed. The panel acknowledged that, if Mr McGettigan wished to do so, it will re-afford him with the opportunity to re-call and re-examine Witness 5. The panel considered that it had a public protection duty to consider the evidence before it. It determined that, it was therefore

appropriate to allow the amendment, as applied for, to ensure clarity and accuracy whilst also highlighting the seriousness of the allegation within charge 13c.

Decision and reasons on application of no case to answer

The panel considered an application made by Mr McGettigan on your behalf of no case to answer in respect of charges 11, 12, 13a, 13b, 13c, 13d, 13e, 13f 13g(i) and 13g(ii).

Mr McGettigan submitted that there is insufficient evidence for these charges to be put forward and stated that the evidence which is available, is entirely hearsay and cannot be fully challenged or tested, and, if taken at its highest, could not result in charges made against you.

Mr McGettigan submitted that the only evidence in relation to charge 11, comes from Witness 7. He submitted that the evidence to support this charge is entirely hearsay, and its level of reliability is low as it has been a period of time since it was provided, namely, 3 years ago. He noted that Witness 7 candidly accepted both the *'vague'* nature of his recollection and his *'lack of personal knowledge'.* Therefore, Mr McGettigan submitted that the evidence for this charge is entirely hearsay, and that the level of the evidence in relation to this charge is limited, cannot be fully challenged or tested, and, if taken at its highest, could not result in charges made against you.

Mr McGettigan submitted that in relation to charge 12, the panel can see evidence provided by Witness 8 and Witness 7.

Mr McGettigan submitted that in relation to the first two dates of 15 June 2023, and 7 July 2022, the evidence provided for these dates are entirely hearsay. He therefore submitted that the evidence in relation to this cannot be fully challenged or tested, and, if taken at its highest, could not result in charges made against you.

Mr McGettigan submitted that, in respect of 16 July 2022, and 24 October 2022, there is no evidence before the panel to support these charges. Therefore, there should be no case to answer in respect of this.

Mr McGettigan submitted that in relation to charge 13a, Witness 5's evidence should be considered. Mr McGettigan also referenced the relevant exhibits. He submitted that the evidence for this sub-charge is entirely hearsay, and therefore, the level of the evidence in relation to this charge is limited, cannot be fully challenged or tested, and, if taken at its highest, could not result in charges being found proved against you.

Mr McGettigan submitted that in relation to charge 13b, Witness 5's evidence should be considered. Mr McGettigan also referenced the relevant exhibits, submitting that there are no actual details of your alleged rudeness. He submitted that there is no specific wording in relation to this sub charge, in terms of what *'rude'* wording you had precisely used. Therefore, in considering this and the hearsay nature of the evidence before the panel, he submitted that this evidence cannot be fully challenged or tested, and, if taken at its highest, could not result in charges being found proved against you.

Mr McGettigan submitted that in relation to charge 13c, Witness 5's evidence should once again be considered. He also referenced the relevant exhibits and documents. He submitted that this evidence is hearsay, *'limited in detail'*, and provides no direct evidence. Therefore, he submitted that the evidence cannot be fully challenged or tested, and, if taken at its highest, could not result in charges being found proved against you. In addition, Mr McGettigan pointed out that the evidence did not support the actual wording of the charge in that the evidence, taken at face value, suggested that offensive language was not used in the presence of patients and/or their families.

Mr McGettigan submitted in relation to charge 13d, Witness 5's evidence should once again be considered. Mr McGettigan referenced the relevant exhibits and documents. He noted that there is no evidence provided of patient details or relevant dates; the evidence before the panel is vague. He submitted that the evidence for this sub-charge is entirely

hearsay, and therefore, the level of the evidence is limited, cannot be fully challenged or tested, and, if taken at its highest, could not result in charges being found proved against you.

Mr McGettigan submitted in relation to charge 13e, the evidence of Witness 6 should be considered. Mr McGettigan referenced the relevant exhibits and documents. He submitted that the evidence for this sub-charge is entirely hearsay, and therefore, the level of the evidence is limited, cannot be fully challenged or tested, and, if taken at its highest, could not result in charges being found proved against you.

Mr McGettigan submitted that charge 13f seems to be a duplication of charge 12. Regardless, he submitted that the evidence derives from Witness 6. He once again submitted that the evidence for this sub-charge is entirely hearsay, and therefore, the level of the evidence in relation to this charge is limited, cannot be fully challenged or tested, and, if taken at its highest, could not result in charges being found proved against you.

Mr McGettigan submitted that in relation to charge 13g(i), the panel should consider the evidence provided by Witness 5. He submitted that there is limited detail as to what you are alleged to have failed to do within the hearsay evidence provided by Witness 5. Consequently, Mr McGettigan submitted that the evidence for this sub-charge is limited, indirect, cannot be fully challenged or tested, and, if taken at its highest, could not result in charges being found proved against you.

Mr McGettigan submitted, in relation to charge 13g(ii), that the panel should consider the fact that there has never been a specific statement made with respect to this section of this sub charge. He submitted that there is no direct, or adverse evidence in relation to this, and ultimately, no evidence in relation to charge 13g(ii), at all.

This application was made under Rule 24(7).

Dr Persaud submitted that in respect of charge 11, Witness 7's evidence should be considered as credible. She referenced the relevant exhibits and documents which relate to the evidence of this charge.

Dr Persaud submitted that in respect of charge 12, schedule 1.1 and 1.2, Witness 7's evidence should be considered as credible. She further submitted that Witness 8's evidence is clear and compelling. Dr Persaud further referenced the relevant exhibits and documents which relate to the evidence of these charges. In respect of charge 12, schedule 1.3 and 1.4, Dr Persaud invited the panel to use its discretion to decide whether or not there is a case to answer in respect of these charges.

Dr Persaud submitted that in respect of charge 13a, the evidence of Witness 5 and Witness 6 should be considered.

Dr Persaud submitted that in respect of charge 13b, the evidence of Witness 5 should be considered.

Dr Persaud submitted that in respect of charge 13c, the evidence of Witness 5 should be considered.

Dr Persaud submitted that in respect of charge 13d, the evidence of Witness 5 should be considered.

Dr Persaud submitted that in respect of charge 13e, the evidence of Witness 6 should be considered.

Dr Persaud submitted that in respect of charge 13f, the evidence of Witness 6 should be considered.

Dr Persaud submitted that in respect of charge 13g(i), and 13g(ii), the panel should use its own discretion to determine whether or not there is a case to answer.

Dr Persaud submitted that, in relation to the above-mentioned charges, there is a case to answer.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel was of the view that there had been sufficient evidence to support some of the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer on some of the charges proposed by Mr McGettigan. In particular, the panel did not conclude that complaints to witnesses who were in a managerial position and who recorded those complaints as part of their responsibilities was so weak or tenuous as to justify a successful submission of no case to answer.

However, the panel *was* willing to accede to an application of no case to answer on some of the charges. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In relation to charge 11, the panel determined that there is some evidence which is not so tenuous or weak as to find no case to answer in relation to this charge. It considered the written and oral evidence and exhibits produced by Witness 7. The panel acknowledged that this evidence is hearsay. However, it determined that the strength or weakness of this hearsay is yet to be judged. Therefore, there is a case to answer in relation to charge 11.

In relation to charge 12, schedule 1.1, the panel determined that the evidence before it is not so tenuous or weak as to find no case to answer. It acknowledged Witness 7's written and oral evidence and contemporaneous documents. The panel acknowledged that this evidence is hearsay, however, determined that the strength or weakness of this hearsay is yet to be judged. Therefore, there is a case to answer in relation to charge 12.

In relation to charge 12, schedule 1.2, the panel determined that the evidence before it is not so tenuous or weak as to find no case to answer. It acknowledged Witness 8's written and oral evidence and contemporaneous documents. The panel acknowledged that this evidence is hearsay, however, determined that the strength or weakness of this hearsay is yet to be judged. Therefore, there is a case to answer in relation to charge 12.

In relation to charge 12, schedule 1.3, the panel determined that there is no evidence before it. Therefore, there is no case to answer in relation to this section of this charge.

In relation to charge 12, schedule 1.4, the panel determined that there is no evidence before it. Therefore, there is no case to answer in relation to this section of this charge.

In relation to charge 13a, the panel determined that there is some evidence which is not so tenuous or weak as to find no case to answer in relation to this charge. It considered the written and oral evidence and contemporaneous documents produced by Witness 5. The panel acknowledged that this evidence is hearsay, however, determined that the strength or weakness of this hearsay is yet to be judged. Therefore, there is a case to answer in relation to charge 13a.

In relation to charge 13b, the panel determined that there is some evidence which is not so tenuous or weak as to find no case to answer in relation to this charge. It considered the written and oral evidence and contemporaneous documents produced by Witness 5. The panel acknowledged that this evidence is hearsay. However, it determined that the strength or weakness of this hearsay is yet to be judged. Therefore, there is a case to answer in relation to charge 13b.

In relation to charge 13c as amended the panel determined that there is some evidence which is not so tenuous or weak as to find no case to answer in relation to this charge. It considered the written and oral evidence and contemporaneous documents produced by Witness 5. The panel acknowledged that this evidence is hearsay. However, it determined that the strength or weakness of this hearsay is yet to be judged. Therefore, there is a case to answer in relation to charge 13c as amended.

In relation to charge 13d, the panel determined that there is some evidence which is not so tenuous or weak as to find no case to answer in relation to this charge. It considered the written and oral evidence and contemporaneous documents produced by Witness 5. The panel acknowledged that this evidence is hearsay. However, it determined that the strength or weakness of this hearsay is yet to be judged. Therefore, there is a case to answer in relation to charge 13d.

In relation to charge 13e, the panel determined that there is some evidence which is not so tenuous or weak as to find no case to answer in relation to this charge. It considered the written and oral evidence and contemporaneous documents produced by Witness 6. The panel acknowledged that this evidence is hearsay. However, determined that the strength or weakness of this hearsay is yet to be judged. Therefore, there is a case to answer in relation to charge 13e.

In relation to charge 13f, the panel determined that there is some evidence which is not so tenuous or weak. However, it was of the view that this is the same evidence which is relied upon in charge 12. The panel therefore determined that charge 13f is a duplication of charge 12. The panel therefore decided not to allow charge 13f to proceed further within this case.

In relation to charge 13g(i), the panel determined that there is some evidence which is not so tenuous or weak as to find no case to answer in relation to this charge. It considered the written and oral evidence and contemporaneous documents produced by Witness 5.

The panel acknowledged that this evidence is hearsay. However, it determined that the strength or weakness of this hearsay is yet to be judged. Therefore, there is a case to answer in relation to charge 13g(i).

In relation to charge 13g(ii), the panel considered the fact there is no written witness statement relating to this charge and no exhibits to refer to as the exhibits before the panel have been removed. Consequently, there is no evidence before the panel. Therefore, there is no case to answer in relation to this charge.

Background

On 23 November 2023 the NMC received a referral from Welsh Employer Link Services on behalf of NHS Professionals (NHSP). You were employed by NHSP as an agency nurse to work at the Crisis Assessment Unit in St Thomas Hospital. In this role you had undertaken approximately 30 shifts as a Band 6 nurse since September 2023. In this time, 11 complaints had been raised against you regarding your attitude and behaviour.

Specifically, the complaints concerned your professional behaviour, allegedly:

- arriving late
- not attending shifts
- not following instructions
- being rude
- use of derogatory language

These allegations were said to have taken place on a number of incidents across various wards.

You were placed on an interim conditions of practice order and agreed undertakings. It is alleged that during both of these periods, you undertook a number of shifts at different locations in breach of the terms of the order and the undertakings.

Decision and reasons on facts

At the outset of the hearing, the panel heard from you, whereby you made full admissions to the following charges: 1a, 1b, 1c, 2, 4, 5, 6a, 6b, 7, 8, 9a, 9b, and 10.

The panel therefore finds charges 1a, 1b, 1c, 2, 4, 5, 6a, 6b, 7, 8, 9a, 9b, and 10 proved in their entirety, by way of your admissions.

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

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

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

Witness 1: Deputy Associate Director and Service Manager for Epsom Community Mental Health Recovery Service at Horizon House, Epsom.

Witness 2: Modern Matron at the Hellingly Centre, Sussex Partnership NHS Foundation Trust.

Witness 3: Mental Health Nurse within the Epsom Community Mental Health Recovery Service, Surrey and Boarders Partnership NHS Foundation Trust.

Witness 4: Clinical Lead for Risk and Improvement, NHS Professionals (NHSP)

Witness 5: Clinical Nurse Specialist, University Hospital of Bristol and Weston.

Witness 6: General Manager in Psychological Medicine and Older Adults Directorate, South London and Maudsley (SLAM) NHS Foundation Trust.

Witness 7: Clinical Service Lead for Neurodevelopmental Disorders and Specialist Psychosis Services, SLAM

Witness 8: Practice Development Nurse (Band 6), SLAM

The panel also took into consideration the written evidence of the following witnesses; these statements were agreed and read into the record:

Witness 9: Senior HR Advisor, NHSP

Witness 10: Mental Health Nurse within the Epsom Community Mental Health Recovery Service, Surrey and Boarders Partnership NHS Foundation Trust.

Witness 11: NMC Investigations Team Manager Professional Regulation Directorate.

The panel also heard evidence from you under oath.

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

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

The panel acknowledged that many of the witness statements relating to this case were provided after a substantial amount of time had passed since the occurrence of the events. Furthermore, the statements were made by witnesses who did not witness the alleged events themselves but received reports from those who did witness the incidents and compiled and submitted the complaint forms. The panel acknowledged that the complaint forms are based on hearsay evidence, however, it noted that these were exhibited by individuals in trusted, managerial positions. The panel determined that there is no evidence to suggest that any of these complainants held any motivation to fabricate any complaint they had made. The panel therefore gave them relevant weight.

Consequently, when making their decision on facts, based on the balance of probabilities, the panel were more reliant on the contemporaneous documentations from the time of the alleged events, than the witnesses who produced the documents.

Charge 3

'On or around 22 December 2022 failed to visit Patient G when requested to do so.'

This charge is found proved.

In reaching this decision, the panel took into consideration the written and oral evidence of Witness 1 and Witness 2. The panel also took into account the exhibited documents relating to Patient G's medical records and the extracts from the multi-disciplinary team (MDT) meeting on 22 December 2022.

The panel were of the view that you were requested by your managers to visit Patient G, as he was allocated to your patient caseload and this was deemed an important task to undertake, at the outset. The panel took into account that there is some recorded/written

evidence that you did take some steps to attempt to locate Patient G within records of management meetings. However, you did not enter this information into Patient G's notes.

The panel concluded that when you were tasked *'to visit Patient G'*, it was your responsibility to take appropriate steps if, for any reason, an actual visit could not take place. Only when such steps had been taken would you have fulfilled your responsibility to visit Patient G.

The panel were of the view that in any case, even if you were entirely unable to locate Patient G on the date of your tasking, you had a responsibility to fully handover information regarding your efforts to contact Patient G, and to liaise with other members in the MDT to formulate the next steps. The panel accepted the evidence of Witness 2, who had submitted that you *should* have briefed the rapid response team or contacted other nursing districts; you did not do this.

Consequently, the panel preferred the evidence of Witness 1 and Witness 2, over your evidence, as it considered these to be *'more reliable'*.

Therefore, the panel determined you failed to visit Patient G when requested to do so.

Charge 11

'On 16 November 2021 had a verbal altercation with an unknown Patient and/or threatened to section them.'

This charge is found proved.

In reaching this decision, the panel took into consideration the written and oral evidence of Witness 7, alongside their written complaint which was submitted digitally after the alleged incident. The panel further took consideration of the complaint provided by a support worker, who had submitted a written statement on 27 November 2021, relating to the

alleged verbal altercation between you and the unknown patient. The panel noted that the evidence of the support worker, corroborates the evidence of Witness 7.

The panel did note however, that Witness 7 could not recall whether it was a doctor, or a nurse, who had reported this alleged verbal altercation to him and this was not included within the original complaint.

The panel acknowledged your evidence that you *'cannot recall'* an altercation with any patient, and do not consider yourself to be a 'rude' person. However, it was of the view, that based on the evidence before it, and on the balance of probabilities, it is more likely than not that you did have an altercation with an 'unknown' patient.

Furthermore, the panel determined that, it is more likely than not that you did threaten to section the unknown patient, as mentioned in the charge above. The panel, in concluding this, considered Witness 7's evidence whereby he states that there was a complaint made to him, that the unknown patient was threatened with a Section 5(4). You initially indicated that you were unable to undertake this action, but later concluded in other evidence that you did have the power to detain patients.

Therefore, the panel preferred the evidence of Witness 7 and determined that charge 11 is found proved.

Charge 12, Schedule 1.1

'On one or more occasions on the dates listed in schedule 1, cancelled or failed to attend a booked shift.

1. *15.06.23'*

This charge is found proved.

In reaching this decision, the panel took into consideration the written and oral evidence of Witness 7, including the complaint form which was submitted contemporaneously, in which it stated that the shift was cancelled 49 minutes prior to its commencement.

The panel acknowledged your evidence whereby you submitted that you have worked on this ward previously and have cancelled shifts in the past, but at no time did you do it outside of the specific time permitted. However, you did submit, that you could not recall whether or not you did cancel or fail to attend this booked shift, given the limited information relating to it.

The panel determined that it preferred the evidence of Witness 7 and the contemporaneous documentation, which it found was more credible and reliable, and concluded that it is more likely than not that you did in fact fail to attend a booked shift on 15 June 2023.

Charge 12, Schedule 1.2

'On one or more occasions on the dates listed in schedule 1, cancelled or failed to attend a booked shift.

2. 07.07.22'

This charge is found proved.

In reaching this decision, the panel took into consideration the written and oral evidence of Witness 8. The panel gave particular attention to the email trail, which related to the complaint to NHSP on 8 July 2022. Within this email trail, it was stated that a staff member on the ward was alleged to have phoned you, to whom you then claimed, you had cancelled the shift. However, Witness 8 had stated clearly in her evidence, that you had not cancelled your shift as it was still available when she had attended work the next day; Witness 8 subsequently cancelled the shift herself.

The panel took into account your submission that you could not recall whether or not you were running late, and that you would have called your workplace to cancel a booked shift. You submitted that, given the limited information relating to this charge, you cannot remember what occurred.

The panel, therefore, preferred evidence of Witness 8 and the contemporaneous documentation which it found to be consistent and reliable. It, on the balance of probabilities, was of the view that it is more likely than not that you did in fact fail to attend your shift on 07 July 2022.

Charge 13a

> *'On one or more occasions failed to uphold the standards of the profession in that you,*
>
> *a. were repeatedly late for work.'*

This charge is found proved.

At the outset of your evidence in relation to this charge, you accepted that you were bound by the provisions of the NMC Code. The panel determined that the allegations, if proved, would amount to a failure to uphold the standards of the nursing profession.

Furthermore, the panel concluded that meetings and shifts, fell within the meaning of *'work'*.

In reaching this decision, the panel considered the written and oral evidence of Witness 5, and the complaint form submitted by them at the time, which indicated that you were arriving late to shifts *'consistently'*.

The panel further considered the supporting evidence from Witness 6, who had claimed that you were late to clinical meetings. This, in the panel's view, sufficiently evidenced your lack of punctuality in relation to your work.

Furthermore, the panel considered the contemporaneous evidence in the form of the complaint which was submitted to NHSP, which indicated that you had arrived to your shifts late consistently, even after having been warned.

You submitted that you don't recall *'being late consistently'.* The panel acknowledged that you did admit to being late to work occasionally but noted that you claimed to have always raised this and explained your reasons to your supervisor.

The panel determined that it preferred the evidence of Witness 5 and Witness 6, alongside the contemporaneous documentation. Therefore, on the balance of probabilities, this charge is found proved.

Charge 13b

> ***'***On one or more occasions failed to uphold the standards of the profession in that you,
>
> b. were rude to colleagues.'

This charge is found proved.

The panel in relation to charge 13b, took into consideration the written and oral evidence of Witness 5, alongside the supporting complaint form. Witness 5 stated the following:

> *'I […] spoke to her about this and she did not take this on board'*

You said that you are not a rude person and did not recall this incident occurring.

The panel determined that it preferred the evidence of Witness 5 along with the supporting documentation, and found that it was more likely than not that you were rude to colleagues. Therefore, this charge is found proved.

Charge 13c

'On one or more occasions failed to uphold the standards of the profession in that you,

c. used derogatory language when communicating with colleagues about patients and/or their families.'

This charge is found proved.

In reaching this decision, the panel took into consideration the written and oral evidence of Witness 5, and the fact that this complaint was reported to her.

The panel acknowledged that the NMC have not produced any evidence of Witness 5 having spoken to you in relation to this complaint. However, the panel did acknowledge the contemporaneous documentation surrounding this complaint.

You submitted that this charge is not true, never occurred and that you have never heard this phrase in your life. The panel considered your account to be unlikely.

The panel preferred the evidence of Witness 5, along with the corroborating evidence, and determined that on the balance of probabilities, it is more likely than not that you did use derogatory language to describe patients and/or their families.

Therefore, this charge is found proved.

Charge 13d

‘On one or more occasions failed to uphold the standards of the profession in that you,

d. refused Patient H leave.’

This charge is found proved.

In reaching this decision, the panel took into consideration the written and oral evidence of Witness 5 and her subsequent complaint form, which was sent on 4 June 2024 to NHSP, containing the details of the allegation.

The panel noted, in your oral evidence, you stated that you *‘can’t remember’* refusing any patient their leave, and that you *‘do not’* have the power to do this. However, under cross examination, you acknowledged that you do in fact have the powers to detain a patient for a period of 6 hours.

The panel preferred the evidence of Witness 5 and the contemporaneous documentation before it, noting that it is more likely than not, that on that date, you did refuse Patient H leave.

Charge 13e

‘On one or more occasions failed to uphold the standards of the profession in that you,

e. did not attend clinical meetings when required to do so.’

This charge is found proved.

In reaching this decision, the panel took into consideration the written and oral evidence of Witness 6 and the supporting documentation.

The panel considered the evidence sent to you by Witness 6 in the form of an email on 19 August 2021, stating the following:

> *'I am concerned you have not attended some of the clinical meetings that are vital to participate to discuss your patients and to participate in wider MDT discussions.'*

Your response was as follows:

> [PRIVATE].

The panel further acknowledged an email sent from Witness 6 to NHSP members of staff in relation to your attendance,

> *' … not attending clinical meetings and other team meetings […]'*

You submitted that you never attended any meetings late, but if you were to have done so, you would have provided a valid reason as to why.

The panel preferred the evidence of Witness 6 and the contemporaneous documentation which supports and highlights your failure to attend clinical meetings when required to do so. The panel found the Witness 6 to be credible.

The panel therefore found this charge proved.

Charge 13g(i)

> *'On one or more occasions failed to uphold the standards of the profession in that you,*
> *g. did not work cooperatively with colleagues in that you,*
> *i. did not follow instructions during the medication round; and/or'*

This charge is found proved.

In reaching this decision, the panel took into consideration the written and oral evidence of Witness 5. The panel took into consideration the contemporaneous evidence in the form of a complaint form which described you as: not working cooperatively with colleagues during the medication rounds.

You submitted that you *'do not recall'.* You noted that your duty was to administer medications, which you *'did'.*

The panel preferred the evidence of Witness 5 and the contemporaneous documentation which it found to be credible.

Consequently, the panel found this charge proved.

Fitness to practise

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

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

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

Submissions on misconduct

Dr Persaud invited the panel to take the view that all 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. She also asked the panel to have 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.'*

Dr Persaud identified the specific breaches of the standards which would lead to a finding of misconduct.

Dr Persaud, in relation to misconduct, submitted the following in a written form:

1. *'The meaning of misconduct as defined in Meadow v GMC [2007] 2 W.L.R 286 is nothing less than "serious professional misconduct". In Roylance v GMC (No. 2) [2000] 1 A.C. 311 the essential element of misconduct was defined as follows:*
   "misconduct involved some act or omission, falling short of what would be proper in the circumstances, which was linked to the profession of medicine, though not necessarily occurring in the carrying out of medical practice, and serious..."

2. *And further at p331:*
   "Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word

"professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which would qualify. The professional misconduct must be serious."

3. *As stated by the courts, misconduct must be "serious professional misconduct", there is no definitive list of what would constitute misconduct and each case warrants consideration on its own merits.*

4. *Also of assistance is the NMC guidance (FTP-2a). Key elements of the same are quoted below:*
   "Because fitness to practise is about keeping people safe, rather than punishing nurses, midwives and nursing associates for past mistakes, one-off clinical incidents won't usually be considered serious professional misconduct.
   Even where there has been serious harm to a patient or service-user, provided there is no longer a risk to patient safety, and the nurse, midwife or nursing associate has been open about what went wrong and can demonstrate that they have learned from it, we will not usually need to take action."

5. *The NMC invites the panel to take the view that the facts found proved amount to misconduct. The panel is referred to 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified specific and relevant standards where the registrant's actions amounted to misconduct.*

   THE CODE

   Code 8 Work co-operatively

   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 health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

Code 10 Keep clear and accurate records relevant to your practice

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

To achieve this you must

10.1 *Complete records at the time or as soon as possible after an event, recording if the notes are written sometime 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*

10.4 *attribute any entries you make in any paper or electronic records to yourself, making sure that it is clearly written, dated and time, and do not included unnecessary abbreviations, jargon or speculation*

Code 16 *Act without delay if you believe that there is a risk of patient safety or public protections*

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.*

Code 20 Promote professionalism and trust

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 time of how your behaviour can affect and influence the behaviour of other people

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

Code 23 Co-operate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperation with requests to act as a witness in any hearing that forms part of an investigation, even after you have left he register:

23.3 *Tell employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body*

Charges 1 & 2

6. *The NMC submits that with respect of charges 1 & 2*
   Alleged Breach: *8.2; 8.3, 8.4, 8.5 & 8.6;*
   Alleged breach: *10.1; 10.2 & 10.4.*

7. *The registrant has admitted to poor record keeping in that the registrant failed to record care for up to six patients you treated on 22 December 2022.*

8. *NMC submits that the allegations found proved are serious and called into question the fundamental basics of clinical practice and could be said to represent conduct that fell significantly short of the standards expected of a mental health nurse.*

9. *The NMC submits that although there was no identifiable patient harm caused, there were risks associated, with regards the registrant's poor record keeping. The clinic provided depot to patients with mental health issues who receive the*

medication intramuscularly at specified times to maintain the patient's well-being and minimise the symptoms of their mental health conditions. It is important that records are accurate to allow the patients' mental health to be effectively and appropriately managed; any failures could result in medication overdoses or a significant deterioration in patients' mental health.

10. *The NMC submits that the identified risks remain valid, whilst Miss Msanide said the record keeping was due to the clinic being busy, another colleague had offered to undertake the clinic, but this was declined. Miss Msanide indicated that she was unaware that clinical notes were not saved to System -1, but there was evidence that she had declined training on the system, because she had worked in other roles within the Trust. In evidence she said that she was never offered training, but responded to Panel questions that Witness 2 had spent time with her before 22nd December 2022 in teaching basic functions of System – 1.*

11. *It also is important to note that Ms. Msanide had also managed to save some patients clinical records and not others, which it is respectfully submitted demonstrates that she was able to save records and failed in her duty and responsibility in record keeping. Good record keeping is an integral part of nursing practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow.*

Charge 3

12. *There is evidence that there was a lack of clear communication between the registrant and witness 1 & 2. She was instructed to visit Patient G and did not do so nor did she document the reasons which she articulated in her evidence. The panel noted that there were some recorded/written evidence that you did take steps to attempt to locate Patient G within records of management meetings. However, you did not enter this information into Patient G's notes.*

Code 8 ***Work co-operatively***

Code breached: *8.2; 8.3; 8.4; 8.5; 8.6*

Code 16 ***Act without delay if you believe that there is a risk of patient safety or public protections***

Code Breached: *16.3*

13. *The panel concluded that when you were tasked to 'visit Patient G' it was your responsibility to take reasonable steps if, for any reason, an actual visit could not take place. Only when such steps had been taken would you have fulfilled your responsibility to Patient G.*

14. *The panel were of the view that in any case, even if you were entirely unable to locate Patient G on the date of your tasking, you had a responsibliyt [sic] to fully hando [sic] over information regarding your efforts to contact Patient G.*

15. *[PRIVATE] It could be said that Miss Msanide's conduct had the potential to expose patients to a serious and unwarranted risk of harm.*

16. ***Charges 4 – 7***

Ms Msanide accepted the facts as alleged in these charges.

Charges 8 – 10

Ms Msanide accepted the facts as alleged in these charges

Dishonesty

Code 23 ***Co-operate with all investigations and audits***

Alleged breach: *23.3*

17. *Ms Msanide accepted that she was dishonest in respect of charges 4 & 6 the dishonesty charge at 5 & 7.*

18. *In cross – examination confirmed her state of mind that she knew that her actions were dishonest when she worked her first shift knowing that she had interim conditions of practice on her registration and had neither disclosed to the NMC details of anywhere she was working nor informed the NHSP of the restrictions and provided a copy.*

19. *The registrant knew that she had breached condition 6 of the ICOPO imposed by the NMC on 31st January 2023 restricting her practice and had neither informed the NMC details of her employer. She also breached condition 8 insofar as she had not informed the NHSP that she was subject to an ICOPO and did not provide a copy of the conditions. It is submitted that she had a genuine state of knowledge or belief regarding her actions.*

20. *It is further submitted that Ms. Msanide's actions as charged at (4 & 7) were dishonest according to the standards of ordinary, decent person in that she intended to deceive the NMC and the NHSP. She did not disclose to the NMC details of anywhere she was working or informed the NHSP of the ICOPO and provided a copy of the conditions.*

21. *It is respectfully submitted the registrant has consciously made the decision to breach the conditions of the ICOPO. She showed no respect for authority and a flagrant disregard to her professional and regulatory expectations. She worked 97 shifts. NHSP gained knowledge of the Undertakings imposed against Ms. Msanide's registration on 23rd November 2023, and cancelled 11 shifts which she had booked to work.*

22. *Breaching interim conditions undermines the principles and the trust placed in the nursing profession.*

Professional behaviour

Charges 11; 12 (i); 12 (ii); 13 (a- e) and g (i)

Code 20 Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code [13 b]

20.3 – be aware at all time of how your behaviour can affect and influence the behaviour of other people [charge 11]

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress [charge 11 and charge 13 (d)

23. *The panel has found charges 11, 12 Schedule 1 & 2, and 13 (i) proved. This calls into the registrant's professional behaviour with her colleagues, and to patients and/or families.*

Conclusion on Misconduct

24. *Breaches of the Code do not necessarily amount to misconduct. However, in this instance, the Council submits that the Registrant's conduct had fallen short of professional standards in a significant way.*

25. *The NMC submits, that breaching an interim conditions of practice order demonstrates a lack of respect of the regulatory process.*

a. *Nurses are expected to adhere to the NMC's code which emphasises:*

i. *Prioritising people – Putting patients needs first*

ii. *Practicing effectively – Delivering high – quality care*

iii. *Preserving safety – Ensuring patient safety at all times*

iv. Promoting professionalism and trust -upholding the reputation of the profession

26. The registrant professional behaviour in dealing with patients and he colleagues, the NMC respectfully submits undermines these principles.

Mr McGettigan, in relation to misconduct, submitted the following in a written form:

'Introduction

1. Nine of the charges in this case were proved by way of admission. The majority of the remaining four charges, including their sub-charges, have been found proved against the Registrant. Three sub-charges within, namely 12(3), 12(4) and 13(g)(ii), were dismissed at the "no case to answer stage."

2. These submissions will address the Panel's next task which is to consider whether the matters proved amount to misconduct, and whether the Registrant's fitness to practise is impaired.

3. At the outset, I can indicate that, albeit they remain matters of judgement for the Panel regardless:

(i) The Registrant concedes misconduct.
(ii) The Registrant accepts that the public component of impairment is likely engaged i.e. a finding of impairment is potentially required on public interest grounds.
(iii) The Registrant disputes impairment in respect of the personal component of fitness to practice i.e. risk to the public/patients.

Misconduct

4. The Panel will be aware of the various case law on misconduct. It is suggested that Roylance and Nandi are a useful starting point.

5. *In Roylance v GMC [2000] 1 AC 311 it was stated that:*

   Misconduct is "a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances".

6. *Nandi v GMC [2004] EWHC 2317 (Admin), Collins J indicated that the test of seriousness must be given its proper weight:*

   …in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree.

7. *R (on the application of Remedy UK Ltd) v General Medical Council [2010] DWHC 1245 (Admin) at 37, after a review of the authorities, identified ten principles to assist in determining whether the conduct in question constituted misconduct. It is submitted that the relevant principles are as follows:*

   (1) Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession.

   (2) Misconduct falling within the first limb need not arise in the context of a doctor exercising his clinical practice, but it must be in the exercise of the doctor's medical calling. There is no single or simple test for defining when that condition is satisfied.

(3) Conduct can properly be described as linked to the practice of medicine, even though it involves the exercise of administrative or managerial functions, where they are part of the day to day practice of a professional doctor. These functions include the matters identified in Sadler, such as proper record-keeping, adequate patient communication, proper courtesy shown to patients and so forth. Usually a failure adequately to perform these functions will fall within the scope of deficient performance rather than misconduct, but in a sufficiently grave case, where the negligence is gross, there is no reason in principle why a misconduct charge should not be sustained.

(4) Misconduct may also fall within the scope of a medical calling where it has no direct link with clinical practice at all. Meadow provides an example, where the activity in question was acting as an expert witness. It was an unusual case in the sense that Professor Meadow's error was to fail to recognise the limit of his skill and expertise. But he failed to do so in a context where he was being asked for his professional opinion as an expert paediatrician. Other examples may be someone who is involved in medical education or research when their medical skills are directly engaged.

(5) Roylance demonstrates that the obligation to take responsibility for the care of patients does not cease simply because a doctor is exercising managerial or administrative functions one step removed from direct patient care. Depending upon the nature of the duties being exercised, a continuing obligation to focus on patient care may co-exist with a range of distinct administrative duties, even where other doctors with a different specialty have primary responsibility for the patients concerned.

(6) Conduct falls into the second limb if it is dishonourable or disgraceful or attracts some kind of opprobrium; that fact may be sufficient to bring the profession of medicine into disrepute. It matters not whether such conduct is directly related to the exercise of professional skills.

(7) Deficient performance or incompetence, like misconduct falling within the first limb, may in principle arise from the inadequate performance of any function which is part of a medical calling. Which charge is appropriate depends on the gravity of the alleged incompetence. Incompetence falling short of gross negligence but which is still seriously deficient will fall under section 35C(2)(b) rather than (a).

(8) Poor judgment could not of itself constitute gross negligence or negligence of a high degree but it may in an appropriate case, and particularly if exercised over a period of time, constitute seriously deficient performance.

(9) Unlike the concept of misconduct, conduct unrelated to the profession of medicine could not amount to deficient performance putting fitness to practise in question. Even where deficient performance leads to a lack of confidence and trust in the medical profession, as it well might - not least in the eyes of those patients adversely affected by the incompetent doctor's treatment - this will not of itself suffice to justify a finding of gross misconduct. The conduct must be at least disreputable before it can fall into the second misconduct limb.

(10) Accordingly, action taken in good faith and for legitimate reasons, however inefficient or ill-judged, is not capable of constituting misconduct within the meaning of section 35C(2)(a) merely because it might damage the reputation of the profession.

8. *It is a matter for the judgement of the Panel as to whether the matters which have been accepted amount to misconduct. The Registrant pragmatically concedes that the findings would amount to misconduct on her part.'*

Submissions on impairment

Dr Persaud addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards

and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Dr Persaud, in relation to impairment, submitted the following in a written form:

1. *'In respect of impairment, the NMC invites the panel to have regard to protecting the public and the wider public interest in its determination. This includes the need to declare and uphold proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.*

DMA – 6

2. *The Fitness to Practise Committee's role is to consider whether the professional's fitness to practise is currently impaired. It's not the aim of fitness to practise proceedings to punish a professional for past events. Fitness to practise proceedings are a way for us to establish whether the professional is able to practise kindly, safely and professionally. There might be many situations where something that the professional did in the past gave cause for concern, but the Committee is satisfied that those concerns have now been put right. If the professional's present way of working no longer raises concerns, such as those based on patient safety or in the public interest, then the likelihood is that they can practise kindly, safely and professionally. This will mean their fitness to practise is unlikely to be impaired.*

3. *Article 22(1)(a) of the Nursing and Midwifery Order 2002 provides for misconduct as one of the potential grounds for a finding that a registrant's fitness to practice is impaired.*

4. *If the Panel holds that, as a result of the facts found proven, the Registrant's actions amounted to misconduct, it must then proceed to decide whether her fitness to practice is impaired.*

5. *Mrs Justice Cox noted in CHRE v NMC and Grant [2011] EWHC 927 (Admin) at paragraph 74 that:*

   "In determining whether a practitioner's fitness to practice 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 professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."

6. *At paragraph 76, she set out the following test:*

   "Do our findings of fact in respect of the doctor's misconduct, deficient professional performance...show that his/her fitness to practice 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.*

Charge 1 & 2

4. *In relation to charge 1 & 2 the registered had breached the fundamental tenet of medicine administration, and the principles of documentation /record keeping for clinical records.*

5. *In the Council's submission, this constituted a very serious breach her duty to administer medicine safely and documentation in clinical records in accordance with the Code. She is not currently in a clinical position, but has not precluded*

returning to such a role in the future. The Registrant set out her insight into the nature of her error in respect of these charge in her Reflective Piece.

Limb (a) and (c)

6. *As set out above, there were no harm to the patients however, the incomplete records hampered the ability to reconstruct what went wrong, as to why these records were incomplete. The failure to record patients medication, and especially vulnerable patients in this case was particularly concerning from the standpoint of clinical safety.*

7. *In respect of insight, the Registrant acknowledges that her documentation at the time was not adequate and not good practice. She said that she had made the team aware that she would be completing the charts at the end of the shift and upon her return, but she could not do this on 23rd December 2023.*

8. *In my respectful submission this suggests a serious failure of Ms. Msanide's insight. Basic nursing skills and especially administration of drugs are completed when they are administered. Records to be completed contemporaneously or as soon as possible.*

9. *Ms. Msanide's evidence is that she had made notes, of her actions, contact with patients, recorded but it 'just did not safe' [sic]. In my respectful submission that suggests a serious failing in as much as she took no action to address her difficulties with saving patient records. She was in a position to ask for help, to assist her with saving patients records. It is interesting that she was able to save clinical records of some patients and not others.*

Charge 3

10. *The registrant has demonstrated limited insight and little acknowledgment of the risk to patients and blame appeared to be attributed to others for the conduct alleged. In her evidence in chief she told the panel 'They were putting*

the blame on me, they need to give answers on what did they do from 23rd to 28th December 2022 to keep him safe. According to them I did not visit Patient G, the 22/12/2022 was my last day, she called me to cancel my contract'.

11. *Invite the panel that limb (a) is engaged in the Council's submission, whilst the Registrant's insight is significant, the Registrant's misconduct is of a serious nature and, as set out above, had the potential to cause harm to the patient.*

Charges 4 - 10

12. *The Council submits that the all four limbs of the Grant test are engaged. In respect of charges 4 & 6 the registrant had breached Condition 6 of the Interim Conditions of Practice Order imposed on 31st January 2023, and failed to disclose to the NMC details of anywhere she was working within 7/days and/or the employer details. She had worked as an agency worker with different employers.*

13. *The panel is invited to consider the 2 – limb test set out by the Supreme Court in the case of Ivey v Genting Casinos [2017] UKSC 67, should be applied when considering dishonesty:*

1. *What is the Registrant's genuine state of knowledge or belief regarding her act?*
2. *Was the Registrant act in light of that state of mind dishonest according to the standards of ordinary decent people*

14. *The panel is invited to find that the first limb of the second limb test in Ivey V Genting Casinos is engaged.*

15. *The registrant has demonstrated a flagrant disregard to the NMC as a regulator. Accordingly, a finding of impairment is necessary on the ground of public interest, in order to uphold and declare professional standards, as well as*

to maintain the public's confidence in the nursing profession and the Council its regulator.

16. *The registrant has completed course (exhibited) however, it is respectfully submitted, that the registrant's decision in relation to charges 4 - 7 were premediated and was a subjective decision she took to breach conditions 6 & 8 of the ICOPO.*

17. *Ms. Msanide demonstrates a lack of insight into the consequences of her decision when she consciously chose to breach the said conditions. Or if she had contemplated the consequences she chose to disregard the Regulation process.*

Charges 11, 12 (1) & 12 (2) – 13 (a – e) and g (i)

18. *These charges relate to professional behaviour with patients and colleagues. The registrant has shown disrespect to her colleagues, by attending shifts late, being rude to colleagues, used derogatory language when communicating with colleagues about patients and /or their families, refused patient leave when he was approved such leave, did not attend clinical meetings. Ms Msanide did not flowing instructions in the medical round.*
19. *The registrant has not demonstrated any insight into her failings and her response is denial or cannot recall.*
20. *In my respectful submissions, this calls into question the registrant's understanding of professional behaviour.'*

Mr McGettigan, in relation to impairment, submitted the following in a written form:

'<u>Impairment of fitness to practise</u>

9. *Notwithstanding the above, it is trite law that a finding of misconduct does not lead inexorably to a finding that the Registrant's fitness to practice is impaired – see Cohen v GMC [2008] EWHC 581 (Admin).*

10. *Those findings are about the past, whereas impairment is an assessment addressed to the future, albeit made in the context of the past conduct (see Cheatle v GMC [2009] EWHC 645 (Admin)).*

11. *The key question that will help decide whether a professional's fitness to practice is impaired is "Can the nurse, midwife or nursing associate practice kindly, safely and professionally?" (NMC Guidance on Impairment, 27/2/24, DMA-1)*

12. *The Panel will be aware that there is both a personal and private component to the question of impairment.*

13. *It is emphasised that the test to be applied is whether the Registrant's fitness to practise <u>is impaired</u>. Essentially, the question of impairment looks forward, not back, albeit that it must take account of past behaviours. As reiterated in the case of CHRE v (1) NMC (2) Grant [2011] EHWC 927 (Admin), at paragraph 69:*

    *It is clear, notwithstanding the references in those passages to whether fitness to practise "has been" impaired, that the question is always whether **it is impaired as at the date of the hearing**, looking forward in the manner indicated by Silber J in his judgment.*

14. *Matters which can properly be taken into account in making a determination on fitness to practise were set out in CHRE, at paragraph 76, the well-known formulation of Dame Janet Smith in the Fifth Shipman report was adopted.*

Do our findings of fact in respect of the doctor's … (misconduct) … show that his/her FTP is impaired in the sense that he/she: …

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 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.

15. *According to the text "Disciplinary and Regulatory Proceedings" by Foster, Treverton-Jones and Hanif, the factors to consider on impairment are as follows:*

(1) the need to protect the public (and the public interest);

(2) whether the practitioner's errors are easily remediable and/or have been remedied and/or are unlikely to be repeated, bearing in mind the nature of misconduct found;

(3) events and steps taken in the meantime (including but not limited to any suspension and/or awareness of the mistake):

1. *(a) the Administrative Court has held that the question of whether the registrant has insight into the particular problems identified by a FTP Panel is relevant to whether competency issues translate into risk to the public;*
2. *(b) in Hosny v GMC, the Administrative Court held that the FTP Committee had been entitled to find that, in applying for jobs, a doctor's repeated failure to disclose earlier misconduct proceedings and suspension from the register demonstrated her lack of insight which impaired her FTP;*

(4) evidence from others (sometimes referred to as testimonial evidence) as to current skills and FTP;

(5) whenever the relevant misconduct may have occurred, the impairment must nonetheless be current. However, the FTP Committee is required to take into account the way in which the person concerned acted or failed to act in the past;

(6) the FTP Committee is also entitled to take into account previous disciplinary decisions when assessing the registrant's current impairment;

(7) the fact that a practitioner does not intend to return to practice is not directly relevant to the question of whether their fitness to practise is impaired.

16. *The case of PSAHSC v NMC [2017] CSIH 29 also contains the following commentary at paragraph 27:*

Not every case of misconduct will result in a finding of impairment. An example might be an isolated error of judgment which is unlikely to recur, and the misconduct is not so serious as to render a finding of impairment plainly necessary. On the other hand, misconduct may be so egregious that, whatever mitigatory factors arise in respect of insight, remediation, unlikelihood of repetition, and the like, any reasonable person would conclude that the registrant should not be allowed to practise on an unrestricted basis, or at all. In such a case, to have been guilty of misconduct of such a nature is itself clear evidence that the practitioner should not be allowed to practise, or to practise unrestricted; and the public interest will point to a finding of impairment, and the imposition of an appropriate sanction. On the other hand, as one judge observed 'the (practitioner's) misconduct may be such that, seen within the context of an otherwise unblemished record, a fitness to practise panel could conclude that, looking forward, his/her fitness to practise is not impaired,

despite the misconduct' – Cheatle v GMC [2009] EWHC 645 (Admin) Cranston J at paragraph 20

17. *The PSHASC case also reiterates the point that a perceived need for a sanction, should not be the rationale behind a finding of impairment. The two stages are evidently distinct. See paragraph 30, which includes:*

    If it is thought that the absence of any sanction leads to a decision which is insufficient for the protection of the public and fails to maintain confidence in the profession and its regulation, that can be attributed to the terms of the 2001 Order, which, unlike in the case of certain other health professionals, make a finding of current impairment a prerequisite to the imposition of a penalty. We do not agree with the submission that a perceived need for a penalty means that a finding of current impairment must be made. Whether to make such a finding is a discrete exercise to be addressed on its merits. In any event, in the circumstances of the present case, we would echo the comments of the learned judge in Uppal to the effect that professional standards and public confidence have been upheld by a rigorous regulatory process which resulted in a finding of misconduct.

    <u>Current Impairment- Application to the facts of this case</u>

18. *It is accepted that the public component of impairment is engaged by the admitted facts. It is not accepted that the personal component of impairment is made out. This will be elucidated below.*

19. *The Panel's attention is drawn to the following factors, in light of the above, in considering whether the Registrant's fitness to practise is currently impaired.*

20. *Whilst it is not the most attractive submission to make, it is observed that during the Registrant's time working in 2023 in breach of Interim Conditions of*

Practice, and in breach of Undertakings, there is no evidence that the Registrant caused any harm to patients, or acted in any particular way which caused a specific risk of harm (beyond the fact of working in breach and related risks thereto). The only charge which relates to 2023 (save for the aforementioned breaches and related dishonesty) relates to cancelling a shift and failing to attend on 15th June 2023 (charge 12(1)). There were thus no charges brought or proven for clinical care issues during that timeframe. Further, in terms of the findings accepted and proven against the Registrant at this hearing, it is submitted that there is limited to no evidence of any actual harm caused to patients, caused as a direct result of the Registrant's actions.

21. *The allegations should be considered in light of the wider context of the Registrant's career. The Registrant has been a nurse since 2014. Prior to nursing, she worked as a health care assistant for around 4 years from 2010. After commencing nursing, the Registrant worked part-time as a Band 5 mental health nurse with Huntercoombe Hospital from June 2014 to January 2016, and a similar role in Shrewsbury Court Hospital from January 2016 to October 16. From October 2016 to September 2020, the Registrant worked full-time as a community psychiatric nurse, with South London Maudsley Hospital NHS ("SLAM") Trust. Thereafter, the Registrant was a Band 6 nurse, and worked in a range of roles (see CV at NMC exhibit bundle, pages 9-13). It is important to note that, during all this time, prior to these proceedings, the Registrant has never faced any regulatory issues.*

22. *The context at the time of the allegations has been indicated by the Registrant, in particular through her oral evidence. [PRIVATE] It is submitted that the Panel could conclude that the actions of the Registrant, including her dishonest decisions, took place in a context where her judgement was clouded by the turbulent time she was encountering. In the Registrant's words from her oral evidence, "At that time I was not thinking straight. I was just doing things. It was quite a difficult time for me." The Registrant added, "Even today I am finding it*

hard to come to terms with what transpired. [PRIVATE] (my note- subject to correction). It is clarified however, for the avoidance of any doubt, that the context is not proffered as an excuse for the actions, the Registrant readily accepts that her actions were inexcusable, the context is simply proffered as a relevant factor for the Panel to take into account.

23. *The Panel might consider that the Registrant has reflected and ruminated upon her actions and the related impacts and risks. The Registrant indicated in oral evidence, "I have reflected. It has been 2 or 3 years. As a professional nurse I should be honest at all times. Be honest and open. Get the help I needed. Called the NMC or RCN. I have learnt and this will definitely not repeat itself" (my note). The Panel might consider that the actions and proceedings have had a salutary impact upon the Registrant, and a stark lesson has been learnt. The Registrant described how she understood the risks that her actions could have caused.*

24. *The Registrant also provided a written response to the breach/dishonesty allegations dated 20th February 2024, prior to an Interim Order Panel hearing (page 2 Registrant bundle 2). This includes:*

(i) *Having reflected back I genuinely regret it and if I could turn back the hands of time I surely wouldn't have made that mistake hence I am sincerely sorry for the measures I took.*

(ii) *I am sincerely sorry for my actions and if I would be given another chance I can ensure I will do better and will take into account what is expected of me and will become a better nurse as I believe experience is the best teacher in life.*

(iii) *I would also like to apologise to the members of the public patients and trust for disappointing with my actions and if given a chance I will be the good nurse I have been for the past 9 years and 9 months.*

25. *The Panel might consider that the Registrant has displayed a degree of insight, regret and remorse.*

26. *The Registrant indicated that in her view, her continued practice would not pose a risk to the public. She conceded that she was "not perfect", but argued that she is a competent nurse, who has got confidence, that this was the first time anything like this had happened, and that it would never happen again.*

27. *The Registrant averred that it was the circumstances at the time which contributed to her dishonesty, but that if similar circumstances were to arise now, there is no possibility that she would act in a similar fashion. The Registrant indicated that nursing has been her passion from childhood and that she fulfilled that dream. [PRIVATE] The Registrant indicated that she believes she is caring, "I just like to see others happy, especially those in my care" (oral evidence- my note). The Registrant indicated that she is a good team worker.*

28. *The Registrant accepted the majority of the allegations at an early opportunity, in particular the most serious allegations of dishonesty, and held her hands up fully. Save for charge 3, the remainder of the charges that the Registrant did not accept were largely around 3 years ago and grounded in hearsay, and it is submitted that she should not be reproached for her approach to those charges. The Panel might accept that it could be difficult to fully accept an allegation one does not specifically recall. The Registrant has engaged with the NMC proceedings, and gave evidence before the Panel. It is submitted that she made no attempt to prevaricate or vacillate regarding the seriousness of her dishonest actions, in particular. The Registrant gave lengthy evidence and withstood skilled cross-examination.*

29. *The Registrant has faced an Interim Suspension Order since 20th February 2024. She has since been unable to practice nursing at all, [PRIVATE] From this, and other elements of the Registrant's oral evidence, the Panel could*

consider that there has been an element of punishment faced by the Registrant as a result of her actions already. The Registrant has had a long opportunity to ruminate upon the consequences of her actions.

30. *The Registrant has provided various training documents (pages 3-6 and 15-18 of the Registrant bundle 2). Some of this training is directly relevant to the concerns in this case including:*

(i) Mental Health Awareness, 29th June 2023 (page 3)
(ii) PSTS/Conflict Management, 17th March 2023 (page 4)
(iii) Clinical Records Keeping Training Course, 20th January 2023 (page 5)
(iv) HSG Medication Awareness Training, 2nd February 2023 (page 6).
(v) Safeguarding and Protection of Adults, 21st June 2024 (page 15).

31. *The Registrant has also provided an email from a Senior Consultant at MSI Group Ltd to NMC dated 16th January 2023 (page 7 RB2) which includes: "We've had no issue in the past with Wezi's safeguarding or record keeping, and this is the first time she has received such complaints." The Registrant has provided 2 testimonials. One is from a nurse…, who has worked directly with the Registrant … (who) speaks positively of the Registrant's skills, attributes and abilities, including:*

(i) Miss Msanide is a very hard working person and a very good team player. Miss Msanide is a problem solver who is always willing to be there for others.
(ii) She takes pride and she's passionate in all that she does. When faced with difficult challenges she's able to handle it well and she's always willing to learn from her mistakes.
(iii) Miss Msanide is always ready to educate others and supports them to attain their full potentials. She is also so funny and whenever she's on duty she is all smiles and will make jokes when necessary.

It is acknowledged that these documents pre-date the most serious charges (the dishonesty charges) therefore can have no weight with respect to those matters, however they are proffered as being potentially relevant to the remainder of the charges, and also to support the argument that the Registrant's actual clinical/patient care and nursing abilities are sufficiently competent for safe practice.

32. *The Panel could conclude that even where there was at any point misconduct, and related impairment, there is no current impairment, at the date of this hearing. It is submitted that the Panel could, in all the circumstances, conclude that the misconduct is "such that, seen within the context of an otherwise unblemished record…….. looking forward, her fitness to practise is not impaired, despite the misconduct." The Panel could conclude, in light of the Registrant's unblemished prior work record, reflection, and further training, that the Registrant is now in a position whereby her fitness to practice is not impaired. The majority of the incidents also occurred a while ago now at this juncture. The panel could consider that "professional standards and public confidence have been upheld by a rigorous regulatory process which resulted in a finding of misconduct."*

33. *It is submitted that, having heard the Registrant's oral evidence, there is no question as to the passion for and commitment to nursing on the part of the Registrant. It is what she wanted to do from a young age. It is her passion. The Registrant averred in her oral evidence, with some force, that nothing similar will ever be repeated.*

34. *It is accepted that the panel will unavoidably approach matters of dishonesty with a significant degree of caution and concern, and the seriousness of the Registrant's actions cannot be gainsaid, however it is respectfully submitted that the context, and surrounding circumstances should be factored in. As above, it is suggested that the dishonesty could be seen in the context of impulsive, foolish decisions, where the Registrant considers that her judgement*

was clouded [PRIVATE]. She did not give sufficient thought to the dishonest element of her actions, and made entirely irrational and inexcusable errors. The Registrant has never done this before, and has no pre-existing issues of dishonesty. There are no wider pre-existing attitudinal concerns in terms of honesty. This was an aberrational episode, for which she indicates regret and remorse. It is submitted that the lesson has been learnt, and there is no risk of repetition. It is suggested that the panel must consider the dishonesty element in light of all of this, the wider circumstances and context, and the Registrant's honesty and candour immediately after the issue was queried, which has continued to date since.

35. *The Registrant has made some admissions from an early opportunity, and co-operated with the NMC in the course of their investigations. The Registrant has fully engaged with the hearing, and been pragmatic in the decisions she has taken, such as accepting most charges and facts alleged, accepting misconduct, and conceding impairment on public interest grounds. It is submitted that she should be given a significant degree of credit for her approach.*

36. *It is respectfully submitted that, in light of all of the above, the panel could find that the personal component of fitness to practise is not engaged in this case. It is submitted on behalf of the Registrant that there would be no risk to the public should the Registrant be permitted to practice unrestricted.*

37. *The Panel need to also consider whether the public component of impairment is engaged by the admitted facts. The Panel will have to address the question of whether, given the nature of the allegations and the facts admitted, public confidence in the profession would be undermined if there were to be no finding of impairment.*

38. *It is respectfully suggested that whilst these incidents must be considered serious matters, the Panel has to consider all of the aforementioned, including the overall circumstances and context. The Panel should take into account the submission that no harm to patients was proven as caused as a direct result of the actions, the context to the actions, the Registrant's personal circumstances, and the stress and pressures she felt under. The Panel should also consider the history of the matter, including how the Registrant responded to the allegations, and the absence of any prior adverse record.*

39. *It is conceded that an ordinary, well-informed member of the public who was aware of all the circumstances, might remain troubled by the absence of a finding of impairment..*

40. *Finally, the panel have heard oral evidence regarding the Registrant's hopes for the future, subject to the outcome of these proceedings. The Registrant desperately hopes to be permitted to return to nursing at some point, and is intensely motivated to be a successful nurse, which is and has always been her passion. [PRIVATE] The Registrant is trying to move on with her life and learn from the very difficult experience which she has put herself through.*

41. *In light of all of the above, it is submitted that the events giving rise to the charges are not matters which should ground a finding of* ***current impairment****, in terms of the protection of the public. It is conceded that the events may give rise to a finding of impairment in terms of the public interest/perception.*

<u>Conclusion</u>

42. *It is submitted that it is matter for the judgement of the Panel as to whether there is misconduct in respect of the charges admitted. For the reasons outlined above, it is conceded that this is likely, and the Registrant takes no issue in this regard.*

43. *Where misconduct is found, it is submitted that the Panel should find that there is no impairment of Ms Msanide's fitness to practice, on the private component.. Whether or not the Panel consider that there was at a previous juncture some level of impairment, it is contended that at this juncture, at the date of this hearing, the Registrant's fitness to practice is not currently impaired, in the private component sense. In short, that there would be no risk to the public relating to the Registrant's unrestricted practice.*

44. *It is contended that where impairment is found, the basis of any such finding should be on the public component only.'*

The panel accepted the advice of the legal assessor which included reference to the principles contained in: *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 Code. The panel considered the charges in turn in deciding whether they amounted to misconduct.

With regards to charge 1 and 2, the panel considered these charges together as they both related to basic nursing functions. The panel noted the context in which these charges arose, which was two days preceding the weekend and the Christmas break, where the mental health team would be closed. The panel determined that by failing to fulfil your relevant tasks you added to the workload of your colleagues which put patients at risk of harm, as you left your colleagues with incomplete information with regards to medication administration records. This could have led to your colleagues to give medication to patients in overdose. The panel noted that both of these charges individually and cumulatively amounted to misconduct.

With regards to charge 3, the panel acknowledged that this was a mental health patient that you were required to visit. The panel accepted that you did take some steps in trying to visit and noted that you should have taken further steps. You failed to document or inform others of the actions you undertook in trying to locate Patient G. However, you did take steps to locate him; in these circumstances the panel determined that your actions were not so poor as to be deplorable and to amount to misconduct.

The panel considered charges 4, 5, 6, 7, 8, 9 and 10 together as they all related to breaches of orders and/or dishonesty, either to your employer or to your regulator. The panel determined that this was pre-meditated, repeated and persistent dishonesty over a period of 9 months during which you worked 97 shifts. The panel determined that any fellow practitioner looking at your actions would consider it to be a serious departure from the standards expected from a nurse, as you are under a duty to be honest with your employer and the regulator. The panel determined that breaching your interim conditions of practice order and undertakings and therefore being dishonest to your employer and the regulator amounted to misconduct.

With regards to charge 11, the panel determined that being in a trusted position as a nurse and then getting into a verbal argument and subsequently threatening a patient to be sectioned was a serious departure from your role. The panel determined that your actions in this charge were a very serious breach of the Code and amounted to misconduct.

With regards to charge 12, the panel determined that such actions had the potential of putting patients at risk of significant harm and therefore amounted to misconduct.

Finally, with regards to charge 13, the panel considered all the sub-charges. The panel determined that all aspect of this charge amounted to serious misconduct. The panel acknowledged that some parts of this charge, particularly the use of derogatory language, refusing a patient leave and not working cooperatively with your colleagues were extremely serious departures from behaviour expected from a registered nurse.

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

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.5 respect and uphold people's human rights.'

*'**2 Listen to people and respond to their preferences and concerns***

To achieve this, you must:

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

*'**8 Always practise in line with the best available evidence***

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 health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk'

*'**10 Keep clear and accurate records relevant to your practice***

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

To achieve this, you must:

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

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 records accurately and …, 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'

'20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

'23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the*

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

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

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

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered the four limbs above in the context of your past actions and it is satisfied that these limbs are engaged in your case. The panel determined that through your misconduct you put patients at unwarranted risk of harm. The panel determined that you brought the nursing profession as a whole into disrepute through your misconduct. Your actions breached fundamental tenets of nursing, relating to prioritising people, practising effectively, preserving safety and promoting professionalism and trust. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel went on to consider whether your misconduct is capable of being remediated, the extent to which you have remediated it and whether, in all of the circumstances your misconduct is highly unlikely to be repeated.

The panel was satisfied that the misconduct in this case is capable of being addressed. The panel was of the view, that all of the misconduct, apart from the dishonesty, could be put right by further retraining.

With regards to dishonesty and breaches of the interim conditions of practice order, the panel determined that this was something extremely difficult to remediate as it related to attitudinal issues.

Therefore, the panel also carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account your insight, remorse and the re-training you having undertaken, as evidenced by training certificates produced by you.

Regarding insight, the panel considered that your reflective piece and oral evidence was limited and inward looking. It determined that it did not address the wider public issues and the impact that your misconduct had on patients, colleagues and the profession. The panel noted your oral evidence in which you told the panel that you realised your mistakes. You told the panel that you understood what checks and balances to put in place so that your actions found proved are not repeated. The panel was of the view, that your insight was still at the very early stages and therefore, limited.

The panel is of the view that there is a risk of repetition based on your lack of insight. The panel noted that you have made early admissions in this case and have done a little bit of retraining. However, the panel was of the view that there being no strengthening of practice and taking into account the fact that you have previously breached conditions in place that were put before you by your regulator, there was a risk of repetition of facts found proved.

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

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

The panel concluded that a well-informed member of the public, who was aware of all your insight and remediation, would still be extremely concerned if no finding of impairment was made, in light of the seriousness of your misconduct. The panel concluded that public confidence in the profession, and the NMC as its regulator, would be undermined if a finding of impairment were not made in this case and further that such a finding is necessary to declare and uphold proper standards amongst members of the profession. Accordingly, the panel was satisfied that your fitness to practise is also impaired on the ground of public interest.

Having regard to all of the above, the panel was satisfied that your 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 you off the register. The effect of this order is that the NMC will show that you have been struck-off the register.

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

Submissions on sanction

Dr Persaud submitted the following in a written form:

*'**Submissions on sanction***

1. *The panel is referred to the NMC guidance which states it should bear in mind proportionality. The panel should strike a fair balance between your rights as a nurse and the NMC's overarching objective of public protection, or otherwise public interest, to declare and uphold professional standards and maintain public confidence in the nursing profession. It should apply the right amount of regulatory force to deal with the 'target risk', but no more, and start at the lowest level in terms of severity, only escalating to increasingly higher ones if it deems that lower ones are inappropriate.*

Misconduct

2. *The panel its' determination found that the registrant's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.*

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

Impairment

4. *The panel then considered the test promulagated re: CHRE v NMC and Grant [2011] EWHC 927 (Admin) and was satisfied that all four limbs were engaged in the registrant's case. The panel determined that the registrant brought the nursing profession as a whole into disrepute through her misconduct, and her actions breached fundamental tenets of nursing, relating to prioritising people, practising effectively, preserving safety and promoting professionalism. The panel is satisfied*

that confidence in the nursing profession would be undermined if it did not find the charges relating to dishonesty extremely serious.

5. *The panel made findings of impairment on grounds of public protection and public interest.*

Sanctions

6. *The NMC submits that the panel should consider the following to be aggravating factors in this case:*
    a. *Breach of the Interim Conditions of Practice Order*
    b. *Breach of Undertakings*
    c. *Potential risk of patient harm*
    d. *Lack of insight - findings by the panel*
    e. *Pattern of behaviour*

7. *The NMC submits that the breach of the ICOPO is a serious breach of trust and professional integrity, as it involves knowingly violating the NMC – imposed restriction and failing to inform an employer of the ICOPO placed on her practice.*

8. *If the panel considered charges 4,5, 6, 7, 8, 9, & 10 together as they all related to breaches of orders and /or dishonesty either to the registrant's employer or to her regulator. The panel determined that this was pre- medicated, repeated and persistent dishonesty over a period of 9 months during which the registrant worked 97 shifts.*

9. *The NMC submits that given the severity of this misconduct the likely sanctions will be at the higher end of the scale.*

10. *The NMC submits that the key factors which are apparent are:*
    a. ***Failure to complete patient records,*** *drug charts and clinical records. In respect of failures relating to record keeping*

- ***The absence of comprehensive clinical records*** *could have greatly impeded the ability to find out when the patients were next due their depot medications. The panel found that this added to the workload of your colleagues which could have put patients at risk of harm, as you left your colleagues with incomplete information with regards to medication administration records. This could have led to your colleagues to give medication to patients in overdose. The panel noted that both of these charges individually and cumulatively amounted to misconduct.*

b. ***Failure to comply with an NMC imposed Order*** *– the ICOPO is a regulatory measure and non – compliance undermines the NMC's authority and effectiveness;*
    - ***Deliberate and sustained breach*** *rather than a one – off mistake; working 97shifts whilst under a ICOPO indicating a prolonged breach of trust rather than an isolated incident*
    - ***Failure to disclose restrictions*** *to the employer indicates a lack of transparency and dishonesty;*
    - ***The duty of candour*** *requires honesty, and this breach erodes trust between health care professionals and their employers;*
    - ***Risk to patients and public confidence****, the conditions were imposed due to concerns about competence, safety or fitness to practice and could have put patients at risk of harm.*

c. ***Professional behaviour –*** *relating to charge 13 and sub – charges; the panel found that all aspect of this charge amounted to serious misconduct. The panel acknowledged that some parts of this charge, particularly the use of derogatory language, refusing a patient leave and not working co-operatively with your colleagues were extremely serious departures from behaviour expected of a registered nurse.*

Case Law

11. *The panel must apply the guidance alongside relevant case law that establishes key principles for sanction breaches involving dishonesty.*

    a. *Bolton v the Law Society* ***[1994] 1 WLR 512***

        - *Established the primary purpose of sanctions is not to punish but to maintain public confidence in the profession.*
        - *Application: The sanction must ensure that trust in the nursing profession is not undermined, even if no harm resulted.*

    b. *Cheatle v GMC* ***[2009] EWHC 645 (Admin)***

        - *Held that not all dishonesty warrants striking off. Especially where there is genuine insight and remediation*
        - *Application: if the registrant demonstrates genuine remorse and takes proactive steps to remediate, a sanction short of striking – off may be appropriate*

    c. *Parkinson v NMC* ***[2010] EWHC 1898 (Admin)***

        - *Established that dishonesty is particularly serious in a professional content, but tribunals must still assess the level of culpability, risk of repetition, and potential rehabilitation*
        - *Application: if dishonesty was not for personal gain, if the registrant has shown genuine remorse, and if they can be rehabilitated, a sanction less severe than striking – off may be proportionate*

    d. *GMC v Donadio* ***[2021]EWHC 562 (Admin)***

        - *in relation to the serious nature of deliberate breaches of interim orders.*
        - *If the panel is satisfied that the registrant has deliberately not complied with an order this is likely to call into question whether that person should remain on the register*

12. *The NMC submits that No Order, Caution Order, Conditions of Practice Order or Suspension Order are not appropriate in this case*

No further action (SAN-3a)

This would not be an appropriate sanction because of the seriousness of the concerns raised, the risks to patients in not completing the clinical records and the failure to ensure a patient had a proper assessment of itself are sufficient to warrant a more serious sanction, then added to this the breach of the ICOPO and undertakings means this course of action would not adequately protect the public from a significant risk of harm, nor would a member of the public properly informed for this case, accept this sanction as there is a need for the regulator to act to uphold proper professional standards.

Caution Order (SAN-3b)

This is the least restrictive order and would not be appropriate in this case because of significant risk of harm patients were put to by the registrant's actions, given their vulnerability and the impact of the actions could have had on the patients concerned. Further the total disregard for the ICOPO and undertakings put in place to safeguard the public, means this type of order would not reflect the wrongdoing, nor would it reflect the impact the registrant's action would have on the nursing profession, patients and the NMC. There is limited evidence of reflection for the initial regulatory concerns however, there is nothing regarding the failure to comply with the undertakings. Such an order would not adequately reflect the seriousness of the concerns, offer sufficient protection for the public, nor the NMC's objective to uphold proper standards in the profession or public protection.

Conditions of Practice Order (SAN-3c)

Conditions are used to address clinical concerns, which prior to the breach of the undertakings may have been an appropriate sanction that would have offered appropriate protection for the clinical matters raised. However, given the breach and total disregard the registrant appears to have for the ICOPO and undertakings that were put in place for the protection of the public, no conditions could be formulated to adequately protect the public or uphold proper standards within in the profession, given the registrants attitude to previous restrictions to her practice

Suspension (SAN-3d)

This order would be appropriate where there is a single incident of misconduct and there is no evidence of harmful deep-seated attitudinal concerns and no evidence of repetition. Further, there ought to be some insight and no indication of a significant risk of repeating the behaviour or a risk to patient safety. This order is unlikely to be appropriate when considering the number of shifts undertaken and/or booked by the registrant, and the failure to inform the employment agency or trusts of the ICOPO and undertakings in place. This is indicative of repetition and a complete disregard for the NMC as a regulator and the reasons as to why undertakings were put in place in the first place, to protect the public. This would be an insufficient sanction, to properly consider the seriousness of the charges in question, the impact on those concerned and the impact on the professions, such an order would not be in the public interest and would not uphold the proper professional standards of the profession, were honesty and integrity is the bedrock of the profession.

Striking-off (SAN-3e)

Whilst this is the most serious sanction it is appropriate when the concerns raised are fundamentally incompatible with being a registered professional. The concerns raised initially were due to clinical concerns and record keeping, however the breaches of the ICOPO and undertakings call in question the Registrant's professionalism, honesty and integrity and the trust that patients and colleagues would place on her and within professions.

The panel is invited to consider the following in 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?*
  NMC's guidance at SAN-2 sets out that where a nurse, midwife or nursing deliberately doesn't comply with an interim or substantive order this will be taken very seriously. This is because it is likely to show a disregard by that person for the steps the NMC has put in place to keep the public safe or uphold confidence in the professions. If the panel is satisfied that a nurse, midwife or nursing associate has deliberately not complied with an order this is likely to call into question whether that person should remain on the register. There can be no mistake as to the registrant's actions on the information, they accepted the undertakings and then wilfully disregarded them. The reasons they were in place was to protect the public from harm and to aid the registrant to demonstrate safe practice.

13. *There is limited insight shown from the Registrant, as to the clinical concerns and merely an apology for the breach of undertaking. There is no reflection dealing with the impact such actions have on the nursing profession. Further it is not simply one shift but multiple over time and an intention to undertake more shifts. The registrant was remorseful in her evidence and when questioned by the panel on what she can do differently, she stated that she will engage family support. She did not once consider the impact on patient care, the nursing profession and her regulator. It is also noteworthy that she could have sought for employment as a support worker, [PRIVATE]. She elected to breach the ICOPO and later booked shifts whilst subject to undertakings.*

14. *On consideration of the cases of GMC v Donadio [2021] EWHC 562 and Kuzmin v GMC [2023] EWHC 60 (Admin). It would appear these actions are fundamental incompatible with continued registration. The NMC role is to protect the public from harm and to uphold the professional standards and reputation of those on our register.*

15. *For these reasons, the NMC submits, strike – off is the only suitable sanction, given the reason the ICOPO and undertakings were in place for public protection and to ensure proper and professional standards were upheld. The FTPC must consider the gravity of evidence and the necessity of ensuring that such behaviour is not tolerated within the nursing profession.*

16. *NMC submits that the Striking – Off order adequately addresses the severity of the registrant's actions, to protect the public, in the public interest and the profession's integrity.'*

Mr McGettigan, on your behalf, submitted the following in a written form:

'Introduction

1. *Nine of the charges in this case were proved by way of admission. The majority of the remaining four charges, including their sub-charges, have been found proved against the Registrant. Three sub-charges within, namely 12(3), 12(4) and 13(g)(ii), were dismissed at the "no case to answer stage."*

2. *The Panel has found that the Registrant's actions constituted misconduct, save for charge 3, and that her fitness to practice is currently impaired.*

3. *These submissions will address the Panel's next task, which is to consider which sanction the Registrant should now face.*

4. *The Panel are asked to have regard to the content of previous written and oral submissions on impairment which cover some relevant matters therefore are not rehearsed herein.*

Sanction and Relevant Guidance Applied

5. *It is acknowledged that a sanction is required. It is acknowledged that a caution order may not proportionately address the findings in this case, and that the Panel will likely spend little time in deciding whether to impose a caution order, before moving upwards in ascending order through the available sanctions.*

6. *It is submitted that a conditions of practice order could proportionately satisfy any relevant concerns. It is acknowledged however that the Registrant has made this argument difficult by breaching a previously imposed interim order of this nature.*

7. *It is submitted that a suspension order would be an appropriate and proportionate outcome in all the circumstances of the case. It is contended that the Registrant should not face the most onerous sanction of a striking off order.*

8. *The Panel will be aware of the various caselaw and NMC Guidance on sanctions therefore this will not be rehearsed in detail herein, however the Registrant points to the following relevant sections of the NMC online guidance, and how they may be applied to her case.*

9. *The NMC Guidance indicates that some of the possible aggravating features are:*
   - *any previous regulatory or disciplinary findings*
   - *abuse of a position of trust*
   - *lack of insight into failings*
   - *a pattern of misconduct over a period of time*
   - *conduct which put patients at risk of suffering harm*

10. *There are no previous adverse findings of any nature, during all of the Registrant's time practicing as a nurse since 2014. It is submitted that there is a degree of insight into the failings on the part of the Registrant. Whilst the Panel have indicated that the insight is "limited" and at its early stages, it is submitted*

that there is not a "lack of insight." Whether or not the insight is imperfect and requires development, a degree of insight exists. It is contended that, for the majority of the offending, the conduct did not put patients at risk of suffering any specific identifiable harm.

11. *The Panel could consider whether there was an abuse of position of trust. It is submitted that where there was any abuse, the realisation of this came after for the Registrant, who did not deliberately set out to abuse her position. Thus, it is submitted, any abuse of position was inadvertent as opposed to consciously intentional.*

12. *The Panel will likely consider that the Registrant's actions represent a pattern of misconduct over a period of time. The only point that can be made with respect to this factor is that, prior to that identified pattern, there is no evidence of similar pattern/ss in the Registrant's relatively lengthy career. It may thus be submitted that this behaviour was out of character for the Registrant, and largely influenced by external personal factors.*

13. *The NMC Guidance breaks the potential mitigating factors into three categories:*

- *Evidence of the nurse, midwife or nursing associate's insight and understanding of the problem, and their attempts to address it. This may include early admission of the facts, apologies to anyone affected, any efforts to prevent similar things happening again, or any efforts to put problems right.*
- *Evidence that the nurse, midwife or nursing associate has followed the principles of good practice. This may include them showing they have kept up to date with their area of practice.*
- *Personal mitigation, [PRIVATE] and the level of support in the workplace.*

14. *It is submitted that all three of the above mitigating factor categories contain elements applicable to the Registrant's case. With respect to the first bullet point, it is submitted that the Registrant has displayed some insight and*

understanding in both her reflections and oral evidence. She has made attempts to address the problems, including through reflection and training. The Registrant admitted the majority of the facts at an early opportunity, and apologised to those affected (see Registrant Bundle 2 page 2 + R Bundle 1- pages 1-6).

15. *With respect to the second bullet point, the Registrant has not been permitted to work since the Interim Suspension Order of February 2024. The Registrant has however endeavoured to keep up to date with training, and has provided a number of documents in that respect (pages 3-6 and 15-18 of the Registrant bundle 2).*

16. *With respect to the third bullet point, it is submitted that it is clear that the Registrant had significant personal mitigation at the time [PRIVATE].*

17. *As above, the Registrant has no prior regulatory proceedings. The Registrant also has significant [PRIVATE] responsibilities. It is submitted that no patients were proven to have been directly harmed as a result of the Registrant's actions. It is submitted that the evidence of the risk of harm posed by the Registrant was largely limited and non-specific.*

18. *It is submitted that there is a high degree of mitigation in this case, and a low degree of aggravation.*

19. *It is acknowledged that the element that raises whether the Registrant's case should be placed into the "serious case" category is the breach/dishonesty. It is submitted that, although it lasted a period of time, this behaviour appears to be generally out of character. There is no evidence of prior dishonesty issues. The dishonesty must be considered alongside all the surrounding circumstances. Further, the NMC Guidance describes the most serious cases of dishonesty as, "when a nurse, midwife or nursing associate deliberately breaches the*

professional duty of candour to be open and honest when things go wrong in someone's care." It is submitted that this is not applicable, as the dishonesty did not take place when things went wrong in the Registrant's care.

20. *The NMC Guidance further states:*

Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*
- *direct risk to patients*
- *premeditated, systematic or longstanding deception*

Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *no risk to patients*
- *incidents in private life of nurse, midwife or nursing associate*

21. *It is submitted that the Registrant's dishonest conduct may fall into the latter "less serious" category, as most of the former bullet points do not neatly apply. The primary one which may be said to apply is "premeditated, systematic or longstanding deception." As above and before, it is submitted that the dishonesty was not necessarily thought out and planned out, it was impulsive*

and irrational, in circumstances where the Registrant "was not thinking straight" and "just doing things" (note of Registrant's oral evidence).

22. *In terms of the latter bullet points, it is submitted that, in the above circumstances, this was opportunistic or spontaneous conduct to an extent, with limited direct risk to patients. It is submitted that "no direct personal gain" is arguably applicable, because it is not the case that the Registrant was not permitted to work and earn money by the Conditions and Undertakings that were in place. The Registrant's breaches, and related dishonesty, related to her failures in open disclosure as required, and working in more than one setting (in short). It is also submitted that there were relevant incidents in the private life of the nurse, [PRIVATE].*

23. *The Registrant has also indicated regret and remorse, and sworn, under oath, that such conduct will never happen again. She described how she would approach matters differently now, in similar circumstances, and the lessons that have been learnt. The Registrant has indicated that experience is the "best teacher" (RB2 page 2). The Registrant made a number of pleas for mercy to the Panel during her oral evidence including:*

    I would really appreciate it. Give me a second chance. I will do whatever it takes to give you the confidence I can practice safely. To be able to fix all the errors that had come against me. I am willing to do whatever if required of me. I can promise I will do better. I won't have to come back here to sit down for the same issues.

24. *The NMC Guidance (SAN-2- 27/2/24) on "Considering sanctions for serious cases, includes with respect to dishonesty" includes, "Nurses, midwives and nursing associates who have behaved dishonestly can engage with the Fitness to Practise Committee to show that they feel remorse, that they realise they acted in a dishonest way, and tell the panel that it will not happen again." As per*

the above, it is submitted that the Registrant has actively done exactly that. The Guidance later states:

It is not the case that the Fitness to Practise Committee only has a choice between suspending a nurse, midwife or nursing associate or removing them from the register in cases about dishonesty. It's vital that, like any other case, the Fitness to Practise Committee should consider the sanctions in ascending order of seriousness, and work upwards to the next most serious sanction if it needs to.

Available Sanctions/ Outcome Submissions

25. *The Panel will likely consider that this is not a case where taking no action whatsoever is an option. The Registrant accepts that her behaviour was unacceptable, and will require to be marked by a sanction. Similarly, it is acknowledged that a caution order is not likely to be deemed sufficient to meet the justice of the matter.*

26. *The Panel should move through the sanctions from the lowest available in ascending order, and next consider a conditions of practice order. The NMC Guidance on the appropriateness of conditions of practice orders includes:*

The key consideration for the panel, before making this order, is ***whether conditions can be put in place that will be sufficient to protect patients or service users, and if necessary, address any concerns about public confidence or proper professional standards and conduct****.*

Conditions may be appropriate when ***some or all*** *of the following factors are apparent (this list is not exhaustive):*

- *no evidence of harmful deep-seated personality or attitudinal problems*

- *identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining*
- *no evidence of general incompetence*
- *potential and willingness to respond positively to retraining*
- *the nurse, midwife or nursing associate has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision*
- *patients will not be put in danger either directly or indirectly as a result of the conditions*
- *the conditions will protect patients during the period they are in force*
- *conditions can be created that can be monitored and assessed.*

27. *It is submitted that a number of the above factors are apparent. It is contended that this was out-of-character and there is no wider evidence of harmful deep-seated personality or attitudinal problems. It is submitted that there is no evidence of general incompetence. Limited issues have been raised with the Registrant's actual clinical/patient care abilities. A potential and willingness to respond to retraining has been indicated. Patients will not be put in danger as a result of conditions. It is submitted that stringent, tailored conditions could be put in place that would protect both patients and the public interest, and which can be monitored and assessed. The Registrant had indicated she would comply with any conditions considered appropriate. Such an order would give the Registrant hope that she can return to nursing, and thus her livelihood, can be protected.*

28. *The Registrant must acknowledge that the fact that she breached interim conditions of practice, makes a plea for a conditions of practice order all the more difficult. The best that the Registrant can do in this regard is indicate that the lesson has been starkly learnt, and issue an unequivocal promise to the Panel that if a conditions of practice order was imposed, it would be complied with, to the letter. The Registrant understands that, if given such an opportunity,*

and she breached an order in any shape or form, the consequences would be almost certainly the most serious consequences available.

29. *It is submitted that in all the circumstances of the case, including the nature and gravity of the allegations, considered against the Registrant's positive unblemished record before these allegations, a suspension order could be considered appropriate and proportionate. The Registrant has faced an interim suspension order for around a year now, and complied without issue. A further period of suspension, it is submitted, would reflect the gravity of the allegations, would protect patients and the public interest, and would ensure that a further deterrent is imposed to enforce the importance of the Registrant's compliance with restrictions, and the importance of her future positive behaviour.*

30. *The NMC Guidance on the appropriateness of suspension orders includes:*

Key things to weigh up before imposing this order include:

- *whether the seriousness of the case require temporary removal from the register?*
- *will a period of suspension be sufficient to protect patients, public confidence in nurses, midwives or nursing associates, or professional standards?*

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

- *a single instance of misconduct but where a lesser sanction is not sufficient*
- *no evidence of harmful deep-seated personality or attitudinal problems*
- *no evidence of repetition of behaviour since the incident*
- *the Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour*
- *in cases where the only issue relates to the nurse, midwife or nursing associate's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions*

- *in cases where the only issue relates to the nurse, midwife or nursing associate's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions*

  When considering seriousness, the Fitness to Practise Committee will look at how far the nurse, midwife or nursing associate fell short of the standards expected of them. It will consider the risks to patients and to the other factors above, and any other particular factors it considers relevant on each case.

31. *The Panel might consider that the seriousness of the case requires temporary removal from the register. Where that is the case, it is submitted that a further period of suspension would be sufficient to protect patients, public confidence in nurses, and professional standards.*

32. *It is submitted that there are insufficient grounds for imposing a striking-off order. It has to be acknowledged that the NMC Guidance on "Considering sanctions for serious cases" (SAN-2, 27/2/24) includes, "If we are satisfied that a nurse, midwife or nursing associate has deliberately not complied with an order this is likely to call into question whether that person should remain on the register." There is similar wording therein for breaches of Undertakings. The Registrant is therefore acutely aware of the fact that such a sanction is on the table for the Panel to consider. The wording of the guidance is clear though, this type of action calls "into question" whether the person should remain on the register, that is the question the Panel must now wrestle with. There is no set rule that breaches of orders or undertakings must result in striking off orders. This is the focus of the Registrant's case and submissions, and this potentiality represents the looming possibility which the Registrant desperately fears. The Registrant urges the Panel to temper justice with mercy, and impose a suspension order, permitting her the opportunity to continue her path of reflection and remediation, before ultimately returning to the nursing register.*

33. *The NMC Guidance includes, "This sanction is likely to be appropriate when what the nurse, midwife or nursing associate has done is fundamentally incompatible with being a registered professional." It is submitted that the Registrant's conduct, whilst admittedly highly serious and entirely unacceptable, was not necessarily such that it is fundamentally incompatible with being a registered professional.*

34. *In case this submission is not accepted however, I will address the key questions which the NMC guidance suggests the Panel should take into account, in terms of striking-off orders:*

- *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
- *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate 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?*

35. *In terms of professionalism, there have been limited concerns raised about the Registrant's actual clinical practice, and professionalism in that respect. In terms of this particular behaviour, the Registrant admitted most of it an early opportunity. It has never featured in her prior history. The Registrant engaged with all proceedings. In short, there are not* ***fundamental*** *questions about her professionalism.*

36. *It is submitted that, in light of the complexion, context and circumstances of these allegations, public confidence could still be maintained, if the Registrant is not removed from the register, and faces a lesser sanction, in particular a suspension order. The Registrant has already been suspended for a year. Where an additional suspension order is imposed, public confidence could be maintained in the sense that an ordinary reasonable member of the public may*

acknowledge that a prevention from nursing for a period of years is a reasonable and proportionate response, with far-reaching adverse consequences upon the Registrant at fault.

37. *It is submitted that striking off is not the only sanction sufficient to protect patients, members of the public, or maintain professional standards, in all the circumstances. Lesser sanctions (in particular a suspension order) would be sufficient to address these issues. A suspension order has been sufficient to protect patients, the public, and professional standards, over the last year.*

38. *It is submitted that striking off should be a last resort, and the high thresholds for its imposition, have not been met.*

39. *Whilst the Registrant is "not perfect", as she candidly acknowledged, the fact that she worked for many years without incident or issue before these allegations, including 4 years in a full-time post, might suggest that there is some truth in her averments that she is a "competent" and "caring" nurse. There is some evidence within the papers of positive commentary, such as the glowing testimonial … . It is submitted that to remove the Registrant entirely from the register, might not only deprive the Registrant of her livelihood, but also patients, staff, and the public in general, of a competent and caring nurse.*

<u>Proportionality</u>

40. *In considering sanction, the Panel has to be mindful of the NMC guidance on proportionality identified at the outset of "Factors to consider before deciding on sanctions" (SAN-1, 2/12/14) which includes, inter alia:*

The Fitness to Practise Committee has to be proportionate when making decisions about sanctions. It's under a legal duty to make sure that any

decisions to restrict a nurse, midwife or nursing associate's right to practise as a registered professional are justified.

To be proportionate, and not go further than it needs to, the Committee should think about what action it needs to take to protect the public and address the reasons why the nurse, midwife or nursing associate is not currently fit to practise.

They should consider whether the sanction with the least impact on the nurse, midwife or nursing associate's practice would be enough to achieve public protection, looking at the reasons why the nurse, midwife or nursing associate isn't currently fit to practise and any aggravating or mitigating features.

41. *It is submitted that when considering which sanction to impose, and considering proportionality, the Panel should also factor in the Registrant's personal circumstances, and the impact of the sanction. Same include but are not limited to the following:*

(i) [PRIVATE].

(ii) The Registrant must discharge the typical monthly expenses that most people face such as rent, gas, electric, council tax etc. and must discharge them [PRIVATE].

(iii) [PRIVATE]

42. *It appears evident that where the Registrant was to face a striking-off order, this could have a devastating impact upon not only her, but also her family, [PRIVATE]. The adverse impact could be immeasurable, [PRIVATE]*

43. *On the other hand, a <u>suspension order</u>, whilst clearly depriving the Registrant of relevant and reasonably remunerated employment for a further period of time thus having its own significant adverse impact, would not close the door to nursing for the Registrant. It would give her an end time to work with and work towards. This could operate as a motivating factor, but also allow the Registrant*

to plan and regulate her financial affairs, and consider her future and the future of the children.

44. *It is submitted that the Panel should factor in the above important personal factors, when approaching the issue of proportionality, with caution and sympathy. The Panel are respectfully urged to temper justice with mercy, and give the Registrant the "second chance" which she desperately seeks. The Registrant has indicated that, if given that opportunity, she will prove herself, and will never be back before a Panel or Committee again.*

45. *The Panel are asked to factor in the circumstances and context surrounding these incidents, as detailed in previous written submissions on impairment. The Panel are asked to give significant weight to the fact that the Registrant has accepted the majority of the matters including the most serious matters at an early opportunity, and has demonstrated some insight, remorse and remediation. It is submitted that an ordinary member of the public, with full knowledge of everything that the Panel have knowledge of now, could have a degree of sympathy for the Registrant, and might not be concerned where the Registrant was ultimately permitted to continue practicing, with an appropriate and proportionate restriction/sanction in place (in particular a suspension order).*

<u>Conclusion</u>

46. *It is respectfully urged that, in light of all of the aforementioned, and in all of the circumstances of the case, the Registrant is dealt with as leniently as possible.*

47. *It is submitted that a conditions of practice order could cover any risks perceived by the panel. It is acknowledged that the Panel might be circumspect about such an order given the history. The Registrant assures the Panel, that if*

they are minded towards a conditions of practice order, she will fully engage and comply with any conditions considered appropriate.

48. *The focus of these submission is respectfully urging the Panel to impose a suspension order in this case. As above, this could give the Registrant some hope and motivation that she can return to nursing, which is her passion. It would give her an end goal to work towards, and an opportunity to prove herself. The Registrant issues a final plea to the Panel, to give her that opportunity.*

49. *It is submitted that a striking off order, in all the circumstances of the case, would be disproportionate. The Registrant fearfully acknowledges the risk of this sanction being imposed, and respectfully urges the Panel away from it. The Registrant indicates, as before, that nursing is what she wanted to do from a young age, and that despite her inexcusable mistakes, she is a caring and competent nurse with a lot left to give to the public. She respectfully urges the Panel not to close that door of nursing to her at this stage.'*

Decision and reasons on sanction

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

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose on you. 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:

1. Your actions were a breach of the interim conditions of practice order placed on your practice;
2. Your actions led to a potential risk of patient harm;
3. You obtained work under false pretences;
4. You have shown limited insight into your failings;
5. Your actions were premeditated and sustained over a lengthy period of time;
6. Your actions resulted in extra-workload being placed on your colleagues in an already over-stretched environment;
7. Your actions resulted in a breach of trust in relation to your dealings with patients.

The panel also took into account the following mitigating features:

1. You admitted to some of the most serious charges at the earliest opportunity;
2. You have presented some efforts in respect of retraining;
3. [PRIVATE].

The panel considered the seriousness of this case and noted that it relates to both dishonest actions and the breaching of interim conditions of practice order and undertakings. The panel considered this to be at the higher end of the spectrum of seriousness. The panel has found that your dishonesty was premeditated, deliberate, and continued for a substantial period of time. The breaching of your interim conditions of practice order and undertakings showed a blatant disregard for your regulator and had a potential to put patients at risk of harm.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of*

impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that your misconduct was not at the lower end of the spectrum. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel further considered your dishonesty alongside your deliberate breaching of your interim order; it noted that this calls into question whether or not you would comply with any further conditions of practice. The panel noted that you have shown a pure disregard for the steps the NMC have taken thus far in order to protect the public and to also uphold their confidence in the NMC as a regulator. The panel noted that you have not complied in the past with your interim conditions of practice order or the undertakings, and therefore, there is no evidence that you would comply with a newly imposed conditions of practice order.

Consequently, the panel determined that a conditions of practice order would not be sufficient or appropriate when considering the public interest.

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

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

The panel determined that your actions were not a single account of misconduct. It determined that you present a clear attitudinal issue, have not displayed sufficient insight and that there is a risk of repetition of your behaviour.

The conduct, as highlighted by the facts found proved, was a very serious departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by your actions are fundamentally incompatible with you 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?*

Your actions were attitudinal in nature and were a very serious departure from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were so serious, that, to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a

striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

Dr Persaud submitted that an interim suspension order for a period of 18 months should be imposed in order to cover any possible appeal period. She submitted that this order is necessary on the grounds of both public protection and the wider public interest.
Mr McGettigan did not provide any submissions in relation to an interim order, and consequently, did not oppose the application made by Dr Persaud.

Decision and reasons on interim order

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

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the

facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

The interim suspension order will take immediate effect. If no appeal is made 28 days after you are sent the decision of this hearing, the interim suspension order will be replaced by the substantive striking-off order.

That concludes this determination.